STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092241	A. BUILDING _____ B. WING _____ OCT 18 2018	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT TRADITIONS	612 RED CLOVER COURT WAKE FOREST, NC 27587

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an initial survey on 07/24/2018 - 07/25/2018.	C 000		
C 140	10A NCAC 13G .0405(a)(b) Test For Tuberculosis 10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or living in a family care home, the administrator, all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with 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, NC 27699-1902. (b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis disease that poses a direct threat to the health or safety of others. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to assure 2 of 3 sampled staff (Staff A and C) were tested upon hire for tuberculosis (TB) disease with the two-step TB skin test in compliance with control measures adopted by the Commission for Health Services. The findings are: 1. Review of Staff A's personnel record revealed:	C 140	•Staff A and Staff C have taken the both Steps TB Test the results are available for review. All employees files have been reviewed are of complaince 10A NCAC 13G.0405(a)(b). •We have added TB test requirements on the employment application as a condition to start work. If an employee presents the First Step TB, completion of the second Step TB within 6 weeks will be a condition to stay employed. The Administrator will add the new employee's profile in scheduling software only after they have completed at least the first TB Test. Our target is to set a completion date of Step 2 TB at 6 weeks from Step 1, this date will be entered in our scheduling software. Both the Administrator and the employee will receive reminders via automatic emails at 21, 14 and 7 days before 6 weeks have been reached. If the employee does not take the Step 2 TB before 6 weeks, their name will be flagged on the schedule screen. The Administrator will give the employee daily reminder and will remove the employee from the schedule if the Administrator believes that the employee is not making good faith effort to get a second TB. All employees TB test shall be compliant to 10A NCAC 13G.0405(a)(b). If a new employee presents a Step 1 TB that is 9 months or more old, he/she will be required to complete Second Step TB test before they can be put on the scheduling software. The Administrator will review all employees to ensure compliance to 10A NCAC 13G.0405(a)(b). Once complete, the Administrator will securely store the TB results with the employee records. •Please review the attached Screenshots to see how we manage this process. This Correction Plan addresses the root cause by preventing a new employee from starting work before the First Step TB is complete, a new employee with Step 1 TB soon to expire from working and provides a mean of following up to ensure that the Second Step TB is complete. •Correction plan will be fully implemented on 08/31/2018.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Rosalie Ndoma-Ogar — Administrator — 10/18/2018

* The Plan of Correction was Reviewed and accepted on 11/15/18. D.H. *

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092241	A. BUILDING: _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT TRADITIONS	612 RED CLOVER COURT WAKE FOREST, NC 27587

(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
C 140	Continued From page 1 -The date of hire was 07/12/18 as a Medication Aide (MA). -There was a step one TB test done on 07/19/17. Telephone interview with Staff A on 07/25/18 at 6:24 p.m. revealed: -She had had a two-step TB test done at her primary care provider's office within the last year. -She would call the office and have them fax the information. Interview with the Administrator on 07/25/18 at 5:53 p.m. revealed she was not aware that Staff A's first TB test was done over a year ago. Refer to the interview with the Administrator on 07/25/18 at 5:53 p.m. 2. Review of Staff C's personnel record revealed: -The hire date was 06/14/2018 as a personal care aide (PCA). -There was no documentation of any tuberculosis (TB) skin test. Telephone interview with Staff C on 07/25/18 at 6:21 p.m. revealed: -She had a TB test done at the time she was hired at the facility on 06/14/18 at a local drug store and thought she had given a copy of the results to the Administrator. -She would go back to the local drug store immediately to see if she could get another copy of her TB test done in June 2018. -She had a prior TB test done from her previous job as well and would attempt to get a copy and provide them to the Administrator. -She had never had a positive TB test. Interview with the Administrator on 07/25/18 at 7:00 p.m. revealed:	C 140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092241	A. BUILDING: _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT TRADITIONS	612 RED CLOVER COURT WAKE FOREST, NC 27587

(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
C 140	Continued From page 2 -Staff C had not provided her with the TB test done in June 2018 but remembered that she had gone to get the test done at hire. -She would follow up to obtain a copy of the TB screenings for Staff C tomorrow (07/26/18) and would provide a copy. Refer to the interview with the Administrator on 07/25/18 at 5:53 p.m. Interview with the Administrator on 07/25/18 at 5:53 p.m. revealed: -She was responsible to assure a two-step TB screening had been done and filed in the personnel records for all staff. -She usually hired staff working at larger facilities in hopes they had already completed two -step TB testing. -Staff had told her they would provide documentation of the two-step test being done but had not done so. -She usually gave staff two weeks to a month to provide the documentation. -She did not have a system in place to remind her to request the documentation from staff. -She planned to require that all new staff get the testing prior to employment. The failure of the facility to ensure staff were free from active tuberculosis (TB) disease placed the residents for potential exposure to TB. This failure was detrimental to the health, safety, and welfare of all residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/25/18 for this violation.	C 140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092241	A. BUILDING: _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT TRADITIONS	612 RED CLOVER COURT WAKE FOREST, NC 27587

