

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
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D 000	Initial Comments The Adult Care Licensure Section conducted an Annual and Follow-Up Survey and a Complaint investigation on 08/31/21-09/03/21 with an exit conference via telephone on 09/03/21. The Franklin County Department of Social Services initiated the complaint investigation on 07/30/21.	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: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#2) who was known to wander into other residents' rooms, causing the other residents to become agitated resulting in two separate altercations with other residents and the resident being injured. The findings are: Review of Resident #2's current FL-2 dated 08/16/21 revealed: -Diagnoses included hyponatremia, pernicious anemia and Alzheimer's disease. -Resident #2 was constantly disoriented. -Resident #2 was ambulatory. -The section for inappropriate behaviors was blank.	D 270	Facility identified all wanderers and residents w/ behaviors on 9/3/21. Behavior care plans will be completed/ followed after each behavior. All care plans w/ identified wanderers/ behaviors have been updated to capture wandering/ behaviors and to include referrals to Psych. Services.	10/1/21

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Donna Dawson

TITLE

Executive Director

(X6) DATE

10/1/2021

STATE FORM

6899

HKWT11

If continuation sheet 1 of 117

Reviewed and acknowledged with addendums on 10/04/21. *Kg*

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D 270	Continued From page 1 -Resident #2 had a wound to her head. Review of Resident #2's personal care flow sheet dated August 2021 revealed: -Level of assistance codes were listed as 1 for supervision and prompting, 2 for limited assistance, 3 for extensive assistance, and 4 fully dependent. -Resident #2 was fully dependent on staff for shower, personal hygiene, grooming, toileting and transfer. -Resident #2 required extensive assistance from staff for dressing. -Resident #2 required supervision for eating, ambulation, mobility and transfers. Review of an incident report dated 07/28/21 revealed: -Resident #2 was laying in the hallway bleeding from a head wound. -Resident #2 was kicked by another resident. -The incident report was signed by a medication aide (MA). Interview with the MA on 09/03/21 at 1:00pm revealed: -She completed the incident report dated 07/28/21. -She saw Resident #2 laying on the floor in the hallway. -When she went over to assess Resident #2, she overheard two residents talking. One resident was asking the other resident "why did you do that to that lady? You did not have to do that lady like that." -While she was trying to assess Resident #2's injuries, a resident came out of the room and proceeded to kick Resident #2 in the face area and the the resident was cursing at the injured resident.	D 270	- For hospice residents w/ behaviors on wandering - Hospice was contacted on 10/1/21 for additional support and/or interventions from interdisciplinary team. <u>ongoing</u> - Completed new Fk-2's on all wanderers/ behaviors to capture this information. <u>10/1/21</u> - POS log updated on all residents w/ wandering and behaviors. <u>10/1/21</u> - In service on wandering started on 9/3/21 - Continued through 9/4, 9/5 and 10/9/21 complete by 10/13/21 - All new hires will be assigned this training on Relias before receiving scheduled assignment. <u>ongoing</u> - ED, RCO, or designee will discuss wanderers and residents w/ behaviors during morning meetings and will review these residents during weekly falls meetings to ensure interventions and processes are effective and followed. - In service on challenging behaviors on 9/29/21 and will be 100% completed on 10/3/2021 <u>10/3/21</u>		

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D 270	Continued From page 2 -Resident #2's head was bleeding very bad. -Two personal care aides (PCA) came to assist the MA with Resident #2 and prevent other residents from causing more harm. Another interview with the MA on 09/03/21 at 1:23pm revealed: -She worked as the MA on 07/28/21 and was the first one to respond when Resident #2 was seen on the floor. -Resident #2 was bleeding from her head and attempting to crawl into another resident's room. -She observed the other resident kick Resident #2 in the face. -Resident #2 had a history of going into other resident rooms causing them to complain to staff. -Other staff and residents had told her Resident #2 would take things from the other residents' rooms. -Staff were trained to redirect out of the rooms when this was observed. Review of the local Emergency Medical Services (EMS) report dated 07/28/21 revealed: -The EMS call was received at 6:30pm for an assault. -Resident #2 was laying on the floor with a pillow under her head. -A facility staff was applying pressure against the top of Resident #2's head. -The staff reported they did not see how the injury occurred, but another unnamed staff had reported they witnessed the resident laying on the floor and another resident kicking the resident in the head. -Resident #2 had several gashes to the top of her head 1.5 inches in length. -It was not known if the resident was hit with an object or if the injuries were from being kicked. -Resident #2 also had a laceration over her right	D 270	-ED, RCD, or designee are to report behaviors by way of incident reports to RDCs after discussing in many meetings -Behavior care plan process will be initiated by ED, RCD, or designee as soon as new behavior is identified. Behavior will be reviewed weekly to ensure processes are followed and interventions are effective. -Behavior care plans will be sent to RDCs for review on the day the new behavior is identified Addendum 10/04/21: Rule Area Completed	ongoing ongoing ongoing 10/03/21	

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D 270	Continued From page 3 eye in the brow. Review of a second incident report dated 07/29/21 revealed: -On 07/28/21 at 6:40pm Resident #2 fell in hallway near room while walking, -Resident #2 was bleeding from top of head, pressure was applied with a cloth and EMS was called. -The report was signed by the Administrator on 07/28/21. Review of Resident #2's Resident Observation Every 30-Minutes Check form dated 08/01/21 revealed: -There was documentation on the form to indicate Resident #2 had been observed between 12:00pm-7:00pm on 08/01/21. -There was no other documentation on the form to indicate Resident #2 had been observed every 30-minutes prior to 12:00pm or after 7:00pm. Review of Resident #2's physician's progress note dated 08/18/21 revealed: -Resident #2's family member had taken her to be seen for a neck injury. -The facility had notified Resident #2's family member on 08/13/21 to report Resident #2 had a cut and a ring of redness around her neck. -There was a 1/2 inch cut on the right lower neck and residual redness noted to be observed during the office visit. Review of Resident #2's physician's progress note dated 08/26/21 revealed Resident #2 was seen for removal of sutures and staples that had been placed to repair a laceration to her scalp following an assault by a fellow resident and was kicked in the head.	D 270		

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D 270	Continued From page 4 Interview with the Administrator on 08/27/21 at 11:00am revealed: -The incident was still under investigation. -Resident #2 was not attacked by another resident on 07/28/21. -Resident #2 fell in the hallway and was crawling toward another resident's room when the resident in the room started yelling at the resident to get away from her. -The Administrator did not feel there was any evidence to support an attack. Interview with a MA on 09/02/21 at 10:00am revealed: -There was a second incident involving Resident #2 in August 2021 but she could not remember the date. -A PCA reported to her that a resident was observed to have her hands around Resident #2's neck and there was a small scratch on her neck. -She noticed a small scratch on Resident #2's neck when she cleaned the area and applied a band aid but noticed red marks around the neck later in the shift. Another interview with the same MA on 09/03/21 at 1:51pm revealed: -There was no increased monitoring of Resident #2 or the other resident that was reported to have put her hands around her neck. -She had reported to the Resident Care Director (RCD) and the Administrator Resident #2 had been going into other resident rooms and they were aggravated with her, but she could not give a date of reporting. -She was instructed to watch Resident #2 by both the RCD and the Administrator, but no interventions were put into place. Interview with the RCD on 09/02/21 at 4:00pm	D 270		

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D 270	Continued From page 5 revealed: -She worked on 07/28/21 and was aware Resident #2 had been kicked in the head by another resident. -She had started but not completed a psychiatric referral for the resident that kicked Resident #2 because she did not think about requesting one until last week and the PCP was on vacation at that time. -She observed a red ring around Resident #2's neck a couple of hours after the PCA reported a scratch on her neck. -The PCA only told her about the scratch and she could not say what the red ring was from on Resident #2's neck. Interview with the RCD on 09/03/21 at 2:20pm revealed: -Resident #2 had a history of going into other residents' rooms and some of the residents did not like it. -Resident #2 would take things that belonged to other residents. -There were other residents in the facility that would go into other residents' rooms and take their things as well. -Staff keep an eye on the residents and no other interventions were put into place. -She thought increased resident engagement might have prevented the incident on 07/28/21. Interview with a resident on 09/01/21 at 3:33pm revealed: -He locked the door to his room because residents would wander in at "all times of the day and night". -Resident #2 would come into his room and take things. -He complained to the staff and he was told to lock his door. -He did not know why Resident #2 was allowed to	D 270			

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D 270	Continued From page 6 steal other residents' belongings. Telephone interview with a resident's family member on 09/03/21 at 1:17pm revealed: -Resident #2 was his family member's roommate. -He was in his family member's room when Resident #2 fell and received a cut to her head. -Resident #2 was not in the room but was walking in the hallway; he knew she was walking around in the hallway because he saw her walk past the open door to the room he was visiting in. -He saw Resident #2 walk passed the open door and then heard "hollering and a commotion"; he heard someone yell "you are not stealing my stuff". -He leaned into the hallway to see what was going on and observed Resident #2 stumbling backwards on her heels as if she had been shoved or pushed from the front; she was facing an open doorway. -From where he was standing, he could not see who was in the room down the hall or who could have pushed Resident #2 because they were still in the room and Resident #2 was the only person in the hallway. -As he stepped into the hallway, a resident stepped out of the room that Resident #2 was still facing and pushed Resident #2. -When the resident pushed Resident #2, she lost her footing and began to fall backwards. -As Resident #2 fell backwards she hit her head against the handrail on the wall. -She fell to the floor and landed on her right side where she curled up into a fetal position. -The resident that pushed the resident continued to yell at Resident #2 but did not touch her anymore. -He did not see the resident that pushed Resident #2 hit, push or kick her after she fell to the ground.	D 270		

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D 270	Continued From page 7 -There were no other residents in the hallway. -He looked back up the hallway and observed a PCA running down the hallway towards Resident #2; the PCA helped Resident #2 into a sitting position and said, "oh my gosh she is bleeding". -He could see the right side of Resident #2's head; blood was running down her forehead and face to her chin but he could not see where the blood was coming from. -Two other staff came to the hallway and began assessing Resident #2; one of the staff was the MA and she said Resident #2 needed to be transported by EMS to the hospital because Resident #2 may need stitches. -He was not asked any questions by anyone from the facility about what happened or what he witnessed. -He did not contact the Administrator or the RCD to report what he witnessed. Interview with a MA/PCA on 09/02/21 at 8:27am revealed: -She worked both the day and the night shifts. -It was hard to keep "eyes on" the residents who wandered. -She had to watch the wandering residents because they would go into other residents' rooms and it made the residents who resided in the rooms upset. -Some of the residents locked their doors to keep the wandering residents out of their room. -Sometimes the wandering residents would become combative. -There were a few residents that had Sundowners (a state of confusion or anxiety that occurs in the evenings) and would wander at night. -There were two residents that wandered at night, even after they were administered a PRN (as needed) medication.	D 270		

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D 270	Continued From page 8 -A couple of the residents locked their doors at night to keep the residents with Sundowners out of their rooms so their sleep was not disturbed. Telephone interview with Resident #2's family member on 09/03/21 at 12:24pm revealed: -Resident #2 wandered the hallway. -The RCD had told her residents who wandered into other resident's rooms were redirected. -Her family member was not the only resident who wandered. -She started noticing bruising on Resident #2 in May 2021 and started to visit her family member more often because she was worried and scared for her family member. -She was afraid to say anything to staff for fear of retaliation. -On 05/10/21, Resident #2 had bruising and bleeding to both ears; she mentioned it to the Administrator. On 05/31/21, Resident #2 had a bad bruise on the backside of her thigh after offering to change the resident's brief. -The staff had tried to get her to not change the brief, that they would do it. -When she questioned the staff about the bruise, she was told "they were having a problem with the night staff." -Resident #2 was having an increase in incidents and she thought the staff "were beating her." -She was shocked when she was informed the incidents, were caused by residents and was surprised the facility staff had allowed it to happen. -On 06/16/21, Resident #2's upper left shoulder was bruised. -On 07/02/21, Resident #2 had bruising on her right thigh between her hips and buttocks. -On 07/11/21, Resident #2's right thigh was bruised, as well as her neck in the exact same	D 270		

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D 270	Continued From page 9 place as the 08/13/21 incident. -She felt the residents did not have supervision and could "do what they wanted to do." -A lot of times during her visits, she did not see staff. -She would leave Resident #2's room between 10:30pm-11:00pm, and staff would be asleep in the dayroom. -She did not take any pictures of the staff asleep because the room was dark. -She would come out of Resident #2's room and staff would not even know she was there. -She had started staying late to try to see who was doing "this to her family member." -She had started staying late sometime before 07/28/21, but she could not recall the exact date. -A family member of Resident #2's roommate was the one who called her about the incident on 08/06/21. -On 08/13/21, she talked to the RCD about the scratch and red area on Resident #2's neck and was told Resident #2 was being supervised but "we cannot hold her down." -She regretted not doing anything sooner about the unexplained bruising she had seen on Resident #2. -She took Resident #2 home with her on, 08/13/21, because she was afraid for Resident #2's life. Telephone interview with a nurse at Resident #2's primary care provider's (PCP) office on 09/03/21 at 2:22pm revealed: -He had spoken to Resident #2's family member on 08/17/21 regarding her concern Resident #2 had been attacked and was increasingly concerned about her safety. -He did not see any documentation in Resident #2's medical record that the facility had reached out for any assistance related to Resident #2.	D 270		

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D 270	Continued From page 10 Review of Resident #2's PCP office visit summary dated 08/06/21 revealed: -Resident #2 was seen to remove sutures. -Resident #2's family member reported the resident was assaulted by another resident and kicked in the head. -There was a large amount of dried blood on the scalp. Review of Resident #2's PCP office visit summary dated 08/18/21 revealed: -Resident #2 presented with a healing ½ inch cut on the right lower neck; there was some residual erythema (redness) around the neck. -Resident #2's family member reported she had received a call on 08/13/21 from facility staff regarding a cut and redness to Resident #2's neck. -The family member reported the resident was only at the facility for a couple of hours on 08/13/21 at which time the incident occurred and no one could tell the family member what happened during that time. Telephone interview with a PCP at the facility on 09/03/21 at 1:45pm revealed: -She was not familiar with Resident #2 because she was only covering for the facility's PCP who was not available. -If she had been notified Resident #2 was wandering, she would have wanted to see what was causing this behavior, such as pain, a urinary tract infection, and many other things that could cause this behavior. -Resident #2 should have been redirected. -Medication would have been considered if there was no underlying reason identified for the wandering behavior. -Resident #2 should have been referred to a	D 270			

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D 270	Continued From page 11 mental health provider for evaluation. Attempted interview with Resident #2's PCP or NP on 09/02/21 at 2:22pm was unsuccessful. Interview with a PCA on 09/03/21 at 11:33am revealed: -She had found residents who wander in another residents room. -She would remove the resident, walk them to the living room and give the a snack. -She reported to the MA when she found a resident who had wandered into another residents room. -She noticed a resident standing at the exit door, looking out side. -She approached the resident and walked with her to the living room. -She noticed "a scratch" around the residents neck as they walked to the living room. -The scratch was about an inch long and red. -She reported the scratch to the MA. -The resident was known to wander into other residents' rooms. -She would take the resident to activities or give her a book to look at pictures. -She worked as dietary aide the day the resident was found on the floor. -The resident would wander in other residents' rooms. -The resident would lock herself in other residents' rooms. Interview with the Regional Director of Clinical Services (RDCS) on 09/01/21 at 10:45am revealed: -She was aware of Resident #2 falling and getting kicked in the head by another resident on 07/28/21 but did not receive the accident/injury report until 08/27/21.	D 270			

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D 270	Continued From page 12 -She received a text message on 07/28/21 indicating Resident #1 had fallen but it did not mention the assault. Interview with the RDCS on 09/02/21 at 12:30pm revealed: -The facility did not have a supervision policy or any policy related to increased supervision of residents. -The facility did not have a policy that addressed aggressive or wandering behaviors. -Staff were instructed to redirect residents when they would go into other resident rooms. -Wandering behaviors, especially going in and out of other resident's rooms, should be care planned to prevent the resident from agitating others in the facility. -She was concerned the agitation could escalate such as what happened on 07/28/21. -The RCD was responsible for ensuring interventions were put into place. Interview with the RDCS on 09/03/21 at 12:46pm revealed: -She was the representative for the facility because the Administrator was unavailable. -A behavioral form should be completed on all residents when they exhibit a behavior. -The RCD would be notified of all residents who continually wander into other residents rooms. -The RCD would give the behavioral form to the staff to complete. -The staff would document the behavioral episode on the behavioral form. -The staff would return the behavioral form to the RCD. -The RCD would document interventions to be implemented on the behavioral form. -The interventions would consist of coloring, going outside for a walk or a snack.	D 270			

