Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R-C 12/23/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey with onsite visits on 12/16/20 and 12/21/20 and a desk review survey from 12/17/20-12/18/20 and 12/22/20-12/23/20 and a telephone exit on 12/23/20.	{D 000}		
{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: The Type B Violation was abated. Non-compliance continues. Based on record reviews and interviews, the facility failed to provided supervision in accordance with the resident's assessed needs for 1 of 5 sampled residents (#4) who had a history of falling out of her wheelchair. The findings are: Review of the facility's Fall Prevention and Management Policy with an effective date of 12/09/19 revealed: -A fall is defined as "unintentionally coming to rest on the ground, floor, or other lower level but not as a result of an overwhelming external force. -An episode where a resident lost his/her balance and would have fallen. -Individualized interventions will be implemented based on the assessment and care planned accordingly.	{D 270}	1. Community will utilize Fall Prevention and Management Program.	3/1/2021

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Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Dennis Finley — Executive Director — 2/3/2021

D. Dawson-Rogers
02/09/2021
POC reviewed and accepted

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{D 270}	Continued From page 1 -Providers will be consulted regarding risks and interventions, feedback, and any further approaches recommended. -Falls will be reviewed by an interdisciplinary team and any new interventions identified will be implemented and the care plan updated as necessary. Review of Resident #4's FL-2 dated 06/09/20 revealed: -Diagnoses included dementia due to Parkinson's disease, Parkinson's disease with behavioral disturbances and hypertension. -Resident #4 was ambulatory with the aid of a walker. Review of Resident #4's current care plan dated 12/17/20 revealed -Resident #4 pushed herself in a wheelchair. -Resident #4's ambulatory device was a wheelchair, and she was non-ambulatory. -Resident #4 required limited assistance with ambulation and transfers. Review of Resident #4's Communication Form for falls dated 07/26/20 revealed: -Resident #4's interventions for falls included a mat on the floor at the bedside; the resident's bed be in lowered position; a wedge cushion in the chair and scoop mattress. -It could not be determined when the interventions were implemented, based on no documented implementation dates on the Communication Form. Review of Resident #4's physician orders revealed no orders for a floor mat, a low bed, a wedge cushion or a scoop mattress. Review of the facility's Occurrence Report for	{D 270}	2. Community will utilize risk assessments, weekly Falls meetings, and post fall investigations with interventions. 3/1/2021 3. Resident Care Director, Executive Director, or Designee to monitor weekly. 3/1/2021	

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{D 270}	Continued From page 2 Resident #4 dated 11/14/20 revealed: -The review was completed by a medication aide (MA). -On 11/14/20 at 1:45pm, Resident #4 fell off the commode and bumped the right side of her head. -The fall was witnessed by a personal care aide (PCA). -Resident #4 remained in the facility. -Resident #4 was followed up by the hospice nurse and primary care physician (PCP) (no date). Review of Resident #4's progress notes dated 11/14/20 at 2:30pm revealed: -Resident #4 fell off the toilet and bumped her head. -The hospice nurse was in the building, and she checked Resident #4. Interview with a PCA on 12/21/20 at 10:45am revealed: -She worked on 11/14/20 when Resident #4 fell off the commode and hit her head. -Resident #4 was trying to stand up on her own and fell off the commode and hit her head when the PCA turned her head to get wipes. -She did not move Resident #4, but she notified the MA to check Resident #4. Interview with the MA who completed the previous report on 12/21/20 at 10:15am revealed: -She worked on 11/14/20 when Resident #4 fell off the commode and hit her head. -She was notified by the PCA about Resident #4 falling off the commode. -She checked Resident #4 for injury and notified the Hospice Nurse who was in the facility. -Resident #4 was assessed by the Hospice Nurse, and the resident remained in the facility. -The process for falls was to notify the Resident	{D 270}		

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{D 270}	Continued From page 3 Care Director (RCD), Administrator, PCP, hospice nurse and family member. -An incident report should be filled out and a progress note should be written in the resident's record. Review of the facility's Occurrence Report for Resident #4 dated 11/22/20 at 4:50pm revealed: -The review was completed by a MA. -Resident #4 fell out of her wheelchair in the dining room after reaching for her Bible. -Resident #4 had no injury. -Resident #4 remained in the facility. -Resident #4 was followed up by the Hospice Nurse and PCP (no date). Review of Resident #4's progress notes dated 11/22/20 at 11:00pm revealed: -Resident #4 was pushing her wheelchair in the dining room. -Resident #4's Bible fell which caused her to lean forward to get it and fell out of the wheelchair. -Resident #4 had no bruises on her body. Telephone interview with the RCD on 12/22/20 at 1:21pm revealed: -The MA who wrote the incident report no longer worked at the facility. -Resident #4 had no injury on 11/22/20. -Resident #4 was assessed by the Hospice Nurse, and the resident remained in the facility. -As a result of the fall, Resident #4 was kept in a central location during the daytime to prevent her from falling out of her wheelchair. -There was no specified time to checked on Resident #4 in the central location. Review of the facility's Occurrence Report for Resident #4 dated 11/25/20 revealed: -The review was completed by a MA.	{D 270}		

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{D 270}	Continued From page 4	{D 270}		

-Resident #4 was found on her left side beside her bed.
-Resident #4 was bleeding from her head.
-Resident #4 remained in the facility.
-Resident #4 was assessed by the Hospice Nurse (no date).