(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
C 140	Continued From page 3 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 08, 2018.	C 140		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family 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: TYPE B VIOLATION Based on record review and interview, the facility failed to assure 2 of 3 residents sampled (#2, #3) were tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: 1. Review of Resident #2's current FL-2 dated 05/16/18 revealed diagnoses included dementia, essential hypertension and anxiety disorder, unspecified. Review of Resident #2's Resident Register revealed:	C 202	•Resident #2 and Resident #3 have taken the first Step TB Test the results are available for review. All Residents have completed both Steps of their TB. •The Administrator will validate and review results of any TB test documented on the FL2 to ensure that the test period is compliant to 10A NCAC 13G.0702(a), If it is not then at least the first Step TB will be administered prior to admission. A request for a second TB test will be scheduled 6 weeks from the date that the first TB test was administered. •The Administrator will review the Residents admission documentation to ensure compliance 10A NCAC 13G.0702(a) within 8 weeks after admission to ensure that the second TB test has been administered. • For all residents admitted with only a First Step TB test, the Administrator has created a check sheet, that shows the admission date, first TB test date and the Second Step TB Scheduled Date and Second Step TB Actual Date. This checksheet provides a single document for quick verification. This Correction Plan addresses the root cause, by forcing the Administrator to validate that the Residents' existing TB Test are compliant with 10A NCAC 13G.0702(a) and a means to ensure that Step 1 and Step 2 TB skin test are completed by proactively scheduling the Second Step TB. •The new process will be completed on 08/31/2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092241	A. BUILDING: _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT TRADITIONS	612 RED CLOVER COURT WAKE FOREST, NC 27587

(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
C 202	Continued From page 4 -The admission date was 06/01/18. -The resident was admitted from another assisted living facility. Review of Resident #2's record revealed there was no documentation of any tuberculosis (TB) skin test. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. Telephone Interview with Resident #2's power of attorney (POA) on 07/25/18 at 9:25 a.m. revealed: -Resident #2 was living at an assisted living facility prior to coming to the current facility. -The resident had been tested for TB when she was initially admitted to the prior assisted living facility and received a second TB test just prior to the resident's admission to the current facility. The POA thought the Administrator read the last TB test that had been placed. Interview with the Administrator on 07/25/18 at 5:30 p.m. revealed: -She was responsible for making sure all residents had TB skin testing upon admission. -Resident #2 was directly admitted from an assisted living facility on 06/01/18. -She thought Resident #2 had completed a 2 step TB screening on admission. -She would contact the facility Resident #2 was admitted from to obtain the TB records. 2. Review of Resident #3's current hospital generated FL-2 dated 02/23/18 revealed diagnoses included history of seizure disorder, acute cystitis with hematuria, nausea, dementia, hypertension and depression.	C 202		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092241	A. BUILDING: _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT TRADITIONS	612 RED CLOVER COURT WAKE FOREST, NC 27587

(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
C 202	Continued From page 5 Review of Hospital Discharge Summary for Resident #3 dated 02/23/18 revealed: -The resident was admitted to hospital on 02/21/2018 and discharged on 02/23/18. -A PPD had been placed. -There were no TB results for the resident in the "Lab Results" section. Review of Resident #3's record revealed there was no documentation of any TB skin test. Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable. Telephone interview with Resident #3's power of attorney on 07/25/18 at 10:26 a.m. revealed: -The resident had a history of tuberculosis screenings in the past. -The POA knew the resident had one approximately one year and 3 months ago when she was admitted to another assisted living facility and another TB screening was done just before to the resident's admission in February 2018. -The resident was admitted to the current facility in February 2018 after a short hospital stay. Interview with the Administrator on 07/25/18 at 5:30 p.m. revealed: -She was responsible for making sure all residents had TB skin testing upon admission. -Resident #3 was admitted from a local hospital in February 2018. -She thought Resident #3 had completed a 2 step TB screening. -The last TB screening was done while she was admitted in the hospital just prior to her admission to the facility. -She would contact the prior facility where	C 202		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092241	A. BUILDING: _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT TRADITIONS	612 RED CLOVER COURT WAKE FOREST, NC 27587

(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
C 202	Continued From page 6 Resident #3 resided and would contact the local hospital where the resident was admitted from. _____ The facility failed to assure Resident #2 and Resident #3 had been tested for tuberculosis disease prior to admission to the facility. The facility's failure was detrimental to the health and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/25/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 08, 2018.	C 202		
C 231	10A NCAC 13G .0801(b) Resident Assessment 10A NCAC 13G .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The	C 231	•The Administrator shall work with new Resident's POA to ensure they select PCP upon or within a week of admission. If the POA remains indecisive, the Administrator will recommend for the POA to allow use of our facility doctor to meet 10 NCAC 13G .0801(b). •A Care Plan for Resident #2 was created and approved by the PCP. •The Administrator shall complete the care plan and review it with the PCP for approval within 30 days. •The Administrator is responsible for ensuring that a Care Plan is developed. •The Administrator will review each resident's file and update assessment at least annually. •Monthly random charts audits related to the care plan and assessment will be performed by the Administrator or designated person. The corrective plan was implemented by 08/31/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092241	A. BUILDING: _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT TRADITIONS	612 RED CLOVER COURT WAKE FOREST, NC 27587