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NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGVILLE, 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 270	Continued From page 13 -The RCD would fax the behavioral form to the RDCS. -The RDCS would review the interventions. -If the RDCS approved of interventions, she would send an email to the RCD. -If the RDCS disapproved of interventions, she would send an email to the RCD with suggestions. -Once the interventions were agreed upon, the RCD would enter the interventions into the resident's personal care log. -The PCAs would implement the interventions. -All residents with behaviors would be placed on a 30-minute check at a minimum of 72 hours. -The 30-minute behavioral checks were taught in the 80-hour personal care training class. -The MA would document in the resident's record each shift at a minimal of 72 hours, regarding any behaviors and effectiveness of the interventions. -The MA would communicate with the RCD regarding behaviors. -The PCP would be notified of all behaviors. -A referral would be made for a mental health evaluation if ordered. Interview with the RCD on 09/03/21 at 1:57pm revealed: -Residents should be re-directed when having behaviors. -The PCA would notify the MA of any residents wandering in other residents rooms. -The PCA and MA would try interventions of coloring, looking a picture books or walking outside when behaviors occurred. -The PCP would be notified if interventions were not helping. -The resident's record would be placed in the "hot box" for staff to document each shift regarding behaviors. -The documentation would continue at least 72	D 270			

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NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
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D 270	Continued From page 14 hours or until the behavior has subsided. -The doctor would make referral for a psychiatry evaluation if needed -The MA should complete an incident report for all unwarranted behaviors. The facility failed to provide supervision for Resident #2 who had a history of wandering into other residents' rooms, which resulted in arguments and altercations with other residents and Resident #2 being pushed by a resident causing Resident #2 to fall to the floor and was then kicked in the head by another resident causing multiple lacerations. The failure of the facility to provide supervision resulted in physical harm and neglect and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/03/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 3, 2021.	D 270			
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by:	D 276	- In service on 9/29/21 related to proper application and removal of Ted hose, including monitoring residents w/ ted hose to ensure they remain in place properly. 100% care steps completed by 10/3/21. - All new hires will be validated on donning and doffing of Ted hose by LHPs nurse.	10/3/21 ongoing	

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D 276	Continued From page 15 Based on observations, interviews, and record reviews, the facility failed to implement physician orders for 2 of 2 sampled residents (#7 and #8) for a resident whose bilateral compression stockings were not applied daily as ordered (#7) and a resident who had an order for finger stick blood sugar (FSBS) checks four times a day (#8). The findings are: 1. Review of Resident #7's current FL-2 dated 08/04/21 revealed: -Diagnoses included Parkinson's disease, anemia, atrial fibrillation, and hypothyroidism. -The resident was semi-ambulatory using a wheelchair and a walker. -The resident required assistance with bathing and dressing. Review of Resident #7's Care Plan dated 05/26/21 revealed the resident needed assistance with toileting, ambulation, bathing, grooming, transfers, and dressing. Review of Resident #7's physician's order dated 06/22/21 revealed Resident #7 had bilateral +2 to +3 pitting edema. Review of Resident #7's physician's orders revealed an order dated 08/10/21 for compression stockings (used to prevent swelling) on in the am and off in the pm. Observation of Resident #7's room on 08/31/21 at 9:15am: -He was seated in his wheelchair. -There were a pair of compression stockings on top of his dresser. Interview with Resident #7 on 08/31/21 at 9:15am	D 276	- ED, RCD or designee will monitor Residents w/ Ted hose daily to ensure they are applied, in place properly, w/out creases or wrinkles and removed at bed time. Addendum 10/04/21: Rule Area Completed	ongoing 10/03/21	

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D 276	Continued From page 16 revealed: -He had to wear his compression stockings every day. -They were to be placed on in the morning before getting out of bed. -He could not put the compression stockings on by himself. -He called the staff to assist him with putting his compression stockings on. -He did not receive assistance every day to put the compression stockings on. Review of Resident #7's Medication Administration Record (MAR) for August 2021 revealed: -There was an entry for compression stockings put on in the morning with an application time of 8:00am and remove at bedtime with a removal time of 8:00pm. -There was a hand-written note on the MAR which read as not on the discharge summary. -There was no documentation the compression stockings had been applied. Telephone interview with Resident #7's primary care provider's (PCP) assistant on 09/01/21 at 9:22am revealed: -Resident #7 was seen by the PCP on 08/26/21. -Resident #7 was supposed to wear his compression stockings daily and the facility staff was expected to assist with applying. -If Resident #7 did not wear the compression stockings as ordered he would have increased swelling in his legs. Observation of Resident #7's legs on 09/01/21 at 11:34am revealed: -The compression stockings were pushed down around his ankles. -The compression stockings had multiple	D 276		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
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D 276	Continued From page 17 wrinkles where the stockings were pushed down. -The pressure caused by the compression stockings being pushed down had caused one-inch circular indentions around both ankles. Interview with Resident #7 on 09/01/21 at 11:34am revealed: -No one offered to remove the compression stockings, last night, 08/31/21, so he pushed them down as far as he could. -It was uncomfortable to sleep in the compression stockings. -His ankle area was hurting from the compression stockings, but he could not get the stockings all the way off. -He had not asked anyone to assist him with the compression stockings because "he had not seen too many people." -He was not able to pull the compression stockings up on his own after a fall on 08/30/21, where he injured his left hand. Interviews with a medication aide (MA) on 09/01/21 at 11:42am and 3:24pm revealed: -Resident #7 usually had his compression stockings on when she came into work. -She documented Resident #7 had his compression stockings on because they were on. -She noticed Resident #7's compression stockings were pushed down around his ankles today, 09/01/21. -She did not ask him about the compression stockings today. -If Resident #7 did not have his compression stockings on he would let the staff know. -She had not talked to Resident #7's PCP about the compression stockings but had talked to the Resident Care Director (RCD). Interview with another MA on 09/01/21 at	D 276			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/03/2021
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NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596
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D 276	Continued From page 18 12:25pm revealed: -She saw Resident #7's compression stockings "bunched" around his ankles on 08/31/21. -Resident #7 had complained the compression stockings were too tight so she removed the stockings. -She had not notified Resident #7's PCP that Resident #7 was not wearing the compression stockings as ordered because she was not usually assigned to the resident. Interview with the RCD on 09/01/21 at 3:25pm revealed: -The MA was responsible for making sure Resident #7 had the compression stockings on in the am and off in the pm. -A personal care aide (PCA) could assist Resident #7 with applying his compression stockings, but the MA would need to make sure the stockings had been applied correctly. -Resident #7 knew he was supposed to wear his compression stockings daily and he tried to put them on himself. -She had observed Resident #7's compressions stockings on backward when the resident had put them on. -She was not aware of Resident #7 ever refusing to wear his compression stockings. -No one had told her Resident #7 had complained of his compression stockings being too tight or that he pushed the compression stockings around his ankles. -She expected the MA to encourage Resident #7 to wear the stockings correctly because pushing them down around his ankles could cause harm by cutting off the circulation. -Resident #7's compression stockings should be removed at night, rinsed, hung to dry, and re-applied in the morning. -A MA had documented on the August 2021 MAR	D 276		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
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D 276	Continued From page 19 the compression stockings were not on the discharge summary. -She had the order for the compression stockings for Resident #7 clarified and she thought she had told staff, but she did not recall who she told, "if anybody." Observation of Resident #7 on 09/02/21 at 8:45am revealed his compression stockings were pulled up to his knees. Interview with Resident #7 on 09/02/21 at :45am revealed: -The staff who delivered his breakfast tray had pulled his compression stockings up this am. -No one had removed the compressions stockings last night, 09/01/21, so he pushed them down around his ankles. -He did not ask anyone to remove the compression stockings at bedtime. Interview with a PCA on 09/02/21 at 8:52am revealed she was assigned to Resident #7, but she had not pulled the compressions stockings up because they were already pulled up when she saw him this morning, 09/02/21. Interview with a second PCA on 09/02/21 at 8:54am revealed: -She had worked with Resident #7 but not today, 09/02/21. -She had been trained to apply compression stockings and make sure they were pulled up with no wrinkles. -Resident #7 liked to have his compression stockings pulled up. Interview with a dietary aide/PCA on 09/02/21 at 9:00am revealed she had delivered Resident #7's breakfast tray today, 09/02/21, but she did not	D 276			

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D 276	Continued From page 20 pull the resident's compression stockings up and did not know who had. Telephone interview with a third shift MA on 09/02/21 at 9:45am revealed: -If Resident #7 had compression stockings on at night, she took them off, washed them, and hung the stockings up to dry. -She did not recall if Resident #7 had worn his compression stockings after he returned from the skilled nursing facility (SNF), but if the compression stockings were not listed on the MAR she would not have applied the compression stockings because she would not have known there was an order. Interview with a third MA on 09/02/21 at 10:00am revealed: -She was the only MA working the night Resident #7 returned from the SNF. -The Administrator gave her the discharge summary from the SNF. -She used the discharge summary as a guide to update Resident #7's MAR. -She had not seen the clarification orders dated 08/10/21. Interview with the rehabilitation manager with the facility's contracted rehabilitation company on 09/02/21 at 2:24pm revealed: -A physical therapist had measured Resident #7 for compression stockings and ordered the stockings on 06/23/21. -Resident #7's compression stockings should be applied in the am and removed in the pm. -She had observed Resident #7 without the compression stockings and had applied them herself. -She reported this to the MA on duty at the time. -Resident #7 had told her it took him two hours to	D 276			

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NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
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D 276	Continued From page 21 put his compression stockings on and an hour to remove them. -The compression stockings had been ordered to prevent swelling and improve blood flow. -If the resident had the stockings pushed down around his ankles, he would experience increased pain and he could stand up and not feel his feet because of decreased sensation which could cause him to have a fall. -Not wearing the compression stockings appropriately would also cause his blood to not circulate appropriately. -Resident #7 would not remember to ask for assistance with his compression stockings and staff should be helping with this task. Interview with the Regional Director of Clinical Services (RDCS) on 09/02/21 at 5:24pm revealed: -She was a representative for the facility because the Administrator was not available. -She expected compression stockings to be applied in the mornings before the resident got out of the bed and removed in the evenings and rinsed out. -Residents who wore compression stockings should be checked throughout the day to make sure the compression stockings did not have any wrinkles because the wrinkles could cause circulatory issues. -She expected Resident #7's order for compression stockings to have been applied and removed as ordered by the facility staff. 2. Review of Resident #8's current FL2 dated 05/04/21 revealed: -Diagnoses included Alzheimer's disease, senile dementia, hyperglycemia, diabetes mellitus type 2, hypertension and anxiety disorder. -There was an order for fingerstick blood sugar	D 276			

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NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
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D 276	Continued From page 22 (FSBS) four times daily. Review of Resident #8's June 2021 medication administration record (MAR) revealed: -There was an entry for fingerstick blood sugar (FSBS) four times daily and record on MAR and flowsheet at 7:45am, 11:45am, 5:45pm and 8:00pm. -There were 14 omissions out of 120 opportunities to obtain FSBS for the month of June 2021. -There were no documented reasons for the omissions. Review of Resident #8's July 2021 MAR revealed: -There was an entry for FSBS four times daily and record on MAR and flowsheet at 7:45am, 11:45am, 5:45pm and 8:00pm. -There were 23 omissions out of 124 opportunities to obtain FSBS for the month of July 2021. -There were no documented reasons for omissions. Review of Resident #8's August 2021 MAR revealed: -There was an entry for FSBS four times daily and record on MAR and flowsheet at 7:45am, 11:45am, 5:45pm and 8:00pm. -There were 5 omissions out of 124 opportunities to obtain FSBS for the month of August 2021. -There were no documented reasons for omissions. Interview with a medication aide (MA) on 08/31/21 at 12:20pm revealed: -She would document the FSBS reading on the blood sugar flow sheet. -Sometimes she would forget to document the FSBS reading if she had to administer insulin.	D 276	2 med techs were immediately removed from med cart and retrained on NCDHHS med administration course. - med tech refresher course of medication administration was completed. - all med techs attended a 15 hour med administration training, new order tracking, meds not available, Coumadin, diabetes, proper transcription of orders to MAR, proper use of BS flowsheets, proper time FSBS checks, calibration of glucometers, following all parameters - such as meds given on empty stomach or w/ foods, high or low BS, timely administration of meds, procedures for med errors, clarification of orders, reordering medications, components of complete medication orders, proper documentation, follow up of PRN meds and to flaglets of medication administration. - ED, RCD, LHPs nurse or designee will conduct med pass observations weekly.	9/2/21 9/10/21 10/1/21 ongoing	

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D 276	Continued From page 23 Interview with a second MA on 09/02/21 at 10:30am revealed: -She would document the FSBS readings on the blood sugar flow sheet if she did not forget. -She would forget to document. Interview with Resident Care Director (RCD) on 09/01/21 at 11:37am revealed: -The MAs should document on the MAR after each FSBS was completed. -The staff was expected to complete all orders as written. Interview with the Regional Director of Clinical Services (RDSCS) on 09/01/21 at 11:55am revealed: -She was the representative for the facility because the Administrator was unavailable. -She was not aware that FSBS were not done as ordered. -All MAs were expected to implement all orders as written. -If it was not documented, it was considered not done. Interview with the RDSCS on 09/02/21 at 6:56pm revealed: -FSBS checks should be obtained 15 - 30 minutes before meals. -The MAs would document the FSBS readings on the blood sugar flow sheet. -She expected the MAs to document on the MAR each time FSBS was checked	D 276			
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of	D 338			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/03/2021
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D 338	Continued From page 24 all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure the residents were treated with respect and dignity by not providing adequate furnishings for residents to eat in their rooms when communal dining was stopped due to COVID 19 and residents were forced to lock the doors to their rooms to keep other residents who wandered from coming in and out of their rooms. The findings are: 1. Observation of the lunch meal on 08/31/21 at 12:15pm revealed: -There were two residents in one resident room; one was seated and holding her plate while eating and the other resident was eating while standing and holding her plate. -There were no bedside tables in the room for the resident to place their plate to eat. Observation of the breakfast meal on 09/01/21 from 8:18am-8:25am revealed: -There were two personal care aides (PCA) serving plates of food from an open food delivery rack to the residents in their rooms. -One resident was sitting on the side of her bed and had her breakfast tray on the seat of her walker. -A second resident was sitting on a chair in her room and was holding her plate with one hand and using her other hand to eat with her fingers. -A third resident had a small table that was as tall as her knees; she held her plate with one hand	D 338	- Inservice on residents rights started on 9/3, 9/4, 9/5 and 9/6 and 100% of staff will be inserviced by 10/3/21 - Tables were purchased for residents and chairs are used from dining room to ensure all residents are provided w/adequate furnishings during in room dining due to Covid 19. - ED, RCD or designee will ensure all new staff have residents rights training at hire and all staff will be retrained biannually and as needed Addendum 10/04/21: Rule Area Completed	10/3/21 9/10/21 ongoing 10/03/21

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGVILLE, 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 338	Continued From page 26 -There was a second resident standing in another room; she stated she did not get breakfast that morning, but she had a full breakfast tray on her dresser. -The breakfast tray had not been eaten. -The resident did not have a place to sit and eat her meal. Interview with the Kitchen Manager (KM) on 08/31/21 at 10:25am revealed: -The residents were eating in their rooms because a kitchen staff had tested positive for COVID-19 on 08/30/21. -When there was a positive case of COVID-19 in the facility the residents' meals were served in their rooms. Interview with the Activity Director on 09/01/21 at 3:43pm revealed: -The residents were eating in their rooms because a staff tested positive for COVID-19. -Some of the residents had over the bed tables because they had been on hospice or received home health services; some families brought in over the bed tables for some residents. -The facility had some over-the-bed tables, but there was not enough for all the residents to have one. Observation of resident room #134 on 09/01/21 at 8:00am revealed: -A resident was in the bed asleep. -There was a disposable plate on the bedside dresser located by a recliner. Observation of resident room #133 on 09/01/21 at 8:03am revealed: -The room was a semiprivate room and the two residents were each asleep in their bed. -There were disposable plates on a bedside	D 338	- ED, RCD, or designee will monitor morning meals, lunches, and dinner meals to ensure there is no cross contamination - Inservice for staff on Cross Contamination started on 9/29 and will be 100% completed by 10/3/21	<i>ongoing</i> <u>10/3/21</u>	

