STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey, and complaint investigation on 3/08/17, 3/09/17, 3/10/17 and 3/13/17 and 3/14/17.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure Tuberculosis (TB) disease testing had been completed upon admission for 2 of 6 (#1 and #4) sampled residents in compliance with the control measures adopted by the Commission for Health Services. The findings are: 1. Review of Resident #1's current FL-2 dated 05/05/16 revealed: -Diagnoses included hypertension, glaucoma and hyponatremia (low sodium in the blood). -The resident's admission date was listed as 05/12/15. Review of Resident #1's Resident Register did not reveal an admission date.	D 234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 234	Continued From page 1 Review of Resident #1's tuberculosis (TB) skin testing on 03/08/17 revealed: -There was a TB skin test given on 06/16/15 and read as negative on 06/18/15. -There was no other documentation of a TB skin test. Interview with Resident #1 on 03/08/17 at 02:37 pm revealed that she was unsure of when her last TB skin test was done. Refer to interview on 3/09/17 at 11:10 a.m. with the Health Services Director (HSD). 2. Review of the FL-2 dated 1/16/17 for Resident #4 revealed: - Diagnoses included Dementia, Disorientation, Anxiety, Expressive Aphasia, Glaucoma, Chronic Atrial Fibrillation, Hypothyroid, Acute Cystitis, and Glaucoma. - Left eye blindness and wanderer were listed. Review of the Resident Register for Resident #4 revealed: - There was not a date of admission listed. - The Resident Register was signed and dated on 6/16/16. Review of TB skin testing for Resident #4 revealed: - TB skin testing was placed on 6/08/16 and read as 0 mm - negative, on 6/10/17. - There was no documentation of another TB skin test in the resident's record. No TB skin testing was provided by the end of the survey. Refer to interview on 3/09/17 at 11:10 a.m. with	D 234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 234	Continued From page 2 the Health Services Director (HSD) _____ Interview on 3/09/17 at 11:10 a.m. with the HSD revealed: - Usually a resident was admitted with TB skin testing prior to admission. - The facility nurse completes TB skin testing when residents are admitted on her regular visits to the facility. - The HSD completed a list of residents for TB testing for the facility nurse to obtain. - The nurse completed the TB testing and the HSD keeps copies of the testing and results sheets in a folder and another copy goes into the resident record. - She was not aware TB skin testing was missing for Resident #1 and Resident #4. - She did no know how these TB skin tests were overlooked and or missing. - The TB skin test system would be reassessed and improved.	D 234		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to provide supervision for 1 of 6	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 270	Continued From page 3	D 270		

sampled residents in accordance with their assessed needs and current symptoms related to multiple falls which resulted in a serious injury of multiple fractures of the right arm and right leg. (Resident #6). The findings are:

Review of the record for Resident #6 revealed there was not a Resident Register.

Review of the current FL-2 dated 8/12/16 for Resident #6 revealed:
- Diagnoses of dementia, right sided hemiparesis and hyperlipidemia.
- The resident was intermittently disoriented.
- The resident was listed as semi-ambulatory.
- The resident had a functional limitation with speech.

Review of Resident #6's Assessment and Care Plan dated 8/08/16 revealed:
- The resident had right sided hemi-paresis.
- The resident was sometimes disoriented and memory was forgetful and needed reminders.
- The Activities of Daily Living section revealed the resident needed extensive assistance with toileting, bathing, dressing, and transferring from staff.
- The resident required limited assistance with ambulation as needed.