(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
C 231	Continued From page 7 assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, a provider of mental health, developmental disabilities or substance abuse services or a community resource. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to complete an initial care plan within 30 days following admission for 1 of 3 sampled residents (#2). The findings are: Review of Resident #2's current FL-2 dated 05/16/18 revealed: -Diagnoses included dementia, essential hypertension and anxiety disorder, unspecified. -The resident was constantly disoriented. -The resident needed personal care assistance in bathing and dressing. Review of Resident #2's Resident Register revealed: -There was an admission date of 06/01/18. -The resident had significant memory loss and must be directed. -The resident required assistance from staff for dressing, bathing, nail care, ambulation correspondence, getting in and out of bed, toileting, hair care and grooming, skin care and "some" feeding assistance. Record review revealed there was not a completed care plan for Resident #2. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.	C 231		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092241	A. BUILDING: _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT TRADITIONS	612 RED CLOVER COURT WAKE FOREST, NC 27587

(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
C 231	Continued From page 8 Interview with two personal care aides (PCAs) on 07/25/18 at 11:30 a.m. revealed: -Resident #2 was under hospice care. -Staff assisted Resident #2 with getting up out of the bed, doing mouth care, combing her hair, dressing, and sometimes assisted with feeding. -Staff could tell by watching Resident #2 when she needed assistance with feeding. -Staff followed a personal care log in order to know what services to provide each resident. The personal care log consisted of a flow sheet where staff checked off the care they provided to each resident. -Resident #2 required assistance to go to the bathroom but was able to tell staff when she needed to go to the bathroom. -Resident #2 was able to stand with two person assistance but usually used her wheelchair to ambulate. -Resident #2 was a fall risk. -Staff became aware of the resident's fall precautions by a memo the Administrator distributed about the use of a chair alarm for Resident #2. -Staff had to bathe Resident #2 but she could wash her own face. -Resident #2 could put her arms into the sleeves of a shirt but required assistance with getting fully dressed. -Resident #2 was forgetful but had no issues with her sight or vision. -Staff had never seen a care plan for Resident #2. Telephone interview with Resident #2's power of attorney (POA) on 07/25/18 at 9:25 a.m. revealed: -The POA visited the resident every 3-4 weeks at the facility and made the last visit on Sunday,	C 231		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092241	A. BUILDING: _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT TRADITIONS	612 RED CLOVER COURT WAKE FOREST, NC 27587

(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
C 231	Continued From page 9 07/22/18. -The resident required assistance from staff with bathing, grooming, dressing, transfers, and toileting needs. -Since the resident had been admitted to the facility, they had never "nailed down" who would be the resident's primary care provider (PCP). -The POA was contacted by the Administrator today (07/25/18) regarding who the PCP would be and the POA thought she would call the Administrator back to inform her to go with the PCP that oversees the resident's hospice services. Telephone interview with the nurse with Resident #2's hospice provider on 07/25/18 at 12:58 p.m. revealed: -The resident was receiving hospice services prior to her admission to the facility. -There had been discussion who would be Resident #2's PCP. -The physician overseeing the resident's current hospice care services would have signed the resident's care plan for the facility if needed until a decision was made in regards to a PCP. Interview with the Administrator on 07/25/18 at 5:30 p.m. revealed: -She was responsible to assure assessments and care plans were done for all residents. -Resident #2 did not have a completed care plan. -She had been waiting to complete Resident #2's care plan since there had been no final decision made who would be the resident's PCP. She had spoken again today (07/25/18) with Resident #2's POA in regards to a decision who the PCP would be. -The care plan did not generate an individual resident care plan for staff to document on. -The specific type of assistance needed for each	C 231		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092241	A. BUILDING: _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT TRADITIONS	612 RED CLOVER COURT WAKE FOREST, NC 27587