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D 338	Continued From page 27 dresser by each bed. -There was no place in the room to set the plate of food. Observation of resident room #135 on 09/01/21 at 8:04am revealed: -A resident was sitting in a chair, removing plastic wrap from a disposable plate he held in his hand. -When he stuck his fork into the donut on his plate, the plate was off balance and began to tip over because the plate was not on a solid surface. -There was another resident asleep in bed with a disposable plate left on the bedside dresser. -There was no place in the room to set the plate of food. Interview with the resident who resided in room # 135 revealed it was "a little aggravating" to have to hold his plate while he ate. Interview with another resident on 09/01/21 revealed: -There was no tray or tray table available for her to eat her meals from. -She held her plate in her hand to eat but managed ok. Observation of resident room #132 on 09/01/21 at 8:20am revealed: -The resident was eating breakfast with his plate rested on an over the bed table. -Another resident was holding his plate while eating. -There was no place in the room to set the plate of food. Observation of resident room #126 on 09/01/21 at 8:22am revealed the resident was holding a plate to eat because there was no place in the room to	D 338	-ED, RCD, or designee are to walk through during breakfast to ensure all residents are up and eating. -For those residents that do not want to get up the ED, RCD, or designee will ensure staff has provided PO hydration/nutrition for residents at a later time -Care plans and PCS logs for late risers updated to capture this information.	<u>ongoing</u> <u>ongoing</u> <u>10/1/21</u>	

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D 338	Continued From page 28 set the plate of food. Observation of the lunch meal service on 09/01/21 between 12:00pm-12:25pm revealed: -A resident was standing in the hallway eating her lunch from a disposable plate. -Another resident was sitting in the day room and staff were setting his meal on the seat of his walker. -The resident was eating the meal that was placed on the seat of his walker. Interview with a resident on 09/01/21 at 4:23pm revealed she sat in her wheelchair and ate from her plate on the bedside dresser since she had to eat in her bedroom. Interview with a MA on 09/02/21 at 1:27am revealed: -The residents would eat in their rooms when the facility was "short-staffed". -Some residents would stay in bed because the bedside table would not fit under their wheelchair. -All residents did not have bedside tables. -Some residents would place their plates on their nightstands. Interview with the Resident Care Director (RCD) on 09/03/21 at 2:20pm revealed: -Staff were expected to assist residents to sit in a chair or up in bed for meals. -Staff were expected to wake a resident up if they were asleep when the meals were served. -Staff should return the plate to the kitchen if the sleeping resident refused to get up for the meal. -Staff should not leave the meal on the dresser or table in the resident's room. -She was aware some of the residents did not have a place in the room to set their plate of food. -Residents with a tray should not have to hold the	D 338			

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D 338	Continued From page 29 plate in their hands to eat, and a chair should be placed by the dresser. Interview with the Regional Director of Clinical Services (RDCS) on 09/02/21 at 5:46pm revealed: -Most of the residents had over the bed tables, but some had nightstands to eat off; she knew it was an issue. -She knew they needed to order some type of table for the residents to eat off; they considered television trays. -The direction from the local health department was the residents were to eat in their rooms. Interview with the RDCS on 09/03/21 at 3:00pm revealed: -She expected residents to be assisted to get up and ready for meals. -If residents refused to eat, their plates should be sent back to the kitchen to be reheated, should the resident decide they wanted the meal later. -She had conducted training approximately 1 month ago about residents missing meals. -She was concerned if residents were not awakened to eat, they could lose weight. -She was also concerned that a resident who did not eat would have decreased protein intake and this would increase the risk of pressure ulcers. 2. Interview with a resident on 09/01/21 at 3:33pm revealed: -He locked the door to his room because other residents would wander in at "all times of the day and night". -There were residents who would take his personal belongings. -He had told the staff when he first moved into the facility, and he was told to lock his door. -He spent most of the day in his room with the	D 338			

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D 338	Continued From page 30 door locked. Interview with a second resident on 09/01/21 at 3:37pm revealed: -He locked his door because other residents would come in and out during the day and night. -One resident came in during the night and took a t-shirt out of his dirty clothes and was trying to put the shirt on like a pair of pants. Interview with the Activity Director (AD) on 09/01/21 at 3:43pm revealed: -Some of the residents kept their doors locked because some of the residents wandered and would wander into rooms they did not reside in. -Some of the residents who wandered would also take items out of rooms that did not belong to them. -She would try to redirect residents, but there was not a lot that could be done because of their dementia. Interview with a MA/personal care aide (PCA) on 09/02/21 at 8:27am revealed: -She worked both the day and the night shifts. -The residents who resided on the right side of the facility required more attention because they were more ambulatory and wandered around a lot. -The residents who resided on the left side of the facility were wheelchair-bound and were easier to care for because they did not wander. -It was hard to keep "eyes on" the residents who wandered. -It became more difficult to monitor residents while the MA administered medication because it took a staff off the floor. -She had to watch the residents who wandered because they would go into other residents' rooms and it made the residents who resided in	D 338	- Facility identified all wanderers and residents w/ behaviors on 9/3. Behavior care plans will be completed/ followed after each behavior. - all care plans w/ identified wanderers/ behaviors have been updated to capture wandering/ behaviors and to include referrals to psych. services - For hospice residents w/ behaviors or wandering. Hospice was contacted on 10/1/21 for additional support and/or interventions from interdisciplinary team. ongoing - Completed new FL-2's on all wanderers/ behaviors to capture this information. - ACS logs updated on all residents w/ wandering and behaviors. - In service on wandering started on 9/3 - Continued through 9/4, 9/5 and 100% Complete by 10/3/21	10/1/21	10/1/21	10/3/21

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D 338	Continued From page 31 the rooms upset and they would lock their doors. -Sometimes the residents who wandered would become combative. -There were a few residents who had Sundowners (a state of confusion or anxiety that occurs in the evenings) and would wander at night. -Some of the residents did not go to sleep until 2:00am or 3:00am and some of them woke up at 3:00am. -There were two residents who wandered at night, even after they were administered a PRN (as needed) medication. -A couple of the residents locked their doors at night to keep the residents out of their rooms, so their sleep was not disturbed. Telephone interview with another MA/PCA on 09/02/21 at 9:15am revealed it was a challenge to monitor, provide care for, and administer medications to the residents because they required so much attention. Telephone interview with a resident's family member on 09/03/21 at 12:24pm revealed: -Her family member wandered the hallway. -The Resident Care Director (RCD) had told her residents who wandered into other resident's rooms were redirected. -Her family member was not the only resident who wandered. -She had a recent encounter with a male resident in her family member's room; the male resident would not leave the room. -She could not find staff to assist her with getting the male resident out of the room; the male resident threw a chair, and she screamed. -She called the desk to get assistance with the male resident and when the MA who answered the phone did not respond to her request to get	D 338	-all new hires will be assigned this training on Relias before receiving scheduled assignment -ED, RCD, or designee will discuss wanderers and residents w/ behaviors during morning meetings and will review these residents during weekly falls meetings to ensure interventions and processes are effective and followed -In service on challenging behaviors on 9/29 and will be 100% completed on 10/3/21 -ED, RCD, or designee are to report behaviors by way of incident reports to RCDs after discussing in morning meetings -Behavior care plan process will be initiated by ED, RCD, or designee as soon as new behavior will be reviewed weekly to ensure processes are followed and intervention are effective. -Behavior Care Plans will be sent to RCDs for review on the day the new behavior is identified.	ongoing ongoing 10/3/21 ongoing ongoing ongoing	

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D 338	Continued From page 32 the male resident out of her family member's room, she immediately hung up and called the RCD who had heard the scream and was on her way to the room. -The RCD stated she was the only staff who could handle the resident. Telephone interview with another resident's family member on 09/03/21 at 1:17pm revealed: -He noticed multiple residents walking around the halls and taking things out of other residents' rooms. -When he talked to the Administrator and RCD about this behavior, he was told it was a dementia unit and it was part of the disease. -When he told a MA about this same behavior, she told him she needed to sit at the front desk because they were short-staffed. -He had complained to the Administrator and the RCD multiple times about staff not engaging the residents but nothing was ever done about it. -Anytime he voiced concern over the wandering behavior he was always told it was part of the dementia. Interview with the RCD on 09/03/21 at 12:08pm revealed: -There were "several" residents who wandered in other resident rooms. -There was one resident who would lock herself in other resident rooms. -There was another resident who would get in other residents' beds. -The staff was encouraged to take residents who wandered to the living room if they were seen in other resident rooms. -The staff would take residents who wandered to the living room when they were seen in other resident rooms. -The MA should be completing an incident report	D 338			

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D 338	Continued From page 33 on residents who continually wander into other resident rooms. -The staff should be implementing interventions to re-direct residents who wandered, such as going outside for a walk or coloring. Interview with Regional Director of Clinical Services on 09/03/21 at 12:46pm revealed: -Residents with a history of wandering should be re-directed. -There should be interventions in place for residents who wandered, such as going for a walk, conversation, or activities provided by the Activity Department. -There were residents in the facility who wandered daily. -She expected the staff to notify her of all incidents, including residents who continually wandered into other resident rooms. -She was concerned if residents continued to wander in other resident's rooms that behaviors would escalate. The facility failed to treat residents with respect and dignity by not providing a place for residents to eat their meals in their rooms resulting in the residents having to eat their meals while using their laps and the seat of their walker as a surface to place their plates; residents were observed walking in the hall carrying their plates trying to eat as they walked; and residents had to lock the doors to their rooms to keep residents who wandered from entering their rooms. This 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 09/03/21 for this violation.	D 338			

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D 338	Continued From page 34	D 338		
	CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 18, 2021.			
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION The findings are: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 4 residents (#3, #10, #11) observed during the morning medication pass including errors with a thyroid medication (#10, #11); a vitamin supplement (#11); omission of an eye drop for dry eyes (#3); omission of a pain medication, a laxative and a topical cream (#10); and for 4 of 5 residents sampled for record review including errors with a medication for blood pressure (#3 and #8); a medication for sleep and medication used to treat high blood sugar (#8); a pain medication and an iron supplement (#3); a medication used to treat atrial fibrillation, a medication used to treat hypothyroidism, and a medication used to treat	D 358	- 2 med techs were immediately removed from med cart and retrained on NCDHHS medication administration course - Med tech refresher course of medication administration was completed. - All med techs attended a 15 hour med. administration training, new order tracking, meds not available, Coumadin, diabetes, proper transcription of orders to mar, proper use of BS flow sheets, proper time FSBS checks, calibration of glucometer, following all order parameters - such as meds given on empty stomach or w/ foods, high or low blood sugars, timely administration of meds,	9/2/21 9/10/21 10/1/21

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D 358	Continued From page 35 insomnia (#7); and an antidepressant (#5). 1. The medication error rate was 23% as evidenced by the observation of 7 errors out of 31 opportunities during the 8:00am/9:00am medication passes on 09/01/21. a. Review of Resident #10's current FL-2 dated 06/22/21 revealed diagnoses included advanced dementia, hypertension, hypothyroidism, gastroesophageal reflux disease, anxiety, depression, chronic pain due to osteoarthritis and gait impairment. 1. Review of Resident #10's physician order dated 06/22/21 revealed an order for levothyroxine (used to treat an underactive thyroid gland) 88mcg one daily on an empty stomach. Observation of the morning medication pass on 9/01/21 at 8:50am revealed: -The medication aide (MA) administered levothyroxine at 8:50am to Resident #10. -Levothyroxine was scheduled to be administered at 7:00am on an empty stomach. Observation of Resident #10 on 09/01/21 at 8:50am revealed she was seated in her wheelchair in her room eating breakfast. Interview with the medication aide (MA) on 08/31/21 at 12:03pm revealed the breakfast meal was usually served between 7:45am and 8:00am. Interview with the MA on 09/01/21 at 10:50am revealed: -She did not know levothyroxine was to be administered on an empty stomach. -She did not notice the directions on the	D 358	<i>Procedures for med errors, Clarification of orders, Reordering medications, Components of complete medication orders, proper documentation, follow up of PRN meds and to rights of medication administration.</i> Addendum 10/04/21: Rule Area Completed /21	10/01

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D 358	Continued From page 36 prescription label. -She thought all of Resident #10's morning medications were scheduled at 8:00am. Review of Resident #10's medication administration record (MAR) for September 2021 revealed: -There was an entry for levothyroxine 88mcg one daily on an empty stomach at 7:00am -There was documentation that levothyroxine 88mcg was given at 7:00am. Telephone interview with the pharmacist at the facility's contracted pharmacy on 09/02/21 at 8:32am revealed: -Levothyroxine should be administered on an empty stomach. -The effectiveness of levothyroxine was decreased when bonded with food. -The laboratory work for thyroid-stimulating hormone (measures how well the thyroid gland is functioning) would not reflect a true reading if the medication was not administered as ordered. -The Primary Care Provider (PCP) would not know how to adjust the dosage of levothyroxine based on labs if the medication was not administered on an empty stomach. -The medication was scheduled for administration at 7:00am by the pharmacy. -The pharmacy would adjust the time if notified by the facility. Interviews with the Resident Care Director (RCD) on 09/02/21 at 11:20am and 2:25pm revealed: -She had not discussed with the MAs about administering levothyroxine before meals. -Third shift MAs should be administering levothyroxine. -The time of administration for levothyroxine should be changed to ensure the medication was	D 358			

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D 358	Continued From page 37 administered before breakfast. -She thought a MA had discussed with her about changing the administration time of levothyroxine to 6:30am. -She had not contacted the pharmacy to change the administration time of levothyroxine. Interview with Resident #10's PCP on 09/02/21 at 1:50pm revealed: -Levothyroxine should be administered before breakfast to maximize the absorption of the medication. -She would expect levothyroxine to be administered before meals to meet maximum benefit for the resident. Refer to the interview with a MA on 09/02/21 at 9:30am. Refer to interviews with the RCD on 09/01/21 at 11:20am and 2:25pm. Refer to the interview with the RCD on 09/03/21 at 2:20pm. Refer to the interviews with Regional Director of Clinical Services (RDCS) on 09/01/21 at 9:50am and 10:45am. Refer to the interview with the RDCS on 09/02/21 at 5:20pm. 2. Review of Resident #10's current FL2 dated 06/22/21 revealed there was an order for gabapentin (used for nerve pain) 100mg three times a day. Observation of the morning medication pass on 9/01/21 at 8:50am revealed: -The medication aide (MA) prepared 11 pills for	D 358			