Review of a Licensed Health Professional Support review (LHPS) for Resident #6 dated 1/17/17 revealed:
- The resident's personal care tasks included staff stand-by transfers.
- He required assistance with an assistive device (wheel chair).
- Ambulates with wheel chair.
- He required dressing changes, nebulizer treatments and heat therapy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 270	Continued From page 4 Review of an Accident/Incident Report for Resident #6 dated 1/08/17 at 11:58 a.m. revealed: - The Assistant Director of Health Services (ADHS) found the resident on the floor. - The resident was sitting up and said he had tried to transfer himself from the bed to the wheel chair. - No injuries were found. - The physician and family were notified. Review of an Accident/Incident Report for Resident #6 dated 1/18/17 revealed: - The resident was found on the floor of the living room - an unwitnessed fall. - No injuries were noted. - The physician and family were notified. Review of an Accident/Incident Report for Resident #6 dated 1/23/17 at 8:30 p.m. revealed: - While completing rounds on residents, the supervisor found the resident on the floor beside his wheel chair. - The resident had a large bruise on his right arm and left hand. - The home health nurse would be called to check the resident. - The physician and family were notified with no new physician orders obtained. Review of an Accident/Incident Report for Resident #6 dated 2/15/17 at 6:10 p.m. revealed: - The resident was found sitting on the floor next to the wheel chair. - He stated he was going to transfer himself from the wheel chair to the chair. - The chair slid out backwards and he fell between the chair and the couch. - Small skin tears were sustained.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 270	Continued From page 5 - The physician and family were notified. - Physician orders for wound care would be faxed to the facility. - Facility staff would "Keep watch on him throughout the shift and pass to the next shift to continue to monitor." Review of an Accident/Incident Report for Resident #6 dated 2/16/17 at 9:45 p.m. revealed: - A personal care aide went to check on the resident. - The resident was found on the bathroom floor. - The resident told her he fell off of the toilet. - No injuries were noted from the fall. - The physician and family were notified. - No orders were obtained from the physician. - It was passed to the next shift to monitor the resident. Review of accident and incident report dated 2/1717 at 11:45 a.m. filed by the same MA revealed: - Resident #6 was found on the floor in the bathroom. - The resident "...was not feeling well and was very pale." - Blood pressure was 176/94 and pulse was 101. - Had skin tear on right forearm. No other injuries were observed. - The resident was transferred by emergency medical service to the hospital. - The physician and family were notified. - No new orders were received from the physician. Review of an Accident/Incident Report for Resident #6 dated 2/22/17 at 2:25 p.m. revealed: - Report filed by the AHSD revealed an aide notified she needed help with Resident #6. - The aide said the resident fell.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 270	Continued From page 6	D 270		

- The resident was found on the floor of his bathroom in front of the toilet.
- His right arm was stuck in the handicapped hand rail and the left foot was under him.
- His arm was bleeding and open."
- "Right arm is injured really bad. Transported to emergency room.
- Physician and family were notified.

Record review for Resident #6 revealed there was no documentation of a fall risk assessment or plan of care related to prevention of falls.

Review of facility Nurse's Comments computerized notes revealed:
- On 2/15/17 at 8:10 p.m. notes revealed the resident had been combative and aggressive with staff.
- On 2/17/17 at 12:29 p.m. the resident went from there assisted living to the hospital.
- On 2/20/17 at 11:29 a.m. note revealed the resident returned from the hospital.
- On 2/22/17 at 3:05 p.m. notes revealed the resident fell in the bathroom and his right arm was stuck on the hand rail by the toilet and was transported to the hospital.

Review of the hospital discharge summary for Resident #6 dated 2/19/17 revealed:
- The resident was admitted on 2/17/17 and discharged on 2/19/17.
- Discharge diagnoses revealed acute lack of blood flow in the left brain with prior evidence of blood flow blockage on both sides; dementia, accelerated hypertension and benign prostate hyperplasia.
- Based on a ultrasound scan the carotid artery system had severe blockage.
- The resident was to be referred for physical therapy (PT)/occupational therapy and could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 270	Continued From page 7	D 270		

participate in activity as tolerated.
- Follow-up with the vascular physician and primary care physician

Review of in hospital physical therapy evaluation dated 2/18/17 included:
- Plan for decreased functional mobility, PT scheduled for return to assisted living.
- Resident had decreased mobility, impaired bed mobility, transfers, recurrent falls, chronic weakness head injury (years ago) .
- "Pt [patient] will benefit from increased level of care at return to [assisted living facility] with transfers and toileting and HHPT [Home Health Physical Therapy]."
- Family prefers return to assisted living facility rather than skilled nursing for familiar environment and staff would be able to increase level of care/supervision as needed.
The resident would require falls precautions.

Interview on 3/14/17 at 1:10 p.m. with the in hospital PT revealed:
- Resident #6 was weakened from the stroke and would need PT at the assisted living facility.
- The resident would need more assistance with transfers as the right leg was weakened and the strength in the right arm was diminished as well.
- Family wanted the resident to come back to the assisted living facility because staff could give the care needed.
- Family refused skilled nursing after discussion.

Hospital record from admission and hospital course on 2/22/17 after fall injury were not available.

Telephone interview on 3/10/17 at 11 a.m. with Resident #6's family member revealed:
- Resident #6 had been living in the facility for a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 270	Continued From page 8	D 270		

few years.
- Recently he had been having frequent falls.
- He was not very mobile with his right side prior to the current falls from an accident years ago.
- He could still bend his leg and use his right arm to move.
- He had been able to transfer himself previously from walker to wheel chair to couch and to the toilet even though his right leg was unsteady.
- This was prior to this last fall with the recent stroke.
- He had a number of falls recently leading up to the last two incidents, and the last one with the fractures of his arm and leg.
- Around 2/16/17 or 2/17/17 he could not communicate verbally what was going on very well.
- He could not move his right leg as well as before.
- She and an personal care aide had to lift the resident from the wheel chair to the living room chair.
- The facility sent him to the hospital and he was diagnosed with a stroke that affected the right side.
- He was sent back to the facility after a couple of days.
- The family member did not expect one on one care, but thought the facility would increase supervision and assistance based on his right leg being even less mobile than before.
- The family member was very familiar with what type of supervision and care assisted living facility's would provide.
- When the arrived back at the facility, another family member told the staff at the facility nurse station that the resident would need increased supervision due to the stroke and his right side being worse than before.
- She thought the facility should "Keep an eye on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 270	Continued From page 9	D 270		