(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
C 231	Continued From page 10 resident was verbally shared with staff by her and staff were also able to refer to the written care plan. -She would complete Resident #2's care plan this week.	C 231		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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: Based on interviews, and record reviews, the facility failed to administer a controlled medication ordered to treat seizures for 1 of 3 residents sampled (#3). The findings are: Review of Resident #3's current hospital generated FL-2 dated 02/23/18 revealed: -Diagnoses included history of seizure disorder, acute cystitis with hematuria, nausea, dementia, hypertension and depression. -There was entry in the medication section "See DC summary". -There was an order for Phenobarbital 97.2mg one at bedtime (used to treat seizures). Review of Resident #3's Resident Register revealed an admission date of 02/24/18.	C 330	•Phenobarbital 97.2mg has been ordered and delivered to the facility. • When Resident #3 came to us, she would call for help over 40 times a day. She had a pan that she constantly carried because she felt that she needed to vomit and she will also feign seizures multiple times a day. Our team responded to every call Resident #3 made and she no longer feign seizures or have a need to carry the vomit pan, •We have added ordering medication on our Electronic Check sheet. The Day Shift Med Tech is responsible for ordering medication and the Night Shift Med Tech is responsible for confirming that the order was placed. Both the Day and Night Shift Mech Tech on different shifts verify the order and that they are processed by the medication provider. Records of each day transaction showing the date and the initial of each employee's transaction are stored in the cloud. •All shifts are required to send a text to the administrator if the order is not processed. This change ensures that the administrator is aware of any issues with processing of the order very early in the process and allow for the records on QuickMAR to show a more complete explanation of why the medication is not available. • The Electronic Check Sheet escalates any issues with ordering or processing medication by early notification of the Administrator. •All transactions on the Electronic Check sheet are kept in the cloud which allows for traceability. •The Electronic Check sheets are helping strengthen weakness identified from the Survey.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092241	A. BUILDING: _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT TRADITIONS	612 RED CLOVER COURT WAKE FOREST, NC 27587

(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
C 330	Continued From page 11 Review of Resident #3's April 2018 electronic medication administration record (eMAR) revealed: -There was a computer printed entry for Phenobarbital 97.2mg, take one at bedtime with a scheduled administration time at 8:00 p.m. -There was documentation Phenobarbital 97.2mg had been administered from 04/02/18 - 04/04/18 and not administered for five days from 04/05/18 - 04/09/18 with additional documentation in the "Exceptions" of the eMAR "Med Not Available" as the reason. -There was a second computer printed entry for Phenobarbital 97.2mg, take one at bedtime with a scheduled administration time at 8:00 p.m. -There was documentation Phenobarbital 97.2mg had been administered from 04/11/18 -04/30/18 and not administered on 04/10/18 with additional documentation in the "Exceptions" section of the eMAR "Med Not Available" as the reason. Review of a physician signed letter addressed to "To Whom it may concern" for Resident #3 dated 04/11/18 revealed Resident #3 missed two days of her Phenobarbital, however, she would be medically fine and was scheduled for in May 2018 for lab work and an office visit. Review of Resident #3's May 2018 electronic medication administration record (eMAR) revealed: -There was a computer printed entry for Phenobarbital 97.2mg, take one at bedtime with a scheduled administration time at 8:00 p.m. -There was documentation Phenobarbital 97.2mg had been administered from 05/01/18 - 05/31/18. Review of Resident #3's June 2018 electronic medication administration record (eMAR)	C 330	•The Administrator or her designee audits the records at least once per week to ensure compliance. •Please see Day and Night Shift responsibility on the attachment. The Electronic Checksheet address Narcotics, PRN and Liquid medications. •The Medication Tracking List mentioned on the Electronic check sheet is also attached. • This Correction Plan addresses the root cause by: - Making the Day Shift Medtech on multiple shifts responsible for ordering medications. -Making the Night Shift Med Tech responsible on each shift to verify that medications are ordered. -Quickly escalating to the Administrator any problems and forcing follow-up with physicians or hospice if there is a delay. -Forces accountability by requiring the MedTech to confirm that either the medication were ordered or that there is no need to order medication on their shift. -Helping guide new employees on the process of ordering medications. -Provide traceabilty and help early identification of employees that need additional training before it impacts the Residents. • This corrective plan was in place by 08/31/18 but it has gone continuous improvement for a more robust application.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092241	A. BUILDING: _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT TRADITIONS	612 RED CLOVER COURT WAKE FOREST, NC 27587

(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
C 330	Continued From page 12 revealed: -There was a computer printed entry for Phenobarbital 97.2mg, take one at bedtime with a scheduled administration time at 8:00 p.m. -There was documentation Phenobarbital 97.2mg had been administered from 06/01/18 - 06/30/18. Review of Resident #3's July 2018 eMAR revealed: -There was a computer printed entry for Phenobarbital 97.2mg, take one at bedtime with a scheduled administration time at 8:00 p.m. -There was documentation Phenobarbital 97.2 mg had been administered from 07/01/18 - 07/20/18 and not administered for three days from 07/21/18 - 07/23/18 with additional documentation in the "Exceptions" of the eMAR "Med Not Available" as the reason. Observation of Resident #3's medications on hand on 07/24/18 at 5:25 p.m. revealed there was no Phenobarbital 97.2mg available. Interview with the Administrator on 07/24/18 at 5:25 p.m. revealed: -Phenobarbital was a controlled medication. -The facility staff had "trouble" getting a refill order for the Phenobarbital from Resident #3's physician at times. -She called Resident #3's physician's office and left a message this afternoon (07/24/18) and received notification from the pharmacy that the resident's Phenobarbital 97.2mg would be available to give to the resident tonight (07/24/18). -She was not aware until today that Resident #3's Phenobarbital was not available. -When new prescriptions for Resident #3's Phenobarbital were needed the pharmacy contacted the resident's physician for the needed	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092241	A. BUILDING: _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT TRADITIONS	612 RED CLOVER COURT WAKE FOREST, NC 27587