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D 358	Continued From page 38 administration. -The MA did not administer the gabapentin 100mg at 8:00am. Observation of Resident #10's medication on hand on 09/01/21 at 10:50am revealed there was a blister pack of gabapentin in the overstock drawer with 30 tablets on hand. Review of Resident #10's medication administration record (MAR) for September 2021 revealed -There was an entry for gabapentin 100mg one three times a day at 8:00am, 2:00pm and 8:00pm. -There was no documentation that gabapentin 100mg was administered at 8:00am. Interview with the MA on 09/01/21 at 10:50am revealed: -The gabapentin was not available in the resident's medication drawer. -She overlooked gabapentin since it was not in the resident's medication drawer. -She did not "think" to look in the overstock drawer for the medication. Telephone interview with the pharmacist at the facility's contracted pharmacy on 09/02/21 at 8:32am revealed: -Gabapentin was used to control nerve pain in the lower extremities. -The resident was ordered gabapentin 100mg three times a day. -Gabapentin's life span was between 5 and 6 hours. -The resident could have pain more frequently in the mornings related to gabapentin's short life span.	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 358	Continued From page 39 Interview with Resident #10's PCP on 09/02/21 at 1:50pm revealed: -Gabapentin was ordered for nerve pain. -Gabapentin had a short life of 5 to 6 hours. -Gabapentin was ordered three times a day because of the short span life. -Resident #10 could have increased pain in the mornings related to the short span life of medication. Refer to the interview with a MA on 09/02/21 at 9:30am. Refer to interviews with the RCD on 09/01/21 at 11:20am and 2:25pm. Refer to the interview with the RCD on 09/03/21 at 2:20pm. Refer to the interviews with the Regional Director of Clinical Services (RDCS) on 09/01/21 at 9:50am and 10:45am. Refer to the interview with the RDSCS on 09/02/21 at 5:20pm. 3. Review of Resident #10's current FL2 dated 06/22/21 revealed there was an order for polyethylene glycol (used for constipation) 17gms with 8-ounces of fluid daily. Observation of the morning medication pass on 9/01/21 at 8:50am revealed the medication aide (MA) did not administer the polyethylene glycol 17gms at 8:00am. Observation of Resident #10's medication on hand on 09/01/21 at 10:50am revealed there was opened bottle of polyethylene glycol on hand that was half full.	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 358	Continued From page 40 Review of Resident #10's medication administration record (MAR) for September 2021 revealed: -There was an entry for polyethylene glycol 3350 17gms/1 dose powder mix with 8-ounces of water daily at 8:00am. -There was no documentation that polyethylene glycol 3350 17gms/1 dose powder mix with 8-ounces of water daily was administered at 8:00am. Interview with the MA on 09/01/21 at 10:50am revealed: -She overlooked the polyethylene glycol medication. -She administered all medications that were in the resident's medication drawer. -This medication was kept in a different drawer. Telephone interview with the pharmacist at the facility's contracted pharmacy on 09/02/21 at 8:32am revealed polyethylene glycol was used for constipation. Refer to the interview with a MA on 09/02/21 at 9:30am. Refer to the interviews with the RCD on 09/01/21 at 11:20am and 2:25pm. Refer to the interview with the RCD on 09/03/21 at 2:20pm. Refer to the interviews with the Regional Director of Clinical Services (RDCS) on 09/01/21 at 9:50am and 10:45am. Refer to the interview with the RDCS on 09/02/21 at 5:20pm.	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
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D 358	Continued From page 41 4. Review of Resident #10's current FL2 dated 06/22/21 revealed there was an order for mineral cream (used for dry skin) apply topically to feet/soles twice a day. Observation of the morning medication pass on 9/01/21 at 8:50am revealed the medication aide (MA) did not administer the mineral cream at 8:00am. Observation of Resident #10's medication on hand on 09/01/21 at 10:50am revealed there was an opened jar of mineral cream on hand. Review of Resident #10's medication administration record (MAR) for September 2021 revealed: -There was an entry for mineral cream apply to feet/soles twice a day at 8:00am and 8:00pm. -There was no documentation that the mineral cream was applied at 8:00am. Interview with the MA on 09/01/21 at 10:50am revealed: -She had overlooked the mineral cream. -She administered all the medications that were in the resident's medication drawer. -This medication was kept in a different drawer. Based on observations, interviews, and record reviews, it was determined Resident #10 was not interviewable. Refer to the interview with a MA on 09/02/21 at 9:30am. Refer to the interviews with the RCD on 09/01/21 at 11:20am and 2:25pm.	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
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D 358	Continued From page 42 Refer to the interview with the RCD on 09/03/21 at 2:20pm. Refer to the interviews with the Regional Director of Clinical Services (RDCS) on 09/01/21 at 9:50am and 10:45am. Refer to the interview with the RDCS on 09/02/21 at 5:20pm. b. Review of Resident #11's current FL-2 dated 05/25/21 revealed diagnosis included alzheimer's dementia, atrial fibrillation, type 2 diabetes mellitus with peripheral vascular disorder, neuropathy, retinopathy, hypothyroidism and hypertension. 1. Review of Resident #11's current FL2 dated 05/25/21 revealed an order for levothyroxine (used to treat an underactive thyroid gland) 25mcg daily. Observation of the morning medication pass on 9/01/21 at 8:50am revealed the medication aide (MA) administered levothyroxine 25mcg at 8:30am to Resident #11. Review of Resident #11's medication administration record (MAR) for September 2021 revealed: -There was an entry for levothyroxine 25mcg daily at 7:00am. -There was documentation that levothyroxine 25mcg was administered at 7:00am. Interview with the MA on 09/01/21 at 11:25am revealed: -She knew levothyroxine was scheduled for 7:00am. -She knew that medications were to be	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 358	Continued From page 43 administered within one hour of scheduling. -She gave all his medications at one time. -The levothyroxine used to be scheduled at 6:30am. -The third shift MA used to administer levothyroxine. -She did not know why the time was changed. -She had not discussed with the Resident Care Director (RCD) about changing the administration time. Telephone interview with the pharmacist at the facility's contracted pharmacy on 09/02/21 at 8:32am revealed: -Levothyroxine should be given on an empty stomach. -The effectiveness of levothyroxine was decreased when bonded with food. -The laboratory work for thyroid-stimulating hormone (measures how well the thyroid gland is functioning) would not reflect a true reading if medication was not administered as ordered. -The Primary Care Provider (PCP) would not know how to adjust the dosage of levothyroxine based on labs if medication was not administered on an empty stomach. -The medication was scheduled for administration at 7:00am by the pharmacy. -The pharmacy would adjust the time if notified by the facility Interviews with the RCD on 09/02/21 at 11:20am and 2:25pm revealed: -Third shift MAs should be administering levothyroxine. -The time of administration for levothyroxine should be changed to ensure medication was administered before "the rush of the morning". -She thought a MA had discussed with her about changing the administration time of levothyroxine	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
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D 358	Continued From page 44 to 6:30am. -She had not contacted the pharmacy to change the administration time of levothyroxine. Interview with Resident #11's PCP on 09/02/21 at 1:50pm revealed: -Levothyroxine should be administered before breakfast to maximize the absorption of the medication. -She would expect levothyroxine to be administered before meals to meet maximum benefit for the resident. Refer to the interview with a MA on 09/02/21 at 9:30am. Refer to the interviews with the RCD on 09/01/21 at 11:20am and 2:25pm. Refer to the interview with the RCD on 09/03/21 at 2:20pm. Refer to the interviews with the Regional Director of Clinical Services (RDCS) on 09/01/21 at 9:50am and 10:45am. Refer to the interview with the RDCS on 09/02/21 at 5:20pm. 2. Review of Resident #11's current FL2 dated 05/25/21 revealed an order for Vitamin B-12 (a vitamin supplement) 1000mg sublingually daily. Observation of the morning medication pass on 9/01/21 at 8:50am revealed the medication aide (MA) administered vitamin B-12 by mouth to Resident #11. Review of Resident #11's medication administration record (MAR) for September 2021	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
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D 358	Continued From page 45 revealed: -There was an entry for vitamin B-12 1000mcg one sublingually daily. -There was documentation that vitamin B-12 1000mcg was administered as ordered at 8:00am. Interview with the MA on 09/01/21 at 11:25am revealed: -She knew the vitamin B-12 was ordered sublingually. -She gave it by mouth because the resident would not take it sublingually. -She had been giving the vitamin B-12 by mouth for "a while". -She had not contacted the PCP to asked for an order to change to by mouth. Telephone interview with the pharmacist at the facility's contracted pharmacy on 09/02/21 at 8:32am revealed: -Vitamin B-12 was ordered to be administered sublingually. -Medications that were ordered sublingually were absorbed quicker. -A quicker absorption of the medication was more beneficial to the resident. -If Vitamin B-12 was given by mouth the absorption rate was decreased due to poor gastric absorption in the elderly. Interview with Resident #11's Primary Care Provider (PCP) on 09/02/21 at 1:50pm revealed: -Vitamin B-12 absorption rate was quicker when given sublingually. -The elderly absorbed vitamin B-12 poorly in the stomach when administered by mouth. -She expected the medication to be given as ordered.	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 358	Continued From page 46 Based on observations, interviews, and record reviews, it was determined Resident #11 was not interviewable. Refer to the interview with a MA on 09/02/21 at 9:30am. Refer to the interviews with the RCD on 09/01/21 at 11:20am and 2:25pm. Refer to the interview with the RCD on 09/03/21 at 2:20pm. Refer to the interviews with the Regional Director of Clinical Services (RDSCS) on 09/01/21 at 9:50am and 10:45am. Refer to the interview with the RDSCS on 09/02/21 at 5:20pm. c. Review of Resident #3's current FL2 dated 01/26/21 revealed diagnoses included vascular dementia without behavioral disturbance, glaucoma, unspecified cataract, dysphagia, anxiety disorder and insomnia. Review of Resident #3's physician order dated 04/21/21 revealed an order for thera-tears (used to treat discomfort caused by dry eyes) 0.25% one drop in both eyes twice daily. Observation of the morning medication pass on 9/01/21 at 8:50am revealed the medication aide (MA) did not administer thera-tears eye drops at 8:00am to Resident #3. Observation of medication on hand for Resident #3 on 09/01/21 at 11:25am revealed a box of 18 of 30 single use vials of thera-tears on hand.	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
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D 358	Continued From page 47 Review of Resident #3's medication administration record for September 2021 revealed: -There was an entry for thera-tears 0.25% one drop in both eyes twice daily at 8:00am and 8:00pm. -There was documentation that thera-tears was administered at 8:00am. Interview with the MA on 09/01/21 at 11:25 revealed: -She realized she had not administered thera-tears when she was reviewing the MARs for accuracy. -She administered the eye drops about 10:00am after reviewing the MARs for accuracy. -She attempted to locate the eye drops on the medication cart to verify what was administered about 10:00am. -She could not locate the eye drops on the medication cart. -She decided she did not administer the eye drops to Resident #10 about 10:00am as previously stated. -She did not know why theria-tears was not administered. -She overlooked the medication. -She was nervous because she was being observed during medication administration. Telephone interview with the pharmacist at the facility's contracted pharmacy on 09/02/21 at 8:32am revealed: -Thera-tears was used for dry, itchy eyes. -The resident may experience increase irritation if the eye drops were not administered. -There was a possibility the resident may experience "altered vision". Based on observations, interviews, and record	D 358			

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D 358	Continued From page 48 reviews, it was determined Resident #3 was not interviewable. Refer to the interview with a MA on 09/02/21 at 9:30am. Refer to the interview with another MA on 09/02/21 at 9:30am. Refer to the interviews with the RCD on 09/01/21 at 11:20am and 2:25pm. Refer to the interview with the RCD on 09/03/21 at 2:20pm. Refer to the interviews with the Regional Director of Clinical Services (RDCS) on 09/01/21 at 9:50am and 10:45am. Refer to the interview with the RDCS on 09/02/21 at 5:20pm. 2. Review of Resident #8's current FL2 dated 05/04/21 revealed diagnoses included Alzheimer's disease, senile dementia, hyperglycemia, diabetes mellitus type 2, hypertension and anxiety disorder. a. Review of Resident #8's current FL2 dated 05/04/21 revealed there was an order for metoprolol (used to treat high blood pressure) 50mg daily. Review of Resident #8's hospital discharge summary dated 05/29/21 revealed there was an order for metoprolol 25mg daily for 30 days with no refills. Review of Resident #8's May 2021 medication administration record (MAR) revealed:	D 358			

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NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
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D 358	Continued From page 49 -There was an entry for metoprolol 50mg daily to be administered at 8:00am. -There was documentation of administration of metoprolol 50mg on 05/30/21 at 8:00am. -There was a hand-written entry dated 05/29/21 for metoprolol 25mg one tablet daily. -There was no documentation of administration of metoprolol 25mg on 05/30/21 or 05/31/21. Review of Resident #8's physician visit dated 06/01/21 revealed there was an order for metoprolol 25mg daily. Review of Resident #8's June 2021 MAR revealed: -There was an entry for metoprolol 25mg daily to be administered at 8:00am. -There was no documentation of administration of metoprolol 25 mg on 9 of 30 days in June 2021. Review of Resident #8's physicians orders signed 07/08/21 revealed there was an order for metoprolol 25mg daily to be administered at 8:00am. Observation of medications on hand for Resident #8 on 08/31/21 at 11:30 revealed there were 13 of 30 tablets of metoprolol 25mg available with a dispense date of 07/27/21. Telephone interview with the pharmacist at the facility's contracted pharmacy on 09/02/21 at 8:32am revealed: -They received the hospital discharge summary on 05/29/21. -The pharmacy dispensed 30 tablets of metoprolol 25mg on 05/29/21 with no refills. -The pharmacy received a physician's order for metoprolol 25mg daily signed 07/08/21. -The pharmacy dispensed 30 tablets of	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
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D 358	Continued From page 50 metoprolol 25mg on 07/27/21. -She did not know why the dispense date was 19 days later than the ordered date. -The pharmacy had not dispensed any metoprolol since 07/27/21. Interview with the Resident Care Coordinator (RCD) on 09/02/21 at 11:20am and 2:25pm revealed: -She or the MA would review all discharge summaries for new orders. -The discharge summary was faxed to the pharmacy. -She added the change for metoprolol to the June 2021 MAR. -She did not know why the MAs did not give metoprolol as ordered on 05/30/21 and 05/31/21. Attempted telephone interview with Resident #8's PCP on 09/2/21 at 11:30am was unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #8 was not-interviewable. Refer to the interview with a MA on 09/02/21 at 9:30am. Refer to interviews with the RCD on 09/01/21 at 11:20am and 2:25pm. Refer to the interview with the RCD on 09/03/21 at 2:20pm. Refer to the interviews with the Regional Director of Clinical Services (RDSCS) on 09/01/21 at 9:50am and 10:45am. Refer to the interview with the RDSCS on 09/02/21 at 5:20pm.	D 358			