him.", toilet him, ensure he had his call bell.
- He fell in the bathroom the next day and fractured his right arm, both bones, and his leg.
- His right arm was caught in the safety railing and he was stuck between the toilet and the wall with the railing.
- Facility staff were unable to get him out. Emergency medical assistance arrived and got him out from between the wall and the toilet.
- He required surgery at another hospital.
- The surgery consisted of pins and plates in both extremities.
- He was now in a rehabilitation facility.

Telephone interview on 3/13/17 at 10:45 a.m. with a second family member frequently contacted by the facility revealed:
- Prior to the recent stroke in February 2017, the resident could get in and out of the wheel chair himself and toilet himself.
- The resident needed bathing assistance.
- In February 2017 the resident had changes in his speech and his face was drawn on one side and his right side was weaker at the time of the recent stroke before the fall injuries a few days later.
- The supervisor and another family member noted this and sent him to the hospital on around 2/17/17.
- He had tests and it was found he had a stroke.
- The resident had physical therapy while in the hospital and was to have continued physical therapy when he returned on 2/20/17
- Upon returning to the facility, family members told staff the resident would require more assistance.
- Within a couple of days of return to the facility, the resident tried to go to the bathroom and did not have assistance.
- On 2/22/17, Resident #6 sustained a fractured

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 270	Continued From page 10	D 270		

arm in two places with pins and wires now on the outside of his arm and plates placed on the two fractures in his right leg from the attempted self transfer on his recent increased weakened leg from the stroke.
- The hospital indicated the resident had four blood transfusions after surgery.
- The resident had surgery and was now in a rehabilitation facility.
- They had not been asked about obtaining one on one sitter assistance.
- The family thought the assisted living facility would have provided more assistance for Resident #6 as they requested upon his return after the stroke.
- The family member had great concern the resident was not watched like they told the facility.
- The family thought assisted living would provide the necessary asstance for the resident.

Interview on 3/10/17 at 3:20 p.m. with the Director of Health Services (DHS) related to falls revealed:
- Resident #6 had some recent falls.
- The resident had a stroke in February 2017 and went to the hospital for evaluation and returned to the facility.
- The DHS usually conducted an evaluation of a resident prior to a resident returning from hospital to ensure facililty could meet the care needs.
- She was not able to asses the resident prior to return as he was brought back first thing in the morning of the day of return.
- The resident was to return on the weekend but was held over by consult with a physician. and there was no one at the facility to do an assessment on the weekend.
- She knew he was weaker and required transfers and toileting by report of staff.
- She did not specifically assess the resident's needs upon returning from the hospital after the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 270	Continued From page 11	D 270		

stroke.
- There was not a specific plan for the resident to ensure increased assistance such as set check times other than the usual every 2 hours.
- She did not have a plan in place to ensure staff were aware of the care needed to supervise the resident to prevent falls and injury.
- The facility did not have a specific falls precaution program in place.
- Upon return from the hospital, staff knew to "watch the resident".
- The facility did not use bed or chair alarms and were a restraint free facility.
- She was aware the family had requested an increased assistance level.
- It was not in their policy to provide one to one sitter care service.
- This was not indicated in the facility contract for residents.
- Usually, the family would engage a sitter for as much time as they wanted.
- One to one assistance was not discussed with the family when he came back from the hospital after the stroke.
- A couple of days after the resident came back from the hospital for a stroke evaluation, he had an unwitnessed accident/fall, fractured his arm and went back to the hospital.
- The resident was not in the facility at present.
- He had been admitted to a rehabilitation center secondary to a stroke leading to the fall with injuries of serious arm and leg fractures.

Interview on 3/10/17 at 4 p.m. with the AHSD revealed:
- Resident #6 had a weak right leg and side when he came to the facility a few years ago.
- Usually the DHS would assess a resident before returning to the facility for care needs.
- She was not aware of the resident having an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 270	Continued From page 12	D 270		