(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
C 330	Continued From page 13 medication refill order. -Resident #3 had not had any seizure activity and would receive Phenobarbital tonight (07/24/18) to take at the 8:00 p.m. medication pass. Observation of Resident #3's medications on hand on 07/25/18 at 9:56 a.m. revealed there was a medication blister pack card with a dispensed prescription label for Phenobarbital 97.2mg, take one at bedtime, dated 07/24/18, a quantity of 30 tablets with 29 tablets remaining. Telephone interview with a pharmacist technician with the contracted pharmacy provider on 07/25/18 at 10:17 a.m. revealed: -The facility was responsible for contacting Resident #3's physician when a new prescription was needed for Phenobarbital. -The pharmacy would call the physician if the facility contacted them for a needed medication refill order but would not automatically call because the pharmacy would not know the exact time the refill would be needed. -The facility's eMAR system provided alert information when no refills remained and there was information also displayed in the lower left corner of the dispensed medication label on the blister pack medication cards -Resident #3 would be at risk of seizure activity when she did not take Phenobarbital daily as ordered. -The contracted pharmacy provider also had a different department that sent monthly notices to advise the facility which medications had refills. Telephone interview with Resident #3's power of attorney (POA) on 07/25/18 at 10 26 a.m. revealed: -Resident #3 had taken Phenobarbital daily since 1996 after developing seizures.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092241	A. BUILDING: _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT TRADITIONS	612 RED CLOVER COURT WAKE FOREST, NC 27587

(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
C 330	Continued From page 14 -In the past, physicians had tried to "wean" Resident #3 off Phenobarbital but were unable to do so because the medication kept her seizures under control. -Resident #3 had to take Phenobarbital daily because she would have seizures. -The POA was not aware of Resident #3 having any seizure activity since living at the facility. Interview with a medication aide (MA) on 07/25/18 at 11:30 a.m. revealed: -She had been instructed to contact the Administrator when a resident did not have any refills on a medication. -The MAs were supposed to re-order medications when there was one row of medications remaining on the medication cards. -MAs were responsible to place a request for a refill from the contracted pharmacy provider in the eMAR system by clicking on "order". -If a medication did not have any refills, a pop-up screen would appear "order rejected" then, the MAs were responsible to contact the Administrator to follow up on getting a refill order for the medication. -The MAs did not call the pharmacy or the ordering physician for needed refills. -She was not aware that Resident #3 had missed any doses of Phenobarbital. -She was not aware of Resident #3 having any seizure activity. Interview with the Administrator on 07/25/18 at 5:30 p.m. revealed: -She was aware Resident #3 had missed doses of her Phenobarbital in April 2018. -Resident #3 had missed doses of Phenobarbital in April and July 2018 because staff told her too late the two times a refill order was needed, "We need to work on communication".	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092241	A. BUILDING: _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT TRADITIONS	612 RED CLOVER COURT WAKE FOREST, NC 27587

(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
C 330	Continued From page 15 -The physician had told her that Resident #3 did not really have "true seizures", but still treated her as if the resident had seizures. -The letter "To whom it may concern" from Resident #3's physician was written after the resident had missed a few doses in April 2018 that explained missing a few doses would not hurt the resident. -She had been told from a family member it was thought that Resident #3 faked "seizures". -She had not contacted Resident #3's physician for the 3 missed doses in July but would do so. Attempted telephone interview with Resident #3's physician on 07/25/18 at 9:20 a.m. and 4:24 p.m. were unsuccessful.	C 330		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were documented by staff after being immediately administered for 1 of 1 residents (#1).	C 341	•Resident #1 came to us with a Stage III ulcer which is now fully healed. She had been living independently in an apartment and she was fully aware of her loss of control. The Administrator worked closely with Resident 1 Nurse and her POA to find ways for her to maintain some control. This effort, the abrupt departure (due to personal reasons) of our Med Tech without a 2 week notice and the failure of our new very experienced Med Tech to execute a standard process of observing the Resident 1 take their medication are the root cause of failure to meet 10 NCAC 13G .1004. The Med Tech that departed worked M-F from 7a to 3p at this location for 4 of the 5 months that we were operational.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092241	A. BUILDING: _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT TRADITIONS	612 RED CLOVER COURT WAKE FOREST, NC 27587