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D 358	Continued From page 51 b. Review of Resident #8's current FL2 dated 05/04/21 revealed there was an order for melatonin (used for sleep) 3mg at bedtime. Review of Resident #8's hospital discharge summary dated 05/29/21 revealed there was an order for melatonin 3mg at bedtime as needed for sleep. Review of Resident #8's physicians orders for July 2021 dated 07/08/21 revealed there was an order for melatonin 3mg at bedtime as needed for sleep. Review of Resident #8's May 2021 medication administration record (MAR) revealed: -There was an entry for melatonin 3mg at bedtime to be administered at 8:00pm -There was documentation of administration of melatonin 3mg on 05/30/21 and 05/31/21 at 8:00pm. Review of Resident #8's June 2021 MAR revealed: -There was an entry for melatonin 3 mg at bedtime to be administered at 8:00pm -There was documentation of administration of melatonin 3mg every night from 06/01/21 to 06/30/21. Observation of medication on hand on 08/31/21 at 11:30am revealed there was no melatonin 3mg available for administration. Telephone interview with the pharmacist at the facility's contracted pharmacy on 09/02/21 at 8:32am revealed: -The pharmacy received the hospital discharge summary on 05/29/21.	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 358	Continued From page 52 -The pharmacy dispensed 30 tablets of melatonin 3mg on 05/11/21 and 30 tablets on 06/16/21. -The pharmacy entered all orders and printed monthly MARs. -The facility was responsible for reviewing the new MARs before the beginning of each month. -The facility was responsible for hand-writing any new orders received after the MARS were printed. -The facility was not on a cycle refill. -The facility would order medications as they needed them. -The facility had not requested melatonin 3mg as needed for sleep to be dispensed since 06/16/21. Interview with a medication aide (MA) on 09/2/21 at 10:30am revealed: -She would audit the medication carts twice a week. -She would re-order the medications that had "about five pills" in the blister pack. -She would fax the pharmacy if the medication was not on the medication cart. -She did not know why the melatonin was not on the medication cart. -She had not faxed the pharmacy to have it re-ordered. Interviews with the Resident Care Director (RCD) on 09/02/21 at 11:20am and 2:25pm revealed: -She or the MA would review all discharge summaries for new orders. -The discharge summary was faxed to the pharmacy. -She did not notice the change in the melatonin order. -She did not know why there was no melatonin in the facility for administration. Attempted telephone interview with Resident #8's	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 358	Continued From page 53 PCP on 09/02/21 at 11:30am was unsuccessful Based on observations, interviews, and record reviews, it was determined Resident #8 was not interviewable. Refer to the interview with a MA on 09/02/21 at 9:30am. Refer to the interviews with the RCD on 09/01/21 at 11:20am and 2:25pm. Refer to the interview with the RCD on 09/03/21 at 2:20pm. Refer to the interviews with the Regional Director of Clinical Services (RDCS) on 09/01/21 at 9:50am and 10:45am. Refer to the interview with the RDCS on 09/02/21 at 5:20pm. c. Review of Resident #8's current FL2 dated 05/04/21 revealed there was an order for Novolog 100unit/1ml (rapid-acting insulin that helps lower blood sugar) inject subcutaneously three times a day before meals and at bedtime per sliding scale insulin (SSI); less than 180 - 0units; 180 to 220 - 1unit; 221 to 260 - 2units; 261 to 300 - 3units; 301 to 340 - 4units; 341 to 380 - 5units; 381 to 400 - 6units; 401 to 425 - 7units; 426 to 450 - 9units; greater than 450 call the Primary Care Provider (PCP). Review of Resident #8's June 2021 medication administration record (MAR) revealed: -There was an entry for Novolog 100unit/1ml inject subcutaneously three times a day before meals and at bedtime per sliding scale insulin (SSI); less than 180 - 0units; 180 to 220 - 1unit;	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 358	Continued From page 54 221 to 260 - 2units; 261 to 300 - 3units; 301 to 340 - 4units; 341 to 380 - 5units; 381 to 400 - 6units; 401 to 425 - 7units; 426 to 450 - 9units; greater than 450 call the PCP. -On 06/07/21 at 11:45am, there was documentation of a blood sugar reading of 193 and 1 unit of insulin should have been administered. -On 06/08/21 11:45am, there was no documentation of a blood sugar reading or documentation of insulin administered. -On 06/17/21 at 11:45am, there was no documentation of a blood sugar reading or documentation of insulin administered. -On 06/18/21 at 5:45pm, there was no documentation of a blood sugar reading or documentation of insulin administered. -On 06/22/21 at 5:45pm, there was documentation of a blood sugar reading of 244 and 2 units of insulin should have been administered. -On 06/26/21 at 11:45am, there was documentation of a blood sugar reading of 288 and 3 units of insulin should have been administered. -On 06/27/21 at 11:45am, there was documentation of a blood sugar reading of 185 and 1 unit of insulin should have been administered. -On 06/29/21 at 5:45pm, there was no documentation of a blood sugar reading or documentation of insulin administered. -On 06/30/21 at 8:00pm, there was no documentation of a blood sugar reading or documentation of insulin administered. Review of Resident #8's July 2021 MAR revealed: -There was an entry for Novolog 100unit/1ml inject subcutaneously three times a day before meals and at bedtime per SSI; less than 180 -	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 55 0units; 180 - 220 1 unit; 221 to 260 - 2units; 261 to 300 - 3units; 301 to 340 - 4units; 341 to 380 - 5units; 381 to 400 - 6units; 401 to 425 - 7units; 426 to 450 - 9units; greater than 450 call the Primary Care Provider (PCP). -On 07/02/21 at 11:45am, there was documentation of a blood sugar reading of 422 and 7 units of insulin should have been administered. -On 07/05/21 at 5:45pm, there was documentation of a blood sugar reading of 198 and 1 unit of insulin should have been administered. -On 07/08/21 at 11:45am, there was documentation of a blood sugar reading of 197 and 1 unit of insulin should have been administered. -On 07/12/21 at 11:45am, there was no documentation of a blood sugar reading or documentation of insulin administered. -On 07/14/21 at 11:45pm, there was documentation of a blood sugar reading of 182 and 1 unit of insulin should have been administered. -On 07/15/21 at 11:45am, there was documentation of a blood sugar reading of 194 and 1 unit of insulin should have been administered. -On 07/25/21 at 5:45pm, there was documentation of a blood sugar reading of 188 and 1 unit of insulin should have been administered. -On 07/28/21 at 11:45am, there was documentation of a blood sugar reading of 288 and 3 units of insulin should have been administered. -On 07/29/21 at 11:45am, there was no documentation of a blood sugar reading or documentation of insulin administration.	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 358	Continued From page 56 Review of Resident #8's August MAR revealed: -There was an entry for Novolog 100unit/1ml inject subcutaneously three times a day before meals and at bedtime per SSI; less than 180 - 0units; 180 to 220 - 1unit; 221 to 260 - 2units; 261 to 300 - 3units; 301 to 340 - 4units; 341 to 380 - 5units; 381 to 400 - 6units; 401 to 425 - 7units; 426 to 450 - 9units; greater than 450 call the Primary Care Provider (PCP). -On 08/31/21 at 5:45pm, there was no documentation of a blood sugar reading or documentation of insulin administered. -On 08/31/21 at 8:00pm, there was no documentation of a blood sugar reading or documentation of insulin administered. Interview with a medication aide (MA) on 08/31/21 at 12:20pm revealed: -She would document the fingerstick FSBS reading on the blood sugar flow sheet. -Sometimes she forgot to document the FSBS reading if she had to administer insulin. -She had forgotten to document on the MAR that the FSBS had been obtained and insulin administered as ordered. -She always administered insulin as ordered. Interview with a second MA on 09/02/21 at 10:30am revealed: -She would document the FSBS readings on the blood sugar flow sheet if she did not forget. -She would administer the SSI as ordered. -She thought she documented each time SSI was administered. Refer to the interview with a MA on 09/02/21 at 9:30am. Refer to the interviews with the RCD on 09/01/21 at 11:20am and 2:25pm.	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 57 Refer to the interview with the RCD on 09/03/21 at 2:20pm. Refer to the interviews with the Regional Director of Clinical Services (RDCS) on 09/01/21 at 9:50am and 10:45am. Refer to the interview with the RDCS on 09/02/21 at 5:20pm. 3. Review of Resident #7's current FL-2 dated 08/04/21 revealed: -Diagnoses included Parkinson's disease, anemia, atrial fibrillation, and hypothyroidism. -Resident #7 was on 2 liters of continuous oxygen. -There was a handwritten note in the medication section that read see attached medication list. a. Review of Resident #7's skilled nursing facility (SNF) order summary report dated 08/04/21 revealed: -The SNF order form dated 08/04/21 was attached to Resident #7's FL-2 dated 08/04/21. -There was also a hospital discharge summary dated 07/08/21 attached to the SNF discharge packet. -Diagnoses listed included chronic obstructive pulmonary disease (COPD) and hypotension. -There was an order for Amiodarone HCL 200mg one tablet daily for 90-days. (Amiodarone is used to treat certain types of serious (possibly fatal) irregular heartbeat (such as persistent ventricular fibrillation/tachycardia). Review of Resident #7's hospital discharge summary dated 07/10/21 revealed: -Resident #7 was diagnosed with atrial fibrillation. -Resident #7 was started on Amiodarone IV and	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 58 downgraded to oral Amiodarone 400 my twice daily with orders to decrease the dose to 200mg twice daily on 07/18/21, then 200mg once daily on 07/25/21 and then daily until further evaluated by a cardiologist. Review of Resident #7's Medication Administration Record (MAR) for August 2021 revealed: -There was an entry that was entered on 08/07/21 for Amiodarone HCL 200mg take two tablets twice a day for six days with an administration time of 8:00am and 8:00pm. -There was documentation Amiodarone had been administered at 8:00am and 8:00pm on 08/07/21-08/11/21. -There was a second entry for Amiodarone HCL 200mg take one tablet twice a day for seven days with an administration time of 8:00am and 8:00pm. -There was documentation Amiodarone had been administered at 8:00am and 8:00pm on 08/11/21-08/18/21. -There was a third entry for Amiodarone HCL 200mg take one tablet daily for ninety days with an administration time of 8:00am. -There was documentation Amiodarone had been administered at 8:00am on 08/18/21-08/31/21. Observation of Resident #7's medications on hand on 08/31/21 at 5:28pm revealed: -There was a punch card for Amiodarone HCL 200mg dispensed on 08/12/21. -The punch card was labeled as 1 of 2 and there were 38 total tablets dispensed. -The punch card contained 8 tablets, and no tablets had been administered. Review of Resident #7's MAR for September 2021 revealed:	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 358	Continued From page 59 -There was an entry for Amiodarone HCL 200mg take one tablet daily for ninety days with an administration time of 8:00am. -There was documentation Amiodarone had been administered at 8:00am on 09/01/21. Another observation of Resident #7's medications on hand on 09/01/21 at 11:02am revealed: -There was a punch card for Amiodarone HCL 200mg dispensed on 08/12/21. -The punch card was labeled as 1 of 2 and there were 38 total tablets dispensed. -The punch card contained 8 tablets, and no tablets had been administered. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 09/01/21 at 8:05am revealed: -Thirty-eight tablets of Amiodarone HCL 200mg was dispensed on 08/12/21 with the orders to administer 2 tablets twice daily for 6 days, then one daily for 7 days and then it ended on 08/27/21. -She received a medication clarification form on 08/10/21, and she did not see the order to continue the one daily for 90-days. -Amiodarone would need to be requested for refills and was not automatically dispensed. Review of Resident #7's medication clarification form dated 08/10/21 revealed Amiodarone HCL 200mg administer 2 tablets twice daily for 6 days, then one daily for 7 days and 1 tablet daily for 90 days. Interview with the Resident Care Director (RCD) on 09/01/21 at 4:58pm revealed: -She had completed Resident #7's medication clarification form. -She had written the medications onto the	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 358	Continued From page 60 medication clarification form based on the medications listed on Resident #7's August 2021 MAR. -Another MA had written the medications onto the MAR from the resident's discharge summary when Resident #7 returned to the facility from the SNF. -She did not know why the Amiodarone taper was started again, as it had already been completed in the SNF based on the discharge summary. -She had placed Resident #7's discharge papers in the PCP's box and expected the papers to be reviewed; she did not know if the PCP reviewed the discharge papers. Interview with a MA on 09/02/21 at 10:00am revealed: -She had used the discharge summary to enter Resident #7's Amiodarone order onto the August 2021 MAR. -She thought she used the SNF discharge summary; she did not know how she had used the hospital discharge summary dated 07/08/21. Telephone interview with a Primary Care Provider (PCP) for the facility on 09/02/21 at 8:56am revealed: -She was covering for Resident #7's PCP who was not available. -Amiodarone had a long half-life and would remain in the resident's system for 52 days. -It was a problem if Resident #7 had not been administered the Amiodarone as ordered. -Resident #7 could experience problems with his heart being out of rhythm, his atrial fibrillation "acting up", dizziness and shortness of breath. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 09/02/21 at 8:13am revealed:	D 358			

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NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 358	Continued From page 61 -Amiodarone had a very long life and could cause toxicity if administered too much. -Amiodarone was typically started in an acute care setting so the resident could be monitored. -Amiodarone interacted with "everything." -Because Resident #7 had been administered increased doses twice, the resident's renal and liver functions would need to be monitored. -Increased doses of Amiodarone could cause hypothyroidism, low blood pressure, low heart rate, and pulmonary toxicity. -It was concerning Resident #7 had been administered increased doses of Amiodarone since he had a diagnosis of hypothyroidism, hypotension and COPD. -If Resident #7 was not being administered Levothyroxine (used to treat hypothyroidism) as ordered, the increased doses of Amiodarone could cause even more issues. Interview with the Regional Director of Clinical Services on 09/02/21 at 5:24pm revealed: -She was not aware Resident #7 returned from the SNF, and the order for Amiodarone was not implemented correctly. -The RCD was responsible for taking orders and entering the orders into the MAR. -She expected orders to be clarified if needed and administered as ordered. Refer to the interview with a MA on 09/02/21 at 9:30am. Refer to interviews with the RCD on 09/01/21 at 11:20am and 2:25pm. Refer to the interview with the RCD on 09/03/21 at 2:20pm. Refer to the interviews with Regional Director of	D 358	- all med techs attended a 15 hour med administration training, new order tracking meds not available, counseling diabetes, proper transcription of orders to MAR, proper use of BS flow sheets, proper time FBS checks, calibration of glucometers, following all order parameters - such as meds given on empty stomach or w/ foods, high or low BS, timely administration of meds, procedures for med errors, clarification of orders, reordering medications,	10/1/21	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 358	Continued From page 62 Clinical Services (RDCS) on 09/01/21 at 9:50am and 10:45am. Refer to the interview with the RDCS on 09/02/21 at 5:20pm. b. Review of Resident #7's skilled nursing facility (SNF) order summary report dated 08/04/21 revealed: -The order form was attached to Resident #7's FL-2 dated 08/04/21. -There was an order for Levothyroxine Sodium 100mg once a day. (Levothyroxine is a thyroid medicine that replaces a hormone normally produced by your thyroid gland to regulate the body's energy and metabolism). Review of Resident #7's Medication Administration Record (MAR) for August 2021 revealed: -There was an entry for Levothyroxine 100mg with an administration time of 7:00am. -There was a hand-written note on the MAR that read as not on the discharge summary. -There was no documentation Levothyroxine 100mg had been administered from 08/07/21-08/31/21. Review of Resident #7's MAR for September 2021 revealed: -There was an entry for Levothyroxine 100mg with an administration time of 7:00am. -There was documentation Levothyroxine 100mg had been administered on 09/01/21. Observation of Resident #7's medications on hand on 08/31/21 at 3:22pm revealed there was no Levothyroxine available to be administered. Interview with a medication aide (MA) on	D 358	- Clarification of orders, reordering medications, Components of Complete medication orders, proper documentation, follow up of PRN meds and the rights of medication administration - ED, RCD, LHPs nurse or designee will monitor transcription of orders and or clarifications daily	10/1/21 ongoing	

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NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGVILLE, NC 27596		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 358	Continued From page 63 09/01/21 at 11:09am revealed: -She administered Resident #7's Levothyroxine today, 09/01/21. -There was no punch card available for Resident #7's Levothyroxine because she had administered the last tablet today, 09/01/21. -She did not have Resident #7's empty Levothyroxine package because it had already been thrown away. -She did not have the sticker off Resident #7's Levothyroxine package because there was no refill sticker on the package. -She had not documented she was going to request a refill for Resident #7's Levothyroxine, because she would remember it when she called the pharmacy. -She did not know why Resident #7's Levothyroxine was not available during the medications on hand observation on 08/31/21, "maybe the punch card had been mixed in with someone else's medication." Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 09/01/21 at 8:05am revealed: -Resident #7's Levothyroxine 100mg administer once daily was still an active order. -Resident #7's Levothyroxine 100mg was dispensed on 06/01/21 for 30-tablets, a one-month supply. -There had been no requests to refill Resident #7's Levothyroxine 100mg. -Resident #7's medication refills had to be requested by the facility staff. Interview with a primary care provider (PCP) for the facility on 09/01/21 at 8:56am revealed: -She was covering for Resident #7's PCP who was not available. -Resident #7's Levothyroxine should have been	D 358	- all med techs attended a 15 hour med administration training, new order tracking, meds not available, Coumadin, diabetes, proper transcription of orders to MAR, proper use of BS flow sheets, proper time FSBS checks, Calibration of glucometer, following all order parameters such as meds given on empty stomach or w/ foods, high or low BS, timely administration of meds, procedures for med errors, clarification of orders, Reordering medications, Components of complete medication orders, proper documentation, follow up of PRN meds and 6 rights of medication administration. - ED, RCO, or designee will monitor daily the reordering of medications.	10/1/21	ongoing

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
D 358	Continued From page 64 administered as ordered because he had a diagnosis of hypothyroidism. -If Resident #7's hypothyroidism was not treated, he would be fatigued, have a low heart rate and problems with constipation. -She was concerned Resident #7's Levothyroxine had not been administered, and she would need to order a laboratory test for a thyroid level and if Resident #7's thyroid level was not therapeutic, his medication would need to be adjusted. Interview with Resident #7 on 09/01/21 at 8:20am and 11:34am revealed: -He did not know what medications he was administered or why the medications were administered. -He was tired a lot during the day because he woke up every morning around 4:00am and could not go back to sleep. -He had been having problems with constipation for "about a month." Telephone interview with a Pharmacist at the facility's contracted pharmacy on 09/02/21 at 8:13am revealed: -It was concerning Resident #7 had not received Levothyroxine as ordered because he had been administered another medication, that could cause hypothyroidism, and he already had a diagnosis of hypothyroidism. -If Resident #7 did not receive Levothyroxine as ordered it would cause his hypothyroidism to be left untreated and his thyroid levels would be "super low" because of the missed doses. Interview with the Resident Care Director (RCD) on 09/02/21 at 2:24pm revealed: -Resident #7's Levothyroxine was not available today, 09/02/21, when she administered medications.	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 358	Continued From page 65 -She did not know Resident #7's Levothyroxine had not been administered after she had clarified the orders on 08/10/21. -She had the order for Resident #7's Levothyroxine clarified, and she thought she had told staff, but she did not recall who she told, "if anybody." Interview with the Regional Director of Clinical Services on 09/02/21 at 5:24pm revealed: -She was not aware Resident #7 returned from the SNF, and the order for Levothyroxine was not implemented. -The RCD was responsible for taking orders and entering the orders into the MAR. -She was told the Administrator was doing this task because the RCD was needed to cover other things. -Sometime in June 2021, the RCD went back to processing orders. -There was no reason for a resident to not have medication in the facility to be administered. Refer to the interview with a MA on 09/02/21 at 9:30am. Refer to interviews with the RCD on 09/01/21 at 11:20am and 2:25pm. Refer to the interview with the RCD on 09/03/21 at 2:20pm. Refer to the interviews with Regional Director of Clinical Services (RDSCS) on 09/01/21 at 9:50am and 10:45am. Refer to the interview with the RDSCS on 09/02/21 at 5:20pm. c. Review of Resident #7's skilled nursing facility	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 358	Continued From page 66 (SNF) order summary report dated 08/04/21 revealed: -The SNF order form dated 08/04/21 was attached to Resident #7's FL-2 dated 08/04/21. -There was an order for Trazadone 50mg administer one-two tablets at bedtime as needed. (Trazadone is used to treat insomnia). Review of Resident #7's Medication Administration Record (MAR) for August 2021 revealed: -There was an entry for Trazadone 50mg take one tablet at bedtime with a scheduled administration time of 8:00pm. -There was documentation Trazadone 50mg was administered at 8:00pm from 08/07/21-08/31/21. -There were 24 tablets of Trazadone 50mg documented as administered. Observation of Resident #7's medications on hand on 08/31/21 at 5:28pm revealed: -There was a punch card for Trazadone 50mg dispensed on 07/23/21 for 30 tablets. -The punch card contained 14 tablets available to be administered. Observation of Resident #7's medications on hand on 09/01/21 at 8:49am revealed: -There was a punch card for Trazadone 50mg dispensed on 07/23/21 for 30 tablets. -The punch card contained 10 tablets available to be administered. Based on interviews, record reviews, and observation of Resident #7's Trazadone on 08/31/21 (14 tablets) and on 09/01/21 (10 tablets) it could not be determined if Resident #7 was administered the correct dosage of Trazadone 50mg at 8:00pm on 08/31/21.	D 358			