assessment before or after return to the facility.
- The resident had never used his call bell the whole time he had been in the facility.
- The call bell was placed near the resident and the one in the bath room was next to commode.
- All call bells and emergency alarms were in working order.
- Many residents were using their call bells and staff had been answering them.
- The resident was encouraged to use the bell to call staff to help with toileting and transfers.
- The resident was very independent and would refuse assistance for personal care - bathing dressing and for toileting and transfers.
- The resident would go to the bathroom and try to transfer on his own without calling.
- He did not call for help after the stroke.
- Staff checked on the resident as all residents were checked on every 2 hours and with more checks than every 2 hours when they could to provide assistance.
- Nursing assistants would check and try to assist him with help to the bathroom but he would refuse on many occasions.
- After the first hospitalization on 2/17/17, the resident was returned to the facility on 2/20/17.
- A family member informed care staff members that the resident would require increased supervision as he had a stroke and his right side was even weaker than before.
- The facility did not have a policy for one on one sitter care. The family would have to obtain a sitter for as much time as they wanted.
- The nursing assistants would try to keep residents with a risk of falling near the front at the nurse station and in the living room at the facility entrance.
- Nursing Assistants (NA) were to assist the resident as he was weaker with transfers, continue every 2 hour checks for toileting, and as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 270	Continued From page 13	D 270		

often as they could, check on the resident.
- He continued to refuse help and would become combative.
- On 2/22/17 at around 2:30 p.m., a nursing assistant called out for help when she found the resident's arm caught in the handicapped railing next to the commode in his bathroom.
- The AHDS found him on the floor with his leg under him and his open and bloody arm caught in the handicapped railing and the wall.
- The resident was next to the commode and the commode raised seat with arm rests.
- She and staff could not get his arm out from between the handicapped railing and the wall.
- Emergency medical services were called and when they arrived, they got the resident's arm out and put a splint sling on it.
- The resident was transferred to the hospital.
- The resident was now in a rehabilitation facility after surgery on his arm and leg. Both were fractured.

Interview on 3/13/17 at 3:32 p.m. with the Administrator revealed:
- Staff should assist residents based on current symptoms and assessed needs.
- Residents would be assessed for return back to the facility based on a longer stay such as at a rehabilitation center prior to return to the facility to assess if the facility could meet the residents needs and current symptoms.
- Short stays at the hospital, such as 1- 3 days, would be assessed after return to the facility.
- He was not aware of an assessment for Resident #6 after his return from the hospital for stroke evaluation after a couple of days.

Interview on 3/14/17 at 9:50 a.m. with an NA revealed:
- Resident #6 stayed mostly in his room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 270	Continued From page 14 - He never used his call bell. We would not know if he needed assistance. - The resident could transfer on his own. He could transfer, pivot and use the commode. - Checked every 2 hours for need of toileting. She checked on him other times as well. - The resident was very independent. He wanted to do for himself. - The resident refused assistance every time and would get upset and refuse assistance. - She was not aware of any changes in supervision for Resident #6's assistance needs after return from the first hospitalization for the stroke. Interview on 3/14/17 at 11:10 a.m. with a second NA revealed: - She provided personal care on occasion to Resident #6. - The resident could feed himself, try to do everything for himself. - The resident could transfer and toilet himself prior to the recent stroke. - The resident was very independent and stubborn when offered assistance. - The resident was checked every 2 hours, like all residents. - There was no information given to her about any changes in the care to be provided for Resident #6 after the stroke on 2/17/17. - She was working on the day the resident broke his arm but was not providing personal assistance that day. Interview on 3/14/17 at 2:45 p.m. with a third NA revealed: - The NA worked some first and second shifts. - Resident #6 had stayed in his room a lot. - The resident was never known to use the call bell for assistance. He was shown where it was,	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 270	Continued From page 15	D 270		

but he never used it.
- He was very independent with transfers and toileting and feeding. He needed some help with bathing.
- He cared for himself as much as possible.
- He would get combative with staff if he did not want assistance which was most of the time.
- The NA checked on the resident every 2 hours as usual after he came back from the hospital after the stroke.
- No information was given to her regarding a change in his care checks for assistance needed due to his stroke.

Interview on 3/14/17 at 3:55 p.m. with a supervisor/ MA on the evening shift revealed:
- The supervisor/MA was working on the day Resident #6 came back from the hospital from the stroke.
- The day the resident returned from hospitalization after the stroke, the family had given facility staff information for him to have more assistance.
- The increased assistance according to the family was with his toileting, transfers, standing and pushing in the wheel chair and other activities of daily living due to the increased weakness on his right side.
- The resident may or may not tell staff if he needed to toilet.
- He was never known to use the call bell even after return from the hospital for stroke evaluation.
- He had be very independent and mostly refused care offered.
- She had not told staff about the resident's needed for increased assistance.
- The staff made every 2 hour rounds on the resident after the stroke and occasionally take him in the wheelchair to the front.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 270	Continued From page 16	D 270		

- Nursing assistants would follow the usual protocol to bring the residents needing observation to the front living room near the nurse station and or right in front of the nurse station.
- There were no instructions from management related to facility staff providing one on one continuous care for Resident #6 .
- A sitter would have to be provided for that constant care.
- That would be decided by the DHS.