Review of Resident #4's progress notes dated 11/25/20 at 10:40pm revealed:
-Resident #4 had an unwitnessed fall with an injury to the left side of her head.
-Resident #4 would be checked by the Hospice Nurse.

Telephone interview with the MA who completed the previous report on 12/21/20 at 2:51pm revealed:
-She worked on 11/25/20 when Resident #4 was found on her left side near the bed.
-Resident #4 had an injury to the left side of her head.
-She notified the RCD of the injury.
-Resident #4 was assessed by the Hospice Nurse and remained in the facility.
-There were interventions in place to prevent Resident #4 from falling out of the bed.
-The interventions were low bed, mat on floor at the bedside and scoop mattress.
-She did not recall when a low bed, a mat on the floor at the bedside and scoop mattress were implemented.
-An incident report should be filled out and a progress note should be written in the resident's record.

Review of the facility's Occurrence Report for Resident #4 dated 12/15/20 revealed:
-The review was completed by a MA.
-Resident #4 was in her wheelchair rolling down the hallway leaning forward.

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{D 270}	Continued From page 5 -Resident #4 had to be assisted back in the wheelchair by the MA. -Resident #4 remained in the facility -Resident#4 was assessed by the Hospice Nurse. Review of Resident #4's progress notes dated 12/15/20 at 5:03pm revealed: -Resident #4 was down the hallway on the left side of the building when the resident fell forward [in the wheelchair]. -Resident #4 had no skin tears or bruises. Telephone interview with the MA who completed the previous report on 12/21/20 at 3:51pm revealed: -She worked on 12/15/20. -Resident #4 was in the hallway, she fell forward in the wheelchair, and she had to be assisted back in the wheelchair by staff. -Resident #4 had no injuries. -She notified the RCD and Resident #4 was assessed by the Hospice Nurse. -Resident #4 fell out of her wheelchair when she was reaching for something on the floor or grabbing at staff. -As a result of the fall, Resident #4 was kept in a central location during the daytime to prevent her from falling out of her wheelchair. -There was no specified time to checked on Resident #4 in the central location, but the staff were usually present. -An incident report should be filled out and a progress note should be written in the resident's record. Telephone interview with Resident #4's family member on 12/22/20 at 4:24pm revealed: -Resident #4 was admitted to the facility in May 2020. -Resident #4 had 2-3 falls in a week in the	{D 270}		

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{D 270}	Continued From page 6 previous facility. -Resident #4's falls have decreased since being admitted to this facility. -Resident #4 had 2-3 falls in the last month in the current facility. -Resident #4 used a wheelchair as her mode of ambulation. -Resident #4 fell out of the wheelchair reaching for things especially her Bible. -The family member did not know about interventions to prevent Resident #4 from falling out of the wheelchair. -There were interventions in place to prevent Resident #4 from falling out of the bed which included a low bed, a mat on floor at the bedside, and a scoop mattress. Telephone interview with the RCD on 12/22/20 at 1:21pm and 12/23/20 at 10:47am revealed: -Resident #4 had 4 falls within the last month. -Resident #4 fell out of the wheelchair because she was reaching for something on the floor especially her Bible. -The only intervention in place to prevent Resident #4 from falling out of the wheelchair was a wedge pillow. -She did not know when a wedge pillow had been implemented as an intervention to prevent Resident #4 from falling out of the wheelchair. -As a result of the fall, Resident #4 was kept in a central location during the daytime to prevent her from falling out of her wheelchair. -There were no other interventions in place to prevent Resident #4 from falling out of the wheelchair. -There were interventions in place to prevent Resident #4 from falling out of the bed which included a low bed, a mat on the floor at the bedside, and a scoop mattress. -She did not know when the interventions were	{D 270}		

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{D 270}	Continued From page 7	{D 270}		

put in place to prevent Resident #4 from falling out of the bed.
-The process for a fall was to notify the RCD, Administrator and the Hospice Nurse within 24 hours of a fall.
-An incident report should be filled out and a progress note should be written in the resident's record.

Observation on 12/21/20 at 11:15am revealed:
-Resident #4 was sitting in her wheelchair in the living room.
-A wedge pillow was not observed in the wheelchair.