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NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 67 Telephone interview with a Pharmacist at the facility's contracted pharmacy on 09/01/21 at 8:05am revealed: -Resident #7's current order was for Trazadone 50mg one tablet at bedtime. -The order was based on signed physician's order dated 08/14/21. -The last dispensing for Resident #7's Trazadone was on 07/23/21 for 30 tablets. Interview with a medication aide (MA) on 09/02/21 at 9:45am revealed: -She administered Resident #7's bedtime medications on 08/31/21. -She administered Resident #7's Trazadone as ordered. -She did not recall how many tablets were on the punch card when she administered the resident's Trazadone. -She did not borrow Resident #7's Trazadone to administer to any other residents. -She had not had to dispose of any of Resident #7's Trazadone. Interview with the Resident Care Director on 09/02/21 at 2:35pm revealed: -She did not know Resident #7 had three tablets of Trazadone missing between 08/31/21 and 09/01/21. -The Trazadone must have been administered to another resident. Interview with the Regional Director of Clinical Services on 09/02/21 at 5:24pm revealed: -She was aware there was an issue with medications being unaccounted for based on a cart audits completed on 09/01/21 and 09/02/21. -She was concerned the missing Trazadone could be drug diversion, and she had already implemented a plan that Trazadone would be	D 358	Trazadone was added to the Controlled medication lock box and will be accounted for on Control logs.	9/2/21

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NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
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D 358	Continued From page 68 added to the controlled medication and accounted for on the control logs. Refer to the interview with a MA on 09/02/21 at 9:30am. Refer to interviews with the RCD on 09/01/21 at 11:20am and 2:25pm. Refer to the interview with the RCD on 09/03/21 at 2:20pm. Refer to the interviews with Regional Director of Clinical Services (RDCS) on 09/01/21 at 9:50am and 10:45am. Refer to the interview with the RDSCS on 09/02/21 at 5:20pm. 4. Review of Resident #5's current FL-2 dated 06/29/21 revealed diagnoses included chronic B-cell lymphoproliferative, chronic lymphocytic leukemia, gastroesophageal reflux without esophagitis, mixed hyperlipidemia, and major depressive disorder. Review of a signed physician's order dated 08/19/21 revealed an order for Mirtazapine 7.5mg to be administered every day.(Mirtazapine is a medication used to treat depression.) Review of Resident #5's medication administration record (MAR) for August 2021 revealed: -There was a hand-written entry for Mirtazapine 7.5mg to be administered by mouth every day. -There was documentation of administration at 8:00pm on 08/20/21 through 08/28/21 for a total of 9 doses.	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
D 358	Continued From page 69 Observation of medications on hand for Resident #5 on 08/31/21 at 3:06pm revealed there was no Mirtazapine 7.5mg available for administration. Interview with the medication aide (MA) on 08/31/21 at 3:06pm revealed she had not administered Mirtazapine 7.5mg to Resident #5. Observation of medication card brought in by the Regional Director of Clinical Services (RDCD) on 09/01/21 at 9:50am revealed: -The medication card was labeled Mirtazapine 7.5mg to be administered every day for Resident #5. -There were 7 of 30 doses missing from the card. Interview with the RDCS on 09/01/21 at 9:50am revealed: -She did not know why the Mirtazapine 7.5mg was not on the cart on 08/31/21. -She did not know why the Mirtazapine 7.5 was not administered on 08/29/21 and 08/30/21. -Staff brought the medication card to her and did not know where it was found. -She expected medications to be administered as prescribed. Interview with a pharmacy technician with the facility's contracted pharmacy on 09/01/21 at 9:37am revealed: -There was an order received for Mirtazapine 7.5mg to be administered every day on 08/19/21 for Resident #5. -Thirty tablets of Mirtazapine 7.5mg were dispensed on 08/19/21. Refer to the interview with a MA on 09/02/21 at 9:30am. Refer to interviews with the RCD on 09/01/21 at	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
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D 358	Continued From page 70 11:20am and 2:25pm. Refer to the interview with the RCD on 09/03/21 at 2:20pm. Refer to the interviews with Regional Director of Clinical Services (RDCS) on 09/01/21 at 9:50am and 10:45am. Refer to the interview with the RDCS on 09/02/21 at 5:20pm. 5. Review of Resident #3's current FL2 dated 01/26/21 revealed diagnoses of vascular dementia without behaviors, glaucoma, unspecified cataract, dysphagia, anxiety disorder and insomnia. a. Review of Resident #3's current FL2 dated 01/26/21 revealed an order for amlodipine (used to treat high blood pressure) 10mg once daily. Review of Resident #3's June 2021 medication administration record (MAR) revealed: -There was an entry for amlodipine 10mg once daily at 8:00am. -Amlodipine was documented as administered from 06/01/21-06/30/21. Review of Resident #3's July 2021 MAR revealed: -There was an entry for amlodipine 10mg once daily at 8:00am. -Amlodipine was documented as administered from 07/01/21-07/31/21. Review of Resident #3's August 2021 MAR revealed: -There was an entry for amlodipine 10mg once daily at 8:00am. -Amlodipine was documented as administered on 08/01/21-08/31/21.	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
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D 358	Continued From page 71 Observation of Resident #3's medications on hand on 08/31/21 at 2:35pm revealed: -Resident #3's amlodipine was packaged individually in a bubble medication card; there was one tablet per bubble. -There were two medication cards for amlodipine. -The first medication card was dated 06/30/21; thirty tables were dispensed, and one tablet was available for administration. -The second medication card was dated 07/24/21; thirty tablets were dispensed, and 12 tablets were available for administration. -There was a total of 13 tablets of amlodipine available for administration. Based on record reviews, observations, and interviews there should have been no amlodipine tablets remaining, but there were 13 tablets on hand. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/31/21 at 3:44pm revealed: -Resident #3's current order for amlodipine 10mg once daily was dated 05/06/21. -Resident #3's amlodipine was not on a cycle fill; the facility had to fax in the request for a refill. -The last three dispense dates for Resident #3's amlodipine was 05/07/21, 06/30/21 and 07/24/21; thirty tablets were dispensed each time. -The amlodipine was dispensed for thirty days and should have been reordered for the month of August 2021. -Amlodipine was used to treat high blood pressure. -An outcome of not administering amlodipine as ordered could be increased blood pressure which could cause a stroke.	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
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D 358	Continued From page 72 Telephone interview with Resident #3's primary care provider (PCP) on 09/01/21 at 9:12am revealed: -Resident #3 had a current order for amlodipine 10mg once daily. -Resident #3 was ordered the amlodipine to treat her high blood pressure. -The PCP expected the facility to administer Resident #3's medication as ordered. -A possible outcome of not administering the amlodipine as ordered could be increased blood pressure which could lead to headaches, chest pains and possible stroke. Interview with a medication aide (MA) on 09/01/21 at 4:12pm revealed: -She worked the day shift and had administered medications on both sides of the facility. -She administered Resident #3 her amlodipine when she worked. -Resident #3 would remind you to administer her medications when it was time to take them. -Sometimes the evening shift would stay over and administer the morning medications. -She referenced the MAR when she administered medication; she could not explain the extra tablets. Telephone interview with a second MA on 09/02/21 at 9:15am revealed: -She administered medications to residents on both sides of the facility. -Resident #3 did not have an order for amlodipine in the morning. -She looked at the MAR and then compared the medication card to the MAR before she "popped" the medication from the medication card. -Resident #3 knew what her medication was and would ask the MA if it was time to take her medication.	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
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D 358	Continued From page 73 Interview with a third MA on 09/02/21 at 10:05am revealed: -She administered Resident #3 her morning medications and any medications that were scheduled for administering during the day shift. -Resident #3 took her medication "faithfully" and never refused it. -Resident #3 knew she took medication every morning, but she could not tell you what medications she took or what they were for. -She always administered medications from the medication cards with the older dates and placed the medication cards with the more current dates in the over stock drawer on the medication cart. -Medications had to be reordered from the pharmacy; none of the medications were on a cycle fill. -If there were extra tablets it sounded like someone did not administer medications. Interview with the Resident Care Director (RCD) on 09/02/21 at 3:44pm revealed: -She administered medications when she worked as a MA. -She knew Resident #3 had amlodipine once daily. -The first medication card with amlodipine for Resident #3 should have been administered before the newer card was began. -If there were 13 tablets available for administration it looked like Resident #3 was not administered her medication as ordered. Interview with the Regional Director of Clinical Services (RDCS) on 09/02/21 at 5:24pm revealed: -Resident #3's amlodipine medication cards should have been administered from the first card dispensed and the second card not started until	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/03/2021
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D 358	Continued From page 74 the first medication card was empty. -If there were extra tablets available for administration the explanation would be that Resident #3 had not been administered her medication as ordered. Refer to the interview with a MA on 09/02/21 at 9:30am. Refer to interviews with the RCD on 09/01/21 at 11:20am and 2:25pm. Refer to the interview with the RCD on 09/03/21 at 2:20pm. Refer to the interviews with Regional Director of Clinical Services (RDCS) on 09/01/21 at 9:50am and 10:45am. Refer to the interview with the RDSCS on 09/02/21 at 5:20pm. b. Review of Resident #3's current FL2 dated 01/26/21 revealed an order for acetaminophen (used to treat pain) 500mg twice daily. Review of Resident #3's June 2021 medication administration record (MAR) revealed: -There was an entry for acetaminophen 500mg twice daily at 8:00am and 8:00pm. -Acetaminophen was documented as administered at 8:00am and 8:00pm from 06/01/21-06/30/21. Review of Resident #3's July 2021 MAR revealed: -There was an entry for acetaminophen 500mg twice daily at 8:00am and 8:00pm. -Acetaminophen was documented as administered 8:00am and 8:00pm from 07/01/21-07/31/21.	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
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D 358	Continued From page 75 Review of Resident #3's August 2021 MAR revealed: -There was an entry for acetaminophen 500mg twice daily at 8:00am and 8:00pm. -Acetaminophen was documented as administered 8:00am and at 8:00pm from 08/01/21-08/31/21. Observation of Resident #3's medications on hand on 08/31/21 at 2:35pm revealed: -Resident #3's acetaminophen was packaged individually in a bubble medication card; there was one tablet per bubble. -There was one medication card for acetaminophen the card was dated 08/08/21 and had 2/2 handwritten in black on the top of the card; thirty tables were dispensed on the card, and 30 tablets were available for administration. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/31/21 at 3:44pm revealed: -Resident #3's current order was for acetaminophen 500mg twice daily. -Resident #3's acetaminophen was not on a cycle fill; the facility had to fax in the request for a refill. -The last three dispense dates for Resident #3's acetaminophen was 05/14/21, 06/07/21 and 08/09/21. -Sixty tablets were dispensed each date in two separate cards; each card contained 30 tablets. -The acetaminophen was dispensed for thirty days and should have been reordered for the month of July 2021. -Acetaminophen was used to treat pain. -An outcome of not administering acetaminophen as ordered could be increased pain and discomfort associated with pain.	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 358	Continued From page 76 Telephone interview with Resident #3's primary care provider (PCP) on 09/01/21 at 9:12am revealed: -Resident #3 had a current order for acetaminophen 500mg twice daily. -Resident #3 was ordered the acetaminophen to control pain due to osteoarthritis. -The PCP expected the facility to administer Resident #3's medication as ordered. -A possible outcome of not administering the acetaminophen as ordered could be the resident would be in pain. -It would be difficult to say if her pain was controlled or how bad her pain was if she was not receiving the acetaminophen as ordered. Interview with a medication aide (MA) on 09/01/21 at 4:12pm revealed: -She worked the day shift and had administered medications on both sides of the facility. -She administered Resident #3 her acetaminophen when she worked. -Resident #3 would remind you to administer her medications when it was time to take them. -Sometimes the evening shift would stay over and administer the morning medications. -She referenced the MAR when she administered medication; she could not explain the extra tablets. Telephone interview with a second MA on 09/02/21 at 9:15am revealed: -She administered medications to residents on both sides of the facility. -She administered Resident #3 her acetaminophen in the mornings. -She looked at the MAR and then compared the medication card to the MAR before she "popped" the medication from the medication card. -Resident #3 knew what her medication was and	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 77 would ask the MA if it was time to take her medication. Interview with a third MA on 09/02/21 at 10:05am revealed: -She administered Resident #3 her morning medications and any medications that were scheduled for administering during the day shift. -Resident #3 took her medication "faithfully" and never refused it. -Resident #3 knew she took medication every morning, but she could not tell you what medications she took or what they were for. -She always administered medications from the medication cards with the older dates and placed the medication cards with the more current dates in the over stock drawer on the medication cart. -Medications had to be reordered from the pharmacy; none of the medications were on a cycle fill. -If there were extra tablets it sounded like someone did not administer medications. Interview with the Resident Care Director (RCD) on 09/02/21 at 3:44pm revealed: -She administered medications when she worked as a MA. -She knew Resident #3 had acetaminophen scheduled twice daily. -Resident #3's acetaminophen was dispensed in two cards; the first card should be used until empty and then the second card used. -The second card would be labeled 2 of 2 and was kept in the overstock drawer on the medication cart until needed. -If there were 30 tablets available for administration it looked like Resident #3 was not administered her medication as ordered. Refer to the interview with a MA on 09/02/21 at	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
D 358	Continued From page 78 9:30am. Refer to interviews with the RCD on 09/01/21 at 11:20am and 2:25pm. Refer to the interview with the RCD on 09/03/21 at 2:20pm. Refer to the interviews with Regional Director of Clinical Services (RDCS) on 09/01/21 at 9:50am and 10:45am. Refer to the interview with the RDSCS on 09/02/21 at 5:20pm. c. b. Review of Resident #3's current FL2 dated 01/26/21 revealed an order for ferrous gluconate (used to treat iron deficiency anemia) 324mg twice daily with meals. Review of Resident #3's June 2021 medication administration record (MAR) revealed: -There was an entry for ferrous gluconate 324mg twice daily with meals 8:00am and 5:00pm. -Ferrous gluconate was documented as administered at 8:00am and 5:00pm from 06/01/21-06/30/21. Review of Resident #3's July 2021 MAR revealed: -There was an entry for ferrous gluconate 324mg twice daily with meals 8:00am and 5:00pm. -Ferrous gluconate was documented as administered at 8:00am and 8:00pm from 07/01/21-07/31/21. Review of Resident #3's August 2021 MAR revealed: -There was an entry for ferrous gluconate 324mg twice daily with meals 8:00am and 5:00pm. -Ferrous gluconate was documented as	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
D 358	Continued From page 79 administered at 8:00am and 8:00pm from 08/01/21-08/31/21. Observation of Resident #3's medications on hand on 08/31/21 at 2:35pm revealed: -Resident #3's ferrous gluconate was packaged individually in a bubble medication card; there was one tablet per bubble. -There was one medication card for ferrous gluconate the card was dated 08/08/21 and had 2 of 2 handwritten in black on the top of the card; thirty tables were dispensed on the card, and 26 tablets were available for administration. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/31/21 at 3:44pm revealed: -Resident #3's current order was for ferrous gluconate 324mg twice daily with meals. -Resident #3's ferrous gluconate was not on a cycle fill; the facility had to fax in the request for a refill. -The last two dispense dates for Resident #3's ferrous gluconate was 07/08/21 and 08/09/21. -Sixty tablets were dispensed each date in two separate cards; each card contained 30 tablets. -The ferrous gluconate was dispensed for thirty-day supply. -Ferrous gluconate was used to treat iron deficiency and could lead to fatigue if not administered as ordered. Telephone interview with Resident #3's primary care provider (PCP) on 09/01/21 at 9:12am revealed: -Resident #3's current order was for ferrous gluconate 324mg twice daily with meals. -Resident #3 was ordered the ferrous gluconate due to a diagnosis of anemia and iron deficiency. -Resident #3's hemoglobin level was 11.2 on	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
D 358	Continued From page 80 02/23/21; a normal hemoglobin level for a woman is 15.5. -Resident #3's levels were low enough for her to be considered anemic. -The PCP expected the facility to administer Resident #3's medication as ordered. -A possible outcome of not administering the ferrous gluconate as ordered continue to have low hemoglobin levels and continue to be anemic. Interview with a medication aide (MA) on 09/01/21 at 4:12pm revealed: -She worked the day shift and had administered medications on both sides of the facility. -She administered Resident #3 her ferrous gluconate twice daily when she worked. -Resident #3 would remind you to administer her medications when it was time to take them. -Sometimes the evening shift would stay over and administer the morning medications. -She referenced the MAR when she administered medication; she could not explain the extra tablets. Telephone interview with a second MA on 09/02/21 at 9:15am revealed: -She administered medications to residents on both sides of the facility. -She administered Resident #3 her ferrous gluconate in the mornings and at the evening meal. -She looked at the MAR and then compared the medication card to the MAR before she "popped" the medication from the medication card. -Resident #3 knew what her medication was and would ask the MA if it was time to take her medication. Interview with a third MA on 09/02/21 at 10:05am revealed:	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
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D 358	Continued From page 81 -She administered Resident #3 her morning medications and any medications that were scheduled for administering during the day shift. -Resident #3 took her medication "faithfully" and never refused it. -Resident #3 knew she took medication every morning, but she could not tell you what medications she took or what they were for. -She always administered medications from the medication cards with the older dates and placed the medication cards with the more current dates in the over stock drawer on the medication cart. -Medications had to be reordered from the pharmacy; none of the medications were on a cycle fill. -If there were extra tablets it sounded like someone did not administer medications. Interview with the Resident Care Director (RCD) on 09/02/21 at 3:44pm revealed: -She administered medications when she worked as a MA. -Resident #3's ferrous gluconate was dispensed in two cards; the first card should be used until empty and then the second card used. -The second card would be labeled 2 of 2 and was kept in the overstock drawer on the medication cart until needed. -If there were 26 tablets available for administration it looked like Resident #3 was not administered her medication as ordered. Refer to the interview with a MA on 09/02/21 at 9:30am. Refer to interviews with the RCD on 09/01/21 at 11:20am and 2:25pm. Refer to the interview with the RCD on 09/03/21 at 2:20pm.	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
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D 358	Continued From page 82 Refer to the interviews with Regional Director of Clinical Services (RDCS) on 09/01/21 at 9:50am and 10:45am. Refer to the interview with the RDCS on 09/02/21 at 5:20pm. <u>Interview with medication aide (MA) on 09/02/21 at 9:30am revealed:</u> -She should administer the medications as ordered. -She should let the RCD know if a medication was not on the medication cart. <u>Interview with Resident Care Director (RCD) on 09/02/21 at 11:20am and 2:25pm revealed:</u> -The MA should be reading and following the orders as written. -The MA should be administering medications within an hour of scheduled time. -She reviewed and signed the MARs for the upcoming month for accuracy. -She or the MA would review all discharge summaries for new orders. -The discharge summary was faxed to the pharmacy. -The MAs were not paying attention when they administered medications. -The MAs were responsible for letting the RCD know if a medication is not available for administration. <u>Interview with the RCD on 09/03/21 at 2:20pm revealed:</u> -There was not always time to complete weekly chart audits, but she would complete them as she got the chance. -MAs looked at the medications on the cart for refilling needs and expiration dates but she did	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 358	Continued From page 83 not know if the MAs were checking the medications on hand against the MAR. Interview with the Regional Director of Clinical Services (RDCS) on 09/01/21 at 9:50am and 10:45am revealed: -She expected medications to be administered as prescribed. -Medication cart audits were expected to be done weekly. -The medication cart audit was to include checking the MAR against the physician's order, ensuring medications were available and checking for expiration dates. -The RCD was responsible for ensuring cart audits were completed. Interview with the RDCS on 09/02/21 at 5:20pm revealed: -The former Administrator assumed the responsibility of faxing new orders to the pharmacy about "mid-June" so the RCD could work the floor. -The RCD had about "2 to 3 weeks" of training before the previous Administrator started managing the orders. -The MAs should administer medications as ordered. -The MAs should follow all instructions in the order. -The MAs should let the RCD know if a medication is not on the medication cart. The facility failed to ensure medications were administered as ordered for 3 residents observed during the medication pass and for 4 sampled residents, including two resident's (#10, #11) thyroid medication was not administered on an empty stomach as ordered which decreased the absorption of the medication; a resident's (#8)	D 358	- 10090 Chart, MAR, and Cart Audits were completed by 9/20/21. Weekly Cart Audits are to be completed by staff and ED, RCD will review weekly Cart Audits prior to submitting to RDCS. <i>ongoing</i>		