Review of the February 2017 personal care service logs revealed:
- Nursing Assistants provided bathing, dressing and toileting when the resident allowed them to help.
- Resident checks were only documented on the forms for toileting every 2 hours.

Telephone interview on 3/14/15 at 5:20 p.m. with Resident #6's physician revealed:
- The physician was notified of the resident's recent frequent falls and then transfer to the hospital for evaluation of a stroke.
- He did not know the extent of the injuries with the fall in the bathroom.
- He did not know about the resident's surgeries with the injuries sustained on about 2/20/17 when he went to the hospital because the resident went on to a rehabilitation center when discharged from the hospital.
- HE said by description of the family, the resident had external stabilization of the two arm bones fractured.
- The resident had a severe brain injury many years ago from a motor vehicle accident.
- He has been very close to being non-verbal all of these years.
- The decades of his dementia and poor cognition would have surely kept him from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 270	Continued From page 17 remembering to use the call bell for assistance. - He would think after the stroke he would have required increased assistance with standing, transfers, toileting, dressing, bathing and ambulation. _____ The facility failed to provide supervision for Resident #6 with dementia, disorientation, previous right sided hemiparesis, six falls from January 2017 - February 17, 2017 leading up to increased right sided weakness after a recent stroke and with a subsequent unsupervised fall with injuries during attempted self transfer for toileting. The fall caught the resident's arm in the handicapped hand rail next to the toilet; he fell to the floor next to the wall, toilet and the riser toilet seat arm rails which resulted in a badly badly fractured arm. The resident sustained multiple leg and arm fractures requiring surgery with external stabilizers and blood transfusions. The failure of the facility to assure supervision based on assessed needs and current symptoms resulted in serious physical injury to the right arm and leg of Resident #6 and constitutes a Type A1 Violation. _____ Review of the facility's Plan of Protection dated 3/14/17 revealed: - Residents will be assessed before or upon return of a hospital or rehabilitation unit stay by the HSD/AHSD to determine care needs. - Staff will be informed on all care needs of the residents. - Based on needs and current symptoms, residents will be monitored every 30 minutes to an hour any nursing assistants on duty. - HSD will schedule a staff meeting to ensure all staff are familiar and up to date on Policy and	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 270	Continued From page 18 Procedures of personal care and supervision. - HSD/AHSD will do chart review and assess residents every quarter for any changes. - HSD/AHSD will monitor every couple of days to assure staff is complying with care orders. - HSD will assess charts of residents recently returned to the facility to assess the care of residents. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 13, 2017.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to report elevated blood sugars (BS) and that ordered insulin was available for 1 of 1 (#2) sampled residents as ordered by the prescribing physician. The findings are: Review of Resident #2's current FL-2 dated 02/23/17 revealed: -Diagnoses included diabetes mellitus Type 2 and hypertension. -An admission date was listed as 03/30/15. Review of Resident #2's Resident Register	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 273	Continued From page 19 revealed the admission date was not listed. Review of Resident #2's phyisician orders revealed: -An order, written by a local endocrinologist, dated 08/03/16 for fingerstick blood sugar (FSBS) checks before each meal with Humulin R insulin based on the results of the FSBS. -The insulin dosage was: if blood sugar (BS) was 150-199 1 unit, if BS was 200-249 2 units, if BS was 250-299 3 units, if BS was 300-349 4 units, if BS 350-399 5 units, if BS 400-449 6 units, if BS 450-499 7 units, if BS 500-549 8 units. -If the FSBS was 400 or higher, the physician was to be called. Review of the January 2017 electronic medication administration record (eMAR) for Resident #2 revealed: -On 01/04/17 at 12 noon, the BS was 460. -On 01/08/17 at 12 noon, the BS was 412. -On 01/08/17 at 5:30 pm, the BS was 524. -On 01/09/17 at 12 noon, the BS was 507. Review of the February and March 2017 eMARS did not reveal a recorded FSBS of 400 or greater. Interview with a Medication Aide on 03/10/17 at 10:46am revealed: -All documentation was done electronically as a clinical note. -If a physician was called about a resident's BS, it should be documented. Interview with the facility's Health Service Director (HSD) on 03/10/17 at 10:58am revealed: -The physician should have been notified of the resident's elevated blood sugars. -She could not explain why the physician had not been notified.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 273	Continued From page 20 -Documentaion of all telephone calls to physicians should be done electronically. Review of the electronic clinical notes for Resident #2 for January 2017 revealed no documentation the physician was notified of the four blood sugars that were greater than 400 and the Humulin N insulun was not available in the facility to be administered. Telephone interview with Resident #2's primary care physician's nurse on 03/13/17 at 2:55pm revealed: -She did not see any reports from the facility of elevated BS in the resident's record. -The resident's insulin orders were written by the endocrinologist -She could not find a copy of the endocrinologist's insulin orders for the resident. -The primary care physician referred all diabetic care to the endocrinologist. Telephone interview with a local endocrinology practice on 03/13/17 at 3:00pm revealed: -The physician who wrote the 08/03/16 order had moved out of state in October 2016. -The resident had a follow-up appointment scheduled in November 2016 but it was canceled by the resident's family member. -A follow-up appointment for the resident had not been scheduled. -The resident was last seen by the practice in September 2016. -The practice had not been notified of the resident's elevated BS. Interview with the HSD on 03/14/17 at 10:31am revealed: -Family members transported residents to specialist medical appointments.