Review of the Medication Administration Records (MARs) for Resident #4 for October 2020, November 2020 and December 2020 revealed there was no order for a wedge pillow.

Attempted interview with Resident #4's PCP on 12/21/20 at 4:08pm was unsuccessful.

Telephone Interview with the Hospice Nurse on 12/23/20 at 10:57am revealed:
-She was notified when Resident #4 had a fall.
-Resident #4 had 4 falls within a month.
-There were no interventions in place to prevent Resident #4 from falling out of the wheelchair.
-She did not know about the wedge pillow.
-She had not seen a wedge pillow.
-There were interventions in place to prevent Resident #4 from falling out of the bed, including a low bed, a mat on floor at the bedside, and a scoop mattress.
-This equipment was provided by the Hospice Agency.
-She did not know the dates the equipment was delivered to the facility.

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{D 270}	Continued From page 8 Telephone interview with the Administrator on 12/23/20 at 11:26am revealed: -Resident #4 had 4 falls within the last month. -Resident #4 fell out of her wheelchair when she was reaching for something on the floor or grabbing at staff. -There were no interventions in place to prevent Resident #4 from falling out of the wheelchair. -Resident #4's interventions to prevent falls out of the bed included a low bed and a fall mat. -There were no dates when the interventions were implemented. -Resident #4 was kept in a central location during the daytime to prevent her from falling out of her wheelchair. -There was no specified time to checked on Resident #4 in the central location, but the staff were usually present. -The process for a fall was to notify the RCD, Administrator, PCP, Hospice Nurse, and family member. -An incident report should be filled out and a progress note should be written in the resident's record. Based on observations, interviews and record reviews, it was determined Resident #4 was not interviewable.	{D 270}		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;	D 344	1. Facility will utilize New Order Tracking Form when receiving new orders.	3/1/2021

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D 344	Continued From page 9 (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on resident records and interviews, the facility failed to ensure the resident's physician was contacted for clarification of unclear medication order for hydrocortisone cream and Tacrolimus ointment for 1 of 5 sampled residents (#5). The findings are: Review of Resident #5's current FL-2 dated revealed diagnoses included dementia, angina pectoris, pulmonary hypertension, insomnia, and mitral valve prolapse. Review of Resident #5's physician orders dated 10/16/20 revealed: -There were orders written by Resident #5's Dermatologist on a facility physician visit form. -There was documentation of "excoriated rash on chest, upper back, back of upper arm" under the heading current findings on the form. -There were three orders written under the heading other comments or suggested follow-up on the form. -There was an order for Allegra 60 mg (an antihistamine used to treat skin itching or hives) twice daily for itching. -There was a second order for triamcinolone 0.1% cream (a steroid used to treat a variety of skin conditions) followed by moisturizer on rash twice daily for 2 weeks.	D 344	2. If orders need clarification due to not being clear, then Medication Technician will call the prescribing practioner to clarify the orders prior to medication administration. 3/1/2021 3. Once the medication order has been clarified, the Medication Technician will complete the new order tracking form and transcribe order onto MAR. 3/1/2021 4. Resident Care Director, Executive Director, or designee will monitor weekly for compliance. 3/1/2021	

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-There was a third order that read "use hydrocortisone 2.5) cream (a steroid used to treat inflammation of the skin) followed by Tacrolimus 0.1% ointment (an immunosuppressant used to treat atopic dermatitis) twice daily after 2 weeks."

Review of Resident #5's progress notes revealed:
-There was an entry dated and timed 10/16/20 at 12:10pm written by a medication aide (MA).
-The entry noted Resident #5 attended an appointment with the Dermatologist and new orders were received for Allegra and triamcinolone.
-The entry included the specific physician orders for Allegra and triamcinolone but did not include the instructions regarding the use of hydrocortisone cream and Tacrolimus ointment.
-There was no documentation of contacting Resident #5's Dermatologist office.

Review of Resident #5's facility new order/medication refill checklist forms dated 10/16/20 revealed:
-There was a form for triamcinolone cream and another form for Allegra that was signed by the same MA who wrote the progress note dated 10/16/20 at 12:10pm.
-There was no form for hydrocortisone cream or Tacrolimus ointment.

Interview with Resident #5 on 12/21/20 at 10:25am revealed she applied cream to the rash on her back and upper arms twice a day after bathing.

Interview with a personal care aide (PCA) on 12/21/20 at 11:07am revealed:
-She assisted Resident #5 with bathing this morning.

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-Resident #5 had a rash on her shoulders and chest.