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NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTRE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
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D 358	Continued From page 84 FSBS was not checked as ordered and without checking the FSBS it was not known whether to administer insulin based on the sliding scale ordered putting the resident at risk of hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar); and a resident (#7) was administered a loading dose of a medication used to treat atrial fibrillation after the resident was already on a maintenance dose which could cause the resident to have low blood pressure, low heart rate, pulmonary issues and increased issues with hypothyroidism. The facility's failure to administer medication as ordered was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/03/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 18, 2021.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .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.	D 366	100% Chart, MAR, and Cart ongoing Audits were completed by 9/20/21. Weekly Cart Audits are to be completed by staff and RCD will review weekly cart audits prior to submitting to RDCS.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
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D 366	Continued From page 85 This Rule is not met as evidenced by: Based on observation, interview, and review of medication administration records (MARs), the facility failed to record on the MARs immediately following administration and observation of 2 of 4 residents taking the medication prior to the next resident (#10, #11); the facility failed by recording administration and observation of the residents taking the medication prior to the residents receiving their medications (#3, #11, #12), observed during the 7:00am/8:00am morning medication pass on 09/01/21. The findings are: 1a. Observation of the 7:00/8:00am morning on 09/01/21 at 8:40am medication pass for Resident # 10 revealed the medication aide (MA) did not initial the MAR immediately following the administration of each of the following medications; vitamin B-12 1000mcg, losartan potassium 100mg, hydrochlorothiazide 25mg, levothyroxine 88mcg, omeprazole 20mg, vitamin D3 125mcg, clonidine 0.1mg, metoprolol 50mg, hydralazine 50mg, hydrocodone/acetaminophen 5/325mg and hysingla 60mg. Observation of Resident #10's September MAR on 09/01/21 at 10:50am revealed the MA had not documented on the MAR for the medications administered at 8:40am. Interview with the MA on 09/01/21 at 10:50am revealed -She would place a "dot" in the block on the MAR, where she would document her initials, when she "popped" the medication into the souffle cup. -She knew the medication had been prepared to administer when she saw a "dot" in the block on the MAR, where her initials would be documented	D 366	- 2 medtechs were immediately removed from med cart and retrained on NCDHHS med administration course - med tech refresher course of medication administration was completed. - all med techs attended a 15 hour med administration training, new orders + tracking, meds not available, Coumadin, diabetes, proper transcription of orders to MAR, proper use of BS flowsheets, proper time FSBS checks, calibration of glucometers, following all order parameters - such as meds given on empty stomach or w/ foods, high or low BS, timely administration of meds, procedures for med errors, classification of orders, reordering medications, components of complete medication orders, proper documentation, follow up of PRN meds and rights of medication administration. - ED, RCD, LHPs nurse or designee will conduct med pass observations weekly.	9/2/21 9/10/21 10/1/21 ongoing	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
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D 366	Continued From page 86 after administration of medications. -She would document on the MAR after medications were administered. -She forgot to document on the MAR medications were administered when she returned to the medication cart. -She was nervous because she was being observed administering medications. Refer to the interview with the Resident Care Director (RCD) on 09/01/21 at 11:37am. Refer to the interview with the Regional Director of Clinical Services (RDCS) on 09/01/21 at 11:55am. Refer to the interview with the RDCS on 09/02/21 at 5:24pm. b. Observation of the 7:00am/8:00am morning on 09/01/21 at 8:30am medication pass for Resident #11 revealed the MA did not initial the September 2021 MAR immediately following the administration of Eliquis. Refer to the interview with a MA on 09/01/21 at 11:25am. Refer to the interview with the Resident Care Director (RCD) on 09/01/21 at 11:37am. Refer to the interview with the Regional Director of Clinical Services (RDCS) on 09/01/21 at 11:55am. Refer to the interview with the RDCS on 09/02/21 at 5:24pm. 2a. Observation of the 7:00am/8:00am morning on 09/01/21 at 8:15am medication pass for	D 366	Addendum 10/04/21: Rule Area Completed		10/01/21

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
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D 366	Continued From page 87 Resident #12 revealed the medication aide (MA) initialed each of the following medications as administered on the September 2021 MAR prior to the actual administration of the medications; aspirin 81mg, senna-plus 8.6mg-50mg and bisoprolol 5mg/HCTZ 6.25mg. Refer to the interview with a MA on 09/01/21 at 11:25am. Refer to the interview with the Resident Care Director (RCD) on 09/01/21 at 11:37am. Refer to the interview with the Regional Director of Clinical Services (RDCS) on 09/01/21 at 11:55am. Refer to the interview with the RDSCS on 09/02/21 at 5:24pm. b. Observation of the 7:00am/8:00am morning on 09/01/21 at 8:30am medication pass for Resident #11 revealed the medication aide (MA) initialed each of the following medications as administered on the September 2021 MAR prior to the actual administration of the medications; levothyroxine 25mcg and vitamin B-12 1000mcg. Refer to the interview with a MA on 09/01/21 at 11:25am. Refer to the interview with the Resident Care Director (RCD) on 09/01/21 at 11:37am. Refer to the interview with the Regional Director of Clinical Services (RDCS) on 09/01/21 at 11:55am. Refer to the interview with the RDSCS on 09/02/21 at 5:24pm.	D 366			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
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D 366	Continued From page 88 c. Observation of the 7:00am/8:00am morning on 09/01/21 at 8:40am medication pass for Resident #3 revealed the medication aide (MA) initialed each of the following medications as administered on the September 2021 MAR prior to the actual administration of the medications; amlodipine 10mg, escitalopram 10mg, lisinopril 2.5mg, vitamin D3 5000 units, ferrous gluconate 324mg, betoptic eye drops, ketorolac tromethamine eye drops and lorazepam 0.5mg one-half tablet. Refer to the interview with a MA on 09/01/21 at 11:25am. Refer to the interview with the Resident Care Director (RCD) on 09/01/21 at 11:37am. Refer to the interview with the Regional Director of Clinical Services (RDSCS) on 09/01/21 at 11:55am. Refer to the interview with the RDSCS on 09/02/21 at 5:24pm. Interview with the medication aide (MA) on 09/01/21 at 11:25am revealed: -She would document on the medication administration record (MAR) medications administered before administration of medications. -She was taught in the medication administration class to document on the MAR medications administered prior to administration of medications. -She forgot to document on the MAR administration of one medication. -She had not noticed that she did not sign the MAR for one of the administered medications.	D 366			

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NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTEF			STREET ADDRESS, CITY, STATE, ZIP CODE 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 366	Continued From page 89 Interview with the Resident Care Director on 09/01/21 at 11:37am revealed: -The MAs should not document on the MAR prior to administration of medications. -The MAs should document on the MAR after administration of medications. -The MAs were taught in the medication administration class to sign the MAR after the administration of medications. -The MAs are expected to document on the MAR as they were taught in class. Interview with the Regional Director of Clinical Services (RDCS) on 09/01/21 at 11:55am revealed: -The MAs are expected to document on the MARs after the medications are administered. -The MAs are expected to follow all medication administration procedures as was taught in the medication administration class. -All the MAs will be going through a refresher course on how to administer medications. Interview with the RDCS on 09/02/21 at 5:24pm revealed documentation on the MAR that medications were administered when they were not was false documentation.	D 366	2 med techs were immediately removed from med carts and retrained on NCCHHS med administration course - med tech refresher course of medication administration was completed - All med techs attended a 15 hour med administration training, new order tracking, meds not available, Coumadin, diabetes, proper transcription of orders to MAR, proper use of BS flow sheets, proper time of BS checks, calibration of glucometers, following all order parameters - such as meds given on empty stomach or w/ foods, high or low BS, timely administration of meds, procedures for med errors, clarification of orders, reordering medications, components of complete medication orders, proper documentation, follow up of PRN meds and 6 rights of medication administration. - ED, RCD, LHPs Nurse or designee will conduct med pass observations weekly Addendum 10/04/21: Rule Area Completed	9/2/21 9/10/21 10/1/21 ongoing	
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication	D 367			

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D 367	Continued From page 90 administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure staff documented on the medication administration record (MAR) the administration of medications immediately following the administration for 3 of 5 sampled residents (#3, #5, and #7). The findings are: 1. Review of Resident #3's current FL2 dated 01/26/21 revealed diagnoses of vascular dementia without behaviors, glaucoma, unspecified cataract, dysphagia, anxiety disorder and insomnia. a. Review of Resident #3's current FL2 dated 01/26/21 revealed an order for amlodipine (used to treat high blood pressure) 10mg once daily. Review of Resident #3's June 2021 medication administration record (MAR) revealed:	D 367		

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D 367	Continued From page 91 -There was an entry for amlodipine 10mg once daily at 8:00am. -Thirty doses of Amlodipine was documented as administered. Review of Resident #3's July 2021 MAR revealed: -There was an entry for amlodipine 10mg once daily at 8:00am. -Thirty one doses of Amlodipine were documented as administered. Review of Resident #3's August 2021 MAR revealed: -There was an entry for amlodipine 10mg once daily at 8:00am. -Thirty one doses of Amlodipine were documented as administered. Observation of Resident #3's medications on hand on 08/31/21 at 2:35pm revealed: -Resident #3's amlodipine was packaged individually in a bubble medication card; there was one tablet per bubble. -There were two medication cards for amlodipine. -The first medication card was dated 06/30/21; thirty tables were dispensed, and one tablet was available for administration. -The second medication card was dated 07/24/21; thirty tablets were dispensed, and 12 tablets were available for administration. -There was a total of 13 tablets of amlodipine available for administration. Based on staff documentation and medications dispensed between June 2021 and August 2021, there should have been no amlodipine tablets remaining, but there were 13 tablets on hand. Interview with a medication aide (MA) on 09/01/21 at 4:12pm revealed:	D 367		

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D 367	Continued From page 92 -She administered Resident #3 her amlodipine when she worked. -She referenced the MAR when she administered medication and only documented when she administered the mediation. Refer to the interview with the medication aide (MA) on 09/01/21 at 11:25am. Refer to the interview with the Resident Care Director on 09/01/21 at 11:37am. Refer to the interview with the Regional Director of Clinical Services (RDCS) on 09/01/21 at 11:55am. Refer to the interview with the RDCS on 09/02/21 at 5:24pm. b. Review of Resident #3's current FL2 dated 01/26/21 revealed an order for acetaminophen (used to treat pain) 500mg twice daily. Review of Resident #3's June 2021 medication administration record (MAR) revealed: -There was an entry for acetaminophen 500mg twice daily at 8:00am and 8:00pm. -Acetaminophen was documented as administered 60 out of 60 opportunities. Review of Resident #3's July 2021 MAR revealed: -There was an entry for acetaminophen 500mg twice daily at 8:00am and 8:00pm. -Acetaminophen was documented as administered 61 out of 61 opportunities. Review of Resident #3's August 2021 MAR revealed: -There was an entry for acetaminophen 500mg twice daily at 8:00am and 8:00pm.	D 367			

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D 367	Continued From page 93 -Acetaminophen was documented as administered 60 out of 61 opportunities. Observation of Resident #3's medications on hand on 08/31/21 at 2:35pm revealed: -Resident #3's acetaminophen was packaged individually in a bubble medication card; there was one tablet per bubble. -There was one medication card for acetaminophen the card was dated 08/08/21 and had 2/2 handwritten in black on the top of the card; thirty tables were dispensed on the card, and 30 tablets were available for administration. Based on staff documentation and medications dispensed between June 2021 and August 2021, there should have been 14 acetaminophen tablets remaining, but there were 30 tablets on hand. Refer to the interview with the medication aide (MA) on 09/01/21 at 11:25am. Refer to the interview with the Resident Care Director on 09/01/21 at 11:37am. Refer to the interview with the Regional Director of Clinical Services (RDCS) on 09/01/21 at 11:55am. Refer to the interview with the RDCS on 09/02/21 at 5:24pm. c. b. Review of Resident #3's current FL2 dated 01/26/21 revealed an order for ferrous gluconate (used to treat iron deficiency anemia) 324mg twice daily with meals. Review of Resident #3's June 2021 medication administration record (MAR) revealed:	D 367			