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 273	Continued From page 21 -The resident was taken to an appointment on 01/19/17 by a family member. -The Health Services Director thought the appointment on 01/19/17 was with the endocrinology practice listed in the medical record. -The family member did not bring any new orders back from the appointment. Telephone interview with Resident #2's family member on 03/13/17 at 5:17pm revealed: -After the resident's physician left the local endocrinology practice, the resident and family members decided to change physicians. -The family member had taken the resident to the 01/19/17 appointment. -She had not taken any medical records with the resident to the appointment. -She was not given any orders to return to the facility. Telephone interview with Resident #2's current endocrinology physician's nurse on 03/14/17 at 10:20am revealed: -A family member had accompanied the resident to the 01/19/17 appointment. -The physician had explained the laboratory results and plans of treatment to the family member. -If a release of information form was completed by the facility and sent to the new physician, any new orders would be provided. -The physician had not known the resident resided in an adult care facility. As of exit, no new orders had been sent to the facility. _____	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 273	Continued From page 22 The facility failed to notify the physician, per orders, when Resident #2's blood sugar level exceeded 400 on 4 different occasions when the ordered insulin was not available on 3 of the 4 occasions in January 2017. The facility's failure to not contact the physician resulted in the resident's blood sugar remaining dangerously high which was detremential to the the health, safety and welfare of the resident. Review of a Plan of Protection completed 03/14/17 revealed: -The Health Service Director and the assistant Health Service Director will review all diabetic resident's orders to verify parameters with the most current medication orders. -The Health Service Director will arrange for a review of diabetic care for all staff. -The Health Service Director and the assistant Health Service Director will review Medication Administration Records each quarter and reinforce to all floor staff to document all care. THE CORRECTION DATE SHALL NOT EXCEED APRIL 28, 2017.	D 273		
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	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 23 (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 that medication (insulin) was available to administer as ordered by a licensed prescribing practitioner to 1 of 1 (#2) sampled residents and 2 of 7 residents (#2, #7) observed during medication administration of ferrous sulfate and enteric coated aspirin. The findings are: 1. Review of Resident #2's current FL-2 dated 02/23/17 revealed: -Diagnoses included diabetes mellitus Type 2 and hypertension. -An admission date listed as 03/30/15. Review of Resident #2's Resident Register revealed that the admission date was not listed. Review of Resident #2's electronic medication administration record (eMAR) for January, 2017 revealed: -An entry for Humulin N insulin (a slow acting insulin) 95 units to be given each morning before breakfast. -An entry for Humulin N insulin 18 units to be given each night at bedtime. -An entry for fingerstick blood sugars (FSBS) to be done before each meal with sliding scale coverage with Humulin R (a fast acting insulin). -An entry for sliding scale with the insulin dosage was: if blood sugar (BS) was 150-199 1 unit, if BS was 200-249 2 units, if BS was 250-299 3 units, if BS was 300-349 4 units, if BS 350-399 5	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 24 units, if BS 400-449 6 units, if BS 450-499 7 units, if BS 500-549 8 units. Review of the January 2017 eMAR for Resident #2 revealed: -On 01/06/17, the bedtime dose of Humulin N insulin, 18 units, was not given; "waiting on phar" was documented in the exceptions -On 01/07/17, the 7:30am dose of Humulin N insulin, 95 units, was not given; "was on order" was documented in the exceptions. -On 01/08/17, the 7:30am dose of Humulin N insulin, 95 units, was not given; "awaiting from pharmacy" was documented in the exceptions. -On 01/08/17, the bedtime dose of Humulin N insulin, 18 units, was not given; "pharmacy" was documented in the exceptions. -On 01/09/17, the 7:30am dose of Humulin N insulin, 95 units, was not given; "awaiting from pharmacy" was documented in the exceptions. -On 01/09/17, the bedtime dose of Humulin N insulin, 18 units, was not given; "awaiting from pharmacy" was documented in the exceptions. -The resident's BS was documented at 6:30am on 01/08/17 as 283 and no insulin was given. -The resident's BS was documented at 5:30pm on 01/08/17 as 524 and no insulin was given; "pharmacy" was documented in the exceptions. Review of the February 2017 and March 2017 eMARs revealed insulin was administered as ordered. Interview with the assistant Health Service Director (HSD) on 03/10/17 at 10:46am revealed: -If a medication was not on available, the providing pharmacy was called. -If a medication was not available on a weekend, the providing pharmacy was called and the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 25	D 358		

providing pharmacy would send a copy of the prescription to the local back up pharmacy and the medication was picked up by a staff member.
-The assistant HSD did not know why this procedure was not followed on the weekend in question.
-The assistant HSD could not explain why no insulin was given on 01/08/17 at 5:30pm.