Interview with a first shift MA on 12/21/20 at 11:48am revealed:
-Resident #5 had a rash on her chest.
-She applied hydrocortisone 2.5% cream and Tacrolimus 0.03% ointment to the rash on Resident #5's chest twice a day.
Telephone interview with the pharmacist at the contracted pharmacy on 12/21/20 at 9:31am revealed:
-Resident #5 had prescriptions from her Dermatologist dated 10/16/20 for triamcinolone and Allegra.
-There were no physician visit forms dated 10/16/20 for Resident #5.
-Resident #5 had active orders for hydrocortisone 2.5% cream dated 06/11/20 and Tacrolimus 0.3% ointment dated 09/29/20.

Attempted telephone interviews with Resident #5's Dermatologist on 12/21/20 at 9:24am and 12/23/20 at 12:30 pm were unsuccessful.

Telephone interview with the Activities Director on 12/22/20 at 1:03pm revealed:
-She reviewed her schedule and she took Resident #5 to a Dermatologist appointment on 10/16/20.
-Resident #5's Dermatologist did not review the instructions written on the physician visit form with her.
-Resident #5's Dermatologist's nurse gave the prescription and the physician visit form to her and she gave the forms to the MA upon return to the facility.

Telephone interview with the MA who processed Resident #5's physician's orders dated 10/16/20

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D 344	Continued From page 12 revealed: -The physician orders for an outside physician visit were given to the MA who was assigned to the side of the facility a resident resided. -Resident #5's physician orders would have come to her if she was working on that side of the facility on 10/16/20. -She completed a new order tracking form which was what she called the new order/medication refill checklist. -She processed orders by faxing the physician orders to the pharmacy, receiving a confirmation of the fax, and completing a new order tracking form for each medication documented on the physician order. -She faxed over Resident #5's Allegra and triamcinolone prescription which had the physician's office logo at the top right corner. -She thought she faxed over Resident #5's physician visit form dated 10/16/20. -She read over Resident #5's physician orders dated 10/16/20 and she had difficulty reading the portion related to the hydrocortisone cream and Tacrolimus ointment. -She stated "it's written so bad, I can't really make it out." -She should have gotten a clarification of the order from Resident #5's Dermatology office. -When an order could not be read clearly, the MAs were supposed to fax or call the physician to obtain an order clarification. -She did not know why she did not get a clarification of Resident #5's orders dated 10/16/20. -Resident #5 was already using hydrocortisone and Tacrolimus and both medications were already on Resident #5's October 2020 medication administration record (MAR). -There were so many things that happened during her shift and she thought this might be a	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R-C 12/23/2020

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

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D 344	Continued From page 13	D 344		

reason there was no clarification obtained for Resident #5's order.
-She did not document on 10/16/20 in Resident #5's record that she contacted the Dermatologist and she did not document any changes on Resident #5's October 2020 MAR for hydrocortisone cream or Tacrolimus ointment.

Telephone interview with the Resident Care Director (RCD) on 12/22/20 at 11:52am revealed:
-Physician orders for an outside physician visit were processed by: the MA faxing the orders to the pharmacy, receiving a confirmation of the fax, transcribing the orders to the resident's MAR, making a copy of the physician order, starting a new order medication checklist, placing the original order in the resident's record, and placing the copied physician order with the new order medication checklist form.
-The new order medication checklist form was signed by the MA who processed the physician order and a co-signor who was either herself or the Administrator.
-She did not co-sign the orders for Resident #5, but the Administrator co-signed the order.
-She had Resident #5's 10/16/20 physician visit form and she read over the form.
-She had difficulty reading the third order on Resident #5's physician visit form dated 10/16/20 and stated, "the writing is so bad, you can't make out what it says."
-If the MA who processed the order had difficulty reading an order, she expected the MA to contact the physician's office via fax or telephone to clarify the order.
-She read the progress note entry in Resident #5's record dated 10/16/20 and she did not see any documentation that the MA notified Resident #5's Dermatologist to clarify the order.
-She held the MA who took the order and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 344	Continued From page 14 co-signor responsible for ensuring unclear orders were clarified. Telephone interview with the Administrator on 12/23/20 at 8:40am revealed: -Residents were taken to outside appointments by him or the Activities Director. -The physician orders received from outside appointments were given to the MA assigned to the side of the facility the resident resided. -Medication orders were processed by the MAs and the process was to read the order, fax the orders to the pharmacy, receive a confirmation of the fax, transcribe the order to the resident's MAR, once medication arrived place the medication in the medication cart, and administer medication as ordered. -He expected the MAs to follow this process each time. -If the MA was not able to read any portion of the physician order, he expected the MA to call the physician or speak with the physician's nurse to clarify the order. -He did not know he was the co-signor for Resident #5's Dermatology order dated 10/16/20. -He did not recall the order or the portion of the order that was unclear. -He expected the MAs to even ask the RCD or himself what to do if they were not able to read an order clearly. -He would instruct the MA to contact the physician who wrote the order to clarify. -The MA was responsible for obtaining clarification of physician orders.	D 344		