(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
C 341	Continued From page 16 The findings are; Review of Resident #1's current FL-2 dated 02/06/18 revealed: -Diagnoses included left artificial hip joint, generalized muscle weakness, dysphagia, and cardiac arrhythmia. -Sight was documented as a functional limitation. Review of Resident #1's Resident Register dated 02/07/18 revealed the resident was forgetful and needed reminders. Observation of Resident #1 on 07/24/18 at 8:54 a.m. revealed: -There was a cup of medication on the tray beside the resident's two glasses of milk and water. -The cup contained four pills,one a pink round pill and three oblong yellowish-white colored pills. Observation of medications on hand on 07/24/18 revealed; -The pink round pill was Aspirin (a medication used to reduce the risk of a heart attack). -The three oblong yellowish-white pills were Lisinopril (a medication used to treat high blood pressure and heart failure). Review of the July 2018 Medication Administration Record (MAR) for Resident #1 revealed the Aspirin and Lisinopril were documented as administered at 8:14 a.m on 07/24/18. Interview with Resident #1 on 07/24/18 at 8:50 a.m. revealed: -She usually took five pills in the morning. -She did not recall specifically what medicines she took in the morning.	C 341	Continue From Page 16 mistake like this again. It also addresses any miscommunication. •All of our staff have been reminded to observe the resident swallow all the medication before administering medication to another resident. •The Electronic Check sheet will ensure that even new employees are aware of this standard practice of administering medication and if there is miscommuni cation,it will prompt the employee to seek clarification. •The Electronic Check sheet is available to the employees when they clock-in to work on a daily basis. •The Electronic Check sheet will remind the employees of Renaissance Care Home practice of observing the resident take their medication. The Electronic Check sheet helps with on boarding new employees and minimize the impact of abruptly losing key employees; it brings the same structure we have implemented for ADLs. •The Administrator will train all employees to our procedures and she will perform random audits to ensure compliance. The Administrator will audit the system at least once a week. •See Screenshots of the Electronic Check sheet on the attachment. • This Correction Plan removes any doubts even for new employees that they must observe the Resident take their medication. •The new system is in place as of 08/10/2018, the Administrator is working on training the employees and ensuring compliance in its use.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092241	A. BUILDING: _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT TRADITIONS	612 RED CLOVER COURT WAKE FOREST, NC 27587

(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
C 341	Continued From page 17 -The medication aide (MA) usually left her medication for her to take. -Some MAs would stand there and watch her swallow the pills. -Her medicine was left with her yesterday to take also. -She planned to take the medication because it would not do her any good to not take them. Observation of Resident #1 on 07/24/18 at 1:15 p.m. revealed: -There was a cup full of medication on the resident's tray along with her lunch plate. -There were three pills in the cup, a round red tablet, an oblong white tablet, and a round yellow tablet. Observation of medications on hand on 07/24/18 revealed: -The round red tablet was a daily multivitamin (a medication used as a dietary supplement). -The oblong white tablet was zinc sulfate (a medication used as a dietary supplement). -The round yellow tablet was Vitamin C (a medication used as a dietary supplement). Review of the July 2018 Medication Administration Record (MAR) for Resident #1 revealed the daily multivitamin, zinc sulfate, and Vitamin C were documented as administered at 1:09 p.m on 07/24/18. Interview with the Administrator on 07/24/18 at 2:30 p.m. revealed: -Resident #1 had dementia and had refused to take all her pills at one time. -She preferred to take her pills one at a time. -They had recently had a meeting with the hospice nurse, social worker, and family of the resident to discuss the resident's issues with	C 341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092241	A. BUILDING: _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT TRADITIONS	612 RED CLOVER COURT WAKE FOREST, NC 27587

(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
C 341	Continued From page 18 taking her medicines. -It was decided that the resident would be allowed to take her medications as she wished to help her maintain some independence. -She had left medications with the resident before and told staff it was okay to do that in order to give the resident time. -She was not concerned about other residents going into the room as there was only one resident who was ambulatory and he did not wander. Interview with the hospice nurse on 07/25/18 at 10:53 a.m. revealed: -Resident #1 sometimes wanted to wait to take her medicine until after she ate. -Changes had been made to the timing of her medications. -She had seen medications on the resident's tray two to three times before while visiting the facility. -She remembered seeing medicines on Resident #1's tray last week. -She would be concerned that the resident might not take the medicine. -If the resident were to drop a pill, she would likely be unable to pick it up but could alert staff that she needed assistance. -She had never found any pills on the floor or in the resident's sheets. Interview with the primary care provider on 07/24/18 at 5:47 p.m. revealed: -Resident #1 was alert and oriented. -She was not aware medications were being left in the room for the resident to take on her own. -Facility staff would contact the hospice nurse first for all medical concerns. -She would be concerned whether the resident would actually get the medication if it were left in a cup.	C 341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092241	A. BUILDING: _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT TRADITIONS	612 RED CLOVER COURT WAKE FOREST, NC 27587