Interview with a Medication Aide (MA) on 01/13/17 at 4:10pm revealed:
-If a medication was not on the [medication] cart, the providing pharmacy was called.
-If a medication "ran out" on the weekend, the providing pharmacy was still called but the medication would be filled at the back up pharmacy.
-Any MA could call the pharmacy to order medications.

Telephone interview with the prescribing pharmacy on 03/10/17 at 2:58pm revealed:
-A request to refill the Humulin N was received on 01/08/17 and it was delivered to the pharmacy on 01/09/17.
-A request to refill the Humulin R was received on 01/24/17 and it was filled the same day.

Review of Resident #2's electronic clinical notes for January, 2017 did not reveal any communication with the prescribing physician.

2. The medication error rate was 6% as evidenced by the observation of 2 errors out of 30 opportunities during the 4 p.m. medication pass on 3/08/17 and 8 a.m. medication pass on 3/09/17.

A. Review of Resident #7's current FL-2 dated 1/13/17 revealed the resident's diagnoses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 26	D 358		

included lower extremity cellulitis, osteomyelitis of the left foot, dementia, coronary artery disease, congestive heart failure, and diabetes.

Observation during the medication pass on 3/08/17 at 4:39 p.m. revealed:
- The medication aide (MA) poured Ferrous Sulfate 325mg into a medication administration cup.
- She administered the Ferrous Sulfate to Resident #7 at 4:39 p.m.

Review a physician's order dated 1/26/17, after administration, revealed Ferrous Sulfate 325mg twice a day with meals. (Ferrous Sulfate is an iron supplement used to treat anemia.)

Review of a printed March 2017 electronic medication administration record (eMAR) for Resident #7 revealed:
- Ferrous Sulfate 325mg twice a day with meals at 8 a.m. and 4 p.m. was listed on the computer printed eMAR.
- It was scheduled for administration at 4 p.m. during the medication pass.

Interview on 3/08/17 at 4:39 p.m. with the MA revealed:
- She was not aware the Ferrous Sulfate directions indicated it was to be administered with a meal.
- She did not know what the facility policy was for medications listed to be administered with meals.
- She thought she had a window of one hour before and one hour after a medication was listed for administration.
- The dinner time was 5:30 p.m. and the resident would usually go into the dining room at 5:20 p.m.