(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
C 341	Continued From page 19 -She was not sure if Resident #1 would be able to pick up the cup or the pill. -She would also be concerned that Resident #1 would get the medication at the right time.	C 341		
C 453	10A NCAC 13G .1301(a) Use of Physical Restraints and Alternatives 10A NCAC 13G .1301 USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES (a) A family care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep	C 453	•The root cause of the problem was that we allowed hospice to install a bed with full rails. •The full rail was removed and replaced with a ¼ rail at the end of the first full day (07/24/2018) of Survey by the 2 member team. The Administrator contacted hospice and requested removal of the full rail. The ¼ rail was in place on the second full day (07/25/2018) of the survey. •We have fully implemented our fall prevention controls on Resident # 2 and Resident #2 has not fallen in over 2 months under our care since implemented. This is a significant improvement from Resident #1's prior history before coming to our facility. •Our fall prevention measures were shared with the State inspectors during the Survey. •The Administrator will proactively inform outside providers that all equipment brough into our home must be compliant to 10A NCAC 13G.1301. •The Administrator will ensure prior to and at delivery that only equipment that meet our guidelines are brought into our facility. The Administrator will perform random audits at least once per week to ensure compliance to 10A NCAC 13G .1301 This plan was fully implemented 08/01/2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092241	A. BUILDING: _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT TRADITIONS	612 RED CLOVER COURT WAKE FOREST, NC 27587

(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
C 453	Continued From page 20 a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions. This Rule is not met as evidenced by: Based on observation, interviews and record review, the facility failed to assure full bedrail restraints were used only after a written physician order; after a team assessment and care planning process; and that alternatives were tried prior to the restraint that would provide safety to the resident, for 1 of 1 residents sampled (#2). The findings are: Review of Resident #2's current FL-2 dated 05/16/18 revealed: -Diagnoses included dementia, essential hypertension and anxiety disorder, unspecified. -The resident was constantly disoriented. Review of Resident #2's Resident Register revealed: -There was an admission date of 06/01/18. -The resident had significant memory loss and must be directed.	C 453		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092241	A. BUILDING: _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT TRADITIONS	612 RED CLOVER COURT WAKE FOREST, NC 27587

(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
C 453	Continued From page 21 Review of Resident #2's record revealed there was no assessment and care plan. Observation of Resident #2's room during the initial tour of the facility on 07/24/18 at 8:49 a.m. revealed: -Bilateral full bedrails were attached to Resident #2's bed that were positioned in an upright position. -The resident was lying in the bed with her eyes closed and the head of the bed was in a flat position. -There was a fall mat beside the bed. Interview with a personal care aide (PCA) on 07/24/18 at 9:33 a.m. and 2:00 p.m. revealed: -Resident #2 had full bedrails on her bed to keep her safe while in bed. -The resident slipped out her wheelchair about a month ago that caused a knot on her forehead and the resident was sent for evaluation at a local emergency department. This was the only fall Resident #2 had since her admission. -Resident #2 required staff assistance to be transferred from the bed to the chair. Observation in Resident #2's room on 07/24/18 at 2:00 p.m. revealed: -The resident was lying in bed in a flat position with full bedrails up bilaterally. -A PCA assisted the resident to reposition from a lying to a sitting position while the resident was in bed. -The PCA and a medication aide (MA) assisted the resident to transfer from the side of the bed, then into a wheelchair. -There was a bed alarm under the resident's incontinent padding in the middle of the bed. Interview with a MA on 07/24/18 at 4:39 p.m.	C 453		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092241	A. BUILDING: _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT TRADITIONS	612 RED CLOVER COURT WAKE FOREST, NC 27587

(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
C 453	Continued From page 22 revealed: -Resident #2 liked to "wiggle and move a lot". -Resident #2 could walk short distance with staff assistance. -Resident #2 could swing her legs over the bedrails. -If Resident #2 did not have full bedrails, the resident would be on the floor. -The full bedrails were not used for Resident #2 to reposition herself, but when they turned her she would grab onto the rails at times. -The MA remembered when Resident #2 first came to the facility she walked into the Resident #2's room and observed the resident with one leg over the bedrail while the resident was attempting to get her other leg over the bedrail. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. Telephone interview with Resident #2's power of attorney (POA) on 07/25/18 at 9:25 a.m. revealed: -The POA visited the resident every 3-4 weeks at the facility and made the last visit on Sunday, 07/22/18. -When the POA visited Resident #2, the full bedrails were always in an upward position on both sides when the resident was in the bed. -Resident #2 resided at another assisted living facility prior to coming to the current facility, but was asked to leave that facility because the resident had too many falls. -The long bedrails were placed on the resident's bed after she arrived at the current facility by the hospice provider within a day or so after the resident's admission. -The long bedrails were placed shortly afterward, the POA thought the Administrator or the	C 453		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092241	A. BUILDING: _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT TRADITIONS	612 RED CLOVER COURT WAKE FOREST, NC 27587

(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
C 453	Continued From page 23 Executive Director had spoken with contracted hospice provider about the need for the full bedrails. -The POA stayed with the resident and had observed the resident throwing her legs over the side of the bed. -The full bedrails kept the resident safe while in bed. -The resident thought "in her mind"' that she could still get up and walk. -The bedrails kept the resident from throwing her legs over the side. -The POA had observed the first night after the bedrails had been placed on the bed that Resident #2 moved her leg over the bedrail, then placed her leg back on the bed. -She was not sure if Resident #2 could pull herself up independently from a lying to sitting position, but doubted it. -The POA was aware of only one fall since the resident had been admitted to the facility which occurred while the resident was sitting in a wheelchair. Review of Resident #2's record revealed: -There was no documentation of alternatives used prior to the hospital bed with the full bedrails and there was no team assessment and care plan for alternatives and/or restraints. -There was no documentation of a consent for the use of the bedrails. Telephone interview with the Director for the current Hospice provider for Resident #2 on 07/24/18 at 12:00 p.m. revealed; -The Hospice provider did not place full bedrails in an assisted living facility. -Prior to ordering any devices for a resident such as alarms and bedrails, the Hospice agency always got a verbal "Ok" from the Administrator.	C 453		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092241	A. BUILDING: _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT TRADITIONS	612 RED CLOVER COURT WAKE FOREST, NC 27587

(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
C 453	Continued From page 24 -Resident #2 had resided at a prior facility but the resident needed one on one care and was discharged from that facility. -Resident #2's falls had decreased since the resident had moved to the current facility. Telephone interview with the Hospice nurse with Resident #2's current hospice provider on 07/24/18 at 12:58 p.m. revealed: -The resident was mostly up in the chair when she made her visits. -Quarter rails were typically ordered for residents to help turn and reposition, anything longer was considered a restraint. -The long rails on the resident's bed might have been ordered under the resident's initial admission to hospice because she did not see where, when, or why the full bedrails had been ordered. -The same hospice provider from a different office location started Resident #2's with hospice but she was unable to track when the long length bedrails were ordered or why they were ordered. Interview with the Administrator and the Executive Director on 07/24/18 at 6:07 p.m. revealed: -The hospital bedrails for Resident #2 were brought in by the resident's hospice provider on admission in June 2018. -Since the full bedrails were placed by the hospice provider they thought this was what was needed for the resident. -The bedrails was not a restraint because the resident did not try to get out of bed. -Resident #2's physician had not been contacted and no assessment or order had been completed for the use of the full bedrails. Interview with the Executive Director on 07/25/18 at 12:00 p.m. revealed:	C 453		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092241	A. BUILDING: _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT TRADITIONS	612 RED CLOVER COURT WAKE FOREST, NC 27587

(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
C 453	Continued From page 25 -Staff had been trained and it was expected for them to follow the fall prevention actions outlined by the facility, -When Resident #2 was in a seated position in her wheelchair this was when the resident was at risk for falls. -No instructions had been given to staff to use the long bedrails up when the Resident #2 was in the bed. Telephone interview with Resident #2's hospice PCA on 07/25/18 at 1:39 p.m. revealed: -She started providing care for Resident #2 around the first of July 2018 under hospice care. -Resident #2 had a bed and chair alarm that would go off if the resident attempted to get up. -A bed alarm and full length bedrails were in place when she made her visits while the resident was still in bed. A second telephone interview with the current Director for the Hospice provider for Resident #2 on 07/25/18 at 3:48 p.m. revealed there was documentation that the Administrator wanted full bedrails to replaced the full bedrails with an order dated 07/25/18. Telephone interview with the Director with the same hospice provider that initiated Resident #2's start of care with hospice services on 07/25/18 at 3:20 p.m. revealed: -Resident #2's start of care with hospice was on 10/27/17. -Resident #2 was admitted at that time under the care of a different office within the same hospice provider. There was an order for a hospital bed and a fall mat but no side rails were ordered for the bed at that time. -On 06/01/18, Resident #2 relocated to the current facility and her care was moved to	C 453		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092241	A. BUILDING: _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT TRADITIONS	612 RED CLOVER COURT WAKE FOREST, NC 27587

(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
C 453	Continued From page 26 another office within the same hospice provider for oversight of care. -If Resident #2 had full length bedrails ordered from their office, then that order would show in the system but she did not see any additional orders for full rails for a hospital bed. -She had tried to trace back the order, however, a system was down and she could not see the information needed.	C 453		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's 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, interview and record review, the facility failed to assure each resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to Tuberculosis testing of residents and Tuberculosis testing of staff, 1. Based on record review and interview, the facility failed to assure 2 of 3 residents sampled (#2, #3) were tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. [Refer to Tag 202, 10A NCAC 13G .702(a) Tuberculosis Test and Medical Examination (Type B Violation)]. 2. Based on record reviews and interviews, the	C 912	Please see C202 and C140, we have implemented procedures to ensure that TB test is administered to each new resident upon admission and to prevent employees that are not compliant with TB testing from working. The new process will ensure that residents' rights are met according to G.S. 131D-21. The plan completion date is 08/31/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092241	A. BUILDING: _____ B. WING _____	07/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT TRADITIONS	612 RED CLOVER COURT WAKE FOREST, NC 27587

(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
C 912	Continued From page 27 facility failed to assure 2 of 3 sampled staff (Staff A and C) were tested upon hire for tuberculosis (TB) disease with the two-step TB skin test in compliance with control measures adopted by the Commission for Health Services. [Refer to Tag 140, 10A NCAC 13G .0405 Test For Tuberculosis (Type B Violation)].	C 912		