Observation on 3/08/17 at 5:35 p.m. the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 27 was in the dining room with food being served. Interview on 3/08/17 at 4:40 p.m. with the Health Services Director (HSD) revealed: - There was no window of time before and after the listed administration time when a medication was to be administered with food according to order and MAR listing. - The MA should have administered the Ferrous Sulfate medication with the meal in the dining room, just after the resident started to eat. - The eMar time for administration would be adjusted. Interview on 3/09/17 at 10:35 a.m. with the resident revealed he did not have any trouble with the iron pills on his stomach yesterday before he ate his dinner at about 5:45 p.m. B. Review of the current FL-2 dated 02/23/17 for Resident #2 revealed diagnoses included diabetes mellitus Type 2 and hypertension. Observation and interview during the medication pass on 3/09/17 at 8:18 a.m. revealed: - The Medication aide (MA) showed a flashing sign on the electronic Medication Administration Record (eMAR) "Do not crush medications." - She pointed out that even though the flashing eMAR sign said "Do not crush medications, there was an order for Resident #2's medications to be crushed. - It had not been entered yet into the electronic eMAR yet. - She prepared all of the resident's medications including the Aspirin 81 mg daily in a medication administration cup to be crushed. - All of the resident's medications were crushed except two capsules. - The medication aide administered all of the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 28 crushed medications in a mixture of applesauce. Review of the medication package for Resident #2 revealed the label listed the Aspirin 81 mg daily. Interview after the medication pass on 3/09/17 at 8:40 a.m. with the MA revealed: - She said there was a message that popped up on the eMAR at the time of administration for medications for Resident #2's medications not to be crushed. - She did not think it was a problem to crush all of Resident #2's medications since there was an order to crush medications. - The eMAR said may crush medications. - He needed them crushed because he had a swallowing problem. - He could swallow the capsules without a problem. - The pharmacy entered changes and instructions into the computerized system for the administration for each resident. - She did not know why the no crush medication direction was not changed. Review of the Resident #2's record revealed a medication order dated 2/23/17 for Aspirin 81 mg EC (enteric coated) daily. (Used to prevent clots.) Review of Resident #2's March electronic Treatment Administration Record (eTAR) revealed: - "May crush appropriate medications as needed for swallowing." - This notation on the eTAR had a date listed next to it of 9/01/2016. Review of the resident's record revealed a Speech Therapy review of the resident's case,	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 29 revealed "Guidelines" which included to crush the residents medications. Review of the record for Resident #2 revealed there was no documentation of physician order to crush appropriate medications as needed for swallowing. Review of the facility's Pharmacy Policy and Procedures under the section "Crushing of Medications" revealed: - Medications may be crushed only with a physician's written order. - An extensive list of drugs that should not be crushed should be posted in the medication room. - The section for Rationale For Not Crushing: Enteric Coated: medication were designed to pass through the stomach without dissolving but would then dissolve in the intestines. - Reasons for this type of drug formulation was to prevent stomach acid causing the destruction of the drug. - The formulation of the enteric coated drug was to prevent irritation of the stomach and to achieve prolonged action of the drug. - If there was any uncertainty of the safety of crushing a medication, the facility should should any supplied medication literature and or the consulting pharmacy. Interview on 3/09/17 at 9:15 a.m. with the HSD revealed: - The Speech Therapist had written an "order" to crush the medications in the "Guidelines" section of her report. - These guidelines by the speech therapist were faxed to the pharmacy when received. - She was not aware this was to be signed by a prescribing practitioner as a current order.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 30 - She would look for a crush medication order for Resident #2. No order to crush medications was provided by the end of the survey. Interview on 3/09/17 with Resident #2 at 12:40 p.m. revealed: - He did not think he needed his medication to be crushed any longer. - He had his esophagus stretched a few times and he could swallow much better now. - He did not have any gastric distress from the crushed medications or capsule medications since. Telephone interview with the pharmacist on 3/09/17 at 3:36 p.m. revealed: - Upon review of the resident's medications, all the medications could be crushed except the Aspirin 81 mg EC (enteric coated) and the residents capsule medications. - Most Aspirin was supplied as enteric coated and should be listed as such. - The facility should have a Do Not Crush medication list to refer to when crushing medications. _____ The facility failed to assure medications, including insulin was administered as ordered resulted in a Resident #2's blood sugars exceeding 400 for four days and 2 of 7 residents observed on a medication pass with administered enteric coated aspirin in crushed form and ferrous sulfate on empty stomach. The facility's failure to administer ferrous sulfate with a meal put the resident at risk for side effects of gastric distress, nausea and vomiting and and by crushing enteric coated aspirin that would protect the gastric lining could	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 31 cause bloody vomiting, gastric distress had put the residents at risk and was detrimental to the health, safety and welfare of the residents. _____ Review of the facility's Plan of Protection dated 3/14/17 revealed: - The Health Service Director (HSD) will review medication administration procedure with all medication aides one on one. - To start today and be completed by 3/17/17. - The community staff are responsible for ensuring insulin and stock medications are checked every week to insure a continuous supply of over a weekend or holiday. - Approximately one week supply of the counter medications should be maintained at all times. - The Assistant HSD and the HSD will reinforce procedures during routine staff meetings. - Policies will be posted in the medication room including Do Not Crush medication list. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 28, 2017.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interviews and record	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092017	A. BUILDING: _____ B. WING _____	R 03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(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 32	D912		

reviews, the facility failed to assure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations as related to medication administration, health care referral and personal care and supervision according to residents assessed needs and symptoms. The findings are:

1. Based on interviews and record reviews, the facility failed to provide supervision for 1 of 6 sampled residents in accordance with their assessed needs and current symptoms related to multiple falls which resulted in a serious injury of multiple fractures of the right arm and right leg. (Resident #6). [Refer to Tag D 270, 10A NCAC 13F.0901 (b) Personal Care & Supervision (Type A1 Violation)]

2. Based on record reviews and interviews, the facility failed to report elevated blood sugars (BS) and that ordered insulin was available for 1 of 1 (#2) sampled residents as ordered by the prescribing physician.[Refer to Tag D 273, 10A NCAC 13 F. 0902 (b) Health Care (Type B Violation)]

3. Based on observations, record reviews and interviews, the facility failed to assure that medication (insulin) was available to administer as ordered by a licensed prescribing practitioner to 1 of 1 (#2) sampled residents and 2 of 7 residents (#2, #7) observed during medication administration of ferrous sulfate and enteric coated aspirin. [Refer to Tag D 358, 10A NCAC 13 F .1004 (a) Medication Administration (Type B Violation)]