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D 367	Continued From page 94 -There was an entry for ferrous gluconate 324mg twice daily with meals 8:00am and 5:00pm. -Ferrous gluconate was documented as administered 60 out of 60 opportunities. Review of Resident #3's July 2021 MAR revealed: -There was an entry for ferrous gluconate 324mg twice daily with meals 8:00am and 5:00pm. -Ferrous gluconate was documented as administered 61 out of 61 opportunities. Review of Resident #3's August 2021 MAR revealed: -There was an entry for ferrous gluconate 324mg twice daily with meals 8:00am and 5:00pm. -Ferrous gluconate was documented as administered 60 out of 61 opportunities. Observation of Resident #3's medications on hand on 08/31/21 at 2:35pm revealed: -Resident #3's ferrous gluconate was packaged individually in a bubble medication card; there was one tablet per bubble. -There was one medication card for ferrous gluconate the card was dated 08/08/21 and had 2 of 2 handwritten in black on the top of the card; thirty tables were dispensed on the card, and 26 tablets were available for administration. Based on staff documentation and medications dispensed between June 2021 and August 2021, there should have been 14 ferrous gluconate tablets remaining, but there were 30 tablets on hand. Refer to the interview with the medication aide (MA) on 09/01/21 at 11:25am. Refer to the interview with the Resident Care Director on 09/01/21 at 11:37am.	D 367			

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D 367	Continued From page 95 Refer to the interview with the Regional Director of Clinical Services (RDCS) on 09/01/21 at 11:55am. Refer to the interview with the RDCS on 09/02/21 at 5:24pm. 6. Review of Resident #5's current FL-2 dated 06/29/21 revealed diagnoses included chronic B-cell lymphoproliferative, chronic lymphocytic leukemia, gastroesophageal reflux without esophagitis, mixed hyperlipidemia, and major depressive disorder. Review of a signed physician's order dated 08/19/21 revealed an order for Mirtazapine 7.5mg to be administered every day. Review of Resident #5's medication administration record (MAR) for August 2021 revealed: -There was a hand-written order for Mirtazapine 7.5mg to be administered by mouth every day. -There was documentation of administration at 8pm on 08/20/21 through 08/28/21 for a total of 9 doses. Observation of medications on hand for Resident #5 on 08/31/21 at 3:06pm revealed there was no medication labeled Mirtazapine 7.5mg available for administration. Interview with the medication aide on 08/31/21 at 3:06pm revealed she had not administered Mirtazapine 7.5mg to Resident #5. Observation of medication card brought in by the regional director of clinical services (RDCD) on 09/01/21 at 9:50am revealed: -The medication card was labeled Mirtazapine	D 367			

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D 367	Continued From page 96 7.5mg to be administered every day by mouth for Resident #5. -There were 7 of 30 doses missing from the card. Based on staff documentation and medications dispensed on 08/19/21, there should have been 21 Mirtazapine tablets remaining, but there were 23 tablets on hand. Interview with the RDCS on 09/01/21 at 9:50am revealed: -She did not know why the Mirtazapine 7.5mg was not on the cart on 08/31/21. -She did not know why the Mirtazapine 7.5 was not administered on 08/29/21 and 08/30/21. -Staff brought the medication card to her and did not know where it was found. -She expected medications to be administered as prescribed. Interview with a pharmacy technician with the facility's contracted pharmacy on 09/01/21 at 9:37am revealed: -There was on ordered received for Mirtazapine 7.5mg to be administered every day on 08/19/21 for Resident #5. -Thirty tablets of Mirtazapine 7.5mg were dispensed on 08/19/21. A second interview with the RDCS on 09/01/21 at 10:45am revealed: -Medication cart audits were expected to be done weekly. -The medication cart audit was to include checking the MAR against the physician's order, ensuring medications were available and checking for expiration dates. -The resident care director (RCD) was responsible for ensuring cart audits were completed.	D 367	- 100% Chart, MAR, and Cart Audits were completed by 9/12/21. Weekly Cart audits are to be completed by staff and ED and RCD will review Weekly Cart Audits prior to submitting to RDCS.	<i>ongoing</i>	

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D 367	Continued From page 97 A third interview with the RDCS on 09/02/21 at 5:24pm revealed: -Medications that were not located and documented as administered were considered false documentation. -Two of the nine doses could not have been administered if there were only 7 pills missing from the 30 doses that were dispensed. -She expected medications to be checked three times prior to administration to the resident. -Documentation of medication administration on the MAR should be completed after the MA administered the medication to the resident. Interview with a second MA on 8:49am revealed: -There was not always time to check medications on the cart during her shift because staff were too busy. -There were a lot of medication errors because there was not always enough staff on duty. Interview with the resident care director (RCD) on 09/03/21 at 2:20pm revealed: -There was not always time to complete weekly cart audits, but she would complete them as she got the chance. -She did not know why only seven doses were missing from the 30 doses that were dispensed. Refer to the interview with the medication aide (MA) on 09/01/21 at 11:25am. Refer to the interview with the Resident Care Director on 09/01/21 at 11:37am. Refer to the interview with the Regional Director of Clinical Services (RDCS) on 09/01/21 at 11:55am.	D 367			

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D 367	Continued From page 98 Refer to the interview with the RDCS on 09/02/21 at 5:24pm. 7. Review of Resident #7's current FL-2 dated 08/04/21 revealed: -Diagnoses included Parkinson's disease, anemia, atrial fibrillation, and hypothyroidism. -Resident #7 was on 2 liters of continuous oxygen. -There was a handwritten note in the medication section that read see attached medication list. Review of Resident #7's skilled nursing facility (SNF) order summary report dated 08/04/21 revealed: -The SNF order form dated 08/04/21 was attached to Resident #7's FL-2 dated 08/04/21. -There was also a hospital discharge summary dated 07/08/21 attached to the SNF discharge packet. -Diagnoses listed included chronic obstructive pulmonary disease (COPD) and hypotension. -There was an order for Amiodarone HCL 200mg administer one tablet daily for 90-days. (Amiodarone is used to treat certain types of serious (possibly fatal) irregular heartbeat (such as persistent ventricular fibrillation/tachycardia). Review of Resident #7's Medication Administration Record (MAR) for August 2021 revealed: -There was an entry that was entered on 08/07/21 for Amiodarone HCL 200mg take two tablets twice a day for six days with an administration time of 8:00am and 8:00pm. -There was documentation Amiodarone had been administered at 8:00am and 8:00pm on 08/07/21-08/11/21. -There was a second entry for Amiodarone HCL 200mg take one tablet twice a day for seven days	D 367			

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D 367	Continued From page 99 with an administration time of 8:00am and 8:00pm. -There was documentation Amiodarone had been administered at 8:00am and 8:00pm on 08/12/21-08/18/21. -There was a third entry for Amiodarone HCL 200mg take one tablet daily for ninety days with an administration time of 8:00am. -There was documentation Amiodarone had been administered at 8:00am on 08/18/21-08/31/21. Observation of Resident #7's medications on hand on 08/31/21 at 5:28pm revealed: -There was a punch card for Amiodarone HCL 200mg dispensed on 08/12/21. -The punch card was labeled as 1 of 2 and there were 38 total tablets dispensed. -The punch card contained 8 tablets, and no tablets had been administered. Review of Resident #7's MAR for September 2021 revealed: -There was an entry for Amiodarone HCL 200mg take one tablet daily for ninety days with an administration time of 8:00am. -There was documentation Amiodarone had been administered at 8:00am on 09/01/21. Observation of Resident #7's medications on hand on 09/01/21 at 11:02am revealed: -There was a punch card for Amiodarone HCL 200mg dispensed on 08/12/21. -The punch card was labeled as 1 of 2 and there were 38 total tablets dispensed. -The punch card contained 8 tablets, and no tablets had been administered. Based on staff documentation and medications dispensed on 08/12/21, there were 48 tablets of Amiodarone documented as administered when	D 367			

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D 367	Continued From page 100 only 30 tablets were not accounted for. Interview with a medication aide (MA) on 09/01/21 at 11:09am revealed: -She meant to put a star to ask the Resident Care Director (RCD) about Resident #7's Amiodarone because she thought it must be a new medication that had not been delivered. -She had not seen Resident #7's Amiodarone in the over-stock drawer. -She meant to circle her initials but had forgotten. Refer to the interview with the medication aide (MA) on 09/01/21 at 11:25am. Refer to the interview with the Resident Care Director on 09/01/21 at 11:37am. Refer to the interview with the Regional Director of Clinical Services (RDCS) on 09/01/21 at 11:55am. Refer to the interview with the RDCS on 09/02/21 at 5:24pm. Interview with the medication aide (MA) on 09/01/21 at 11:25am revealed: -She would document on the medication administration record (MAR) medications administered before administration of medications. -She was taught in the medication administration class to document on the MAR medications administered prior to administration of medications. -She forgot to document on the MAR administration of one medication. -She had not noticed that she did not sign the MAR for one of the administered medications.	D 367			

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D 367	Continued From page 101 Interview with the Resident Care Director on 09/01/21 at 11:37am revealed: -The MAs should not document on the MAR prior to administration of medications. -The MAs should document on the MAR after administration of medications. -The MAs were taught in the medication administration class to sign the MAR after the administration of medications. -The MAs are expected to document on the MAR as they were taught in class. Interview with the Regional Director of Clinical Services on 09/01/21 at 11:55am revealed: -The MAs are expected to document on the MARs after the medications are administered. -The MAs are expected to follow all medication administration procedures as was taught in the medication administration class. -All the MAs will be going through a refresher course on how to administer medications. Interview with the RDCS on 09/02/21 at 5:24pm revealed medications that were not located and documented as administered were considered false documentation.	D 367			
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to	D 468	100% employee file audit will be completed, Identifying which employees have not completed the required SCU orientation and training.	10/15/21	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGVILLE, NC 27596			
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D 468	Continued From page 102 be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (A, B) who worked in the Special Care Unit (SCU) had completed 6 hours of training within the first week of employment; and 2 of 3 sampled staff (A, C) who worked in the SCU had completed 20 hours of training within the first six months of employment. The findings are: 1. Review of Staff A's personnel record revealed: -Staff A was hired on 09/14/20. -There was no documentation Staff A had completed 6 hours of special care unit (SCU) training within her first week of employment. -There was no documentation Staff A had	D 468	Employee's have been notified that the required training must be completed by 10/15/2021. - Those employees that have not completed the required training by 10/15/21 due date will not be scheduled for work until trainings are completed. - all new hires will be required to complete 6 hours of SCU orientation prior to being scheduled for assignment. - Employee files will be audited monthly by BOM or designee to ensure all staff have completed the required SCU training and competency.	10/15/21	10/15/21

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D 468	Continued From page 103 completed 20 hours of SCU training within her first six months of employment. -There was no other documentation of additional SCU training for Staff A. Interview with Staff A on 09/03/21 at 12:30pm revealed: -She had been employed about "one year". -She did not receive any SCU training her first week of employment. -She had not received any SCU training since employment. Refer to interview with the Resident Care Director (RCD) on 09/03/21 at 1:57pm. Refer to interview with the Business Office Manager (BOM) on 09/03/21 at 3:33pm. Refer to interview with the Regional Director of Clinical Services on 09/03/21 at 4:30pm. 2. Review of Staff B's personnel record on 09/02/21 revealed: -Staff B was hired on 05/28/21. -There was no documentation Staff B had completed 6 hours of special care unit (SCU) training within her first week of employment. -There was no other documentation of additional SCU training for Staff B. Interview with Staff B on 09/03/21 at 1:25pm revealed: -She had been employed about "five months". -She did not receive any SCU training her first week of employment. -She had not received any SCU training since employment. Refer to interview with the Resident Care Director	D 468	- Employee's identified as not having completed this required training will be removed from the schedule until its completed. Addendum 10/04/21: Rule Area Completed	<i>ongoing</i> 10/15/21	

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D 468	Continued From page 104 (RCD) on 09/03/21 at 1:57pm. Refer to interview with the Business Office Manager (BOM) on 09/03/21 at 3:33pm. Refer to interview with the Regional Director of Clinical Services (RDCS) on 09/03/21 at 4:30pm. 3. Review of Staff C's personnel record on 09/02/21 revealed: -Staff C was hired on 12/04/18. -There was no documentation Staff C had completed 20 hours of special care unit (SCU) training within her first six months of employment. -There was no other documentation of additional SCU training for Staff C. Interview with Staff C on 09/03/21 at 11:33am revealed: -She had been employed about "four years". -She worked part-time as a personal care aide and part-time as a dietary aide. -She had not received the 20-hour SCU training. Refer to interview with the Resident Care Director (RCD) on 09/03/21 at 1:57pm. Refer to interview with the Business Office Manager (BOM) on 09/03/21 at 3:33pm. Refer to interview with the Regional Director of Clinical Services (RDCS) on 09/03/21 at 4:30pm. Interview with the Resident Care Coordinator (RCD) on 09/03/21 at 1:57pm revealed the former Administrator was responsible for making sure the SCU training was complete. Interview with the Business Office Manager (BOM) on 09/03/21 at 3:33pm revealed:	D 468			

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D 468	Continued From page 105 -She had been employed about "one month". -There were employees who had not completed their training. Interview with the Regional Director of Clinical Services on 09/03/21 at 4:30pm revealed: -She was the facility representative for the facility because the Administrator was unavailable -All employees should go through the 6-hour training and the 20-hour training to work in the Special Care Unit (SCU). -The former Director was responsible for ensuring all employees completed their training timely. -The BOM and RCC were responsible for ensuring all employees completed their training timely.	D 468		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility's IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: Based on observations, interviews, and record	D 612	- Daily Resident temperature checks were implemented on 8/31/2021 - Daily Covid screenings were implemented on 9/28/21. ED, RCC, or Designee will Review for completion daily. - Infection Control training held on 9/29/2021 and 100% Staff participation by 10/15/21 Addendum 10/04/21: Rule Area Completed	ongoing ongoing 10/15/21

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D 612	Continued From page 106 reviews the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were implemented when caring for residents during the global Coronavirus (COVID-19) pandemic as related to the screening of residents. The findings are: Review of the CDC guidelines dated 03/29/21 for the prevention and spread of the Coronavirus Disease in long term care (LTC) facilities revealed: -A strong infection prevention and control program is critical to protect both residents and healthcare personnel. -Actively monitor all residents at least daily for fever and symptoms consistent with COVID-19. Review of the NC Department of Health and Human Services COVID-19 Long Term Care (LTC) Infection Control Assessment and Response Tool for local health department (LHD) dated October 2020 revealed staff and residents should be screened daily for fever, signs and symptoms of COVID-19. Based on record review of the facility's Infection Control (COVID-19) policy revealed there was no policy available to review. Interview with a resident on 08/31/21 at 3:37pm revealed he thought the facility staff checked his temperature when he had a fall, but his temperature was not checked daily. Interview with another resident on 09/01/21 at 3:33pm revealed:	D 612			

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D 612	Continued From page 107 -He did not have his temperature taken daily; the staff only took his temperature when he did not feel good. -He could not remember the last time his temperature was taken. Telephone interview with the Communicable Disease Nurse at the local health department on 08/31/21 at 4:52pm revealed: -It was her understanding the dietary staff who had tested positive had been in and out of the resident rooms, therefore residents were exposed. -The guidance provided when someone has tested positive for COVID-19 was to monitor for symptoms for anyone who may have been exposed. Interview with a medication aide (MA) on 09/01/21 at 3:49pm revealed: -She had not taken daily temperatures of the residents. -She only took the resident's temperatures when the Resident Care Director (RCD) told her to. -She knew there was a recommendation to take residents temperatures daily, but she did not know why they were not taken at the facility. Telephone interview with a MA/personal care aide (PCA) on 09/02/21 at 9:15am revealed: -She only took a resident's temperature if it was on the medication administration record (MAR). -She was not required to take the residents' temperature once daily. Interview with another MA on 09/02/21 at 10:11am revealed: -They were taking resident temperatures daily; they had stopped "a while back". -The previous RCD told her the facility was clear	D 612			

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D 612	Continued From page 108 of COVID-19 so they did not have to take and document temperatures any more. Interview with the Regional Director of Clinical Services (RDCS) on 09/02/21 at 5:46pm revealed: -The facility was conducting biweekly rapid testing for COVID-19 so she thought they did not need to do daily temperature checks. -They had begun to do daily temperature checks and document the results on 08/31/21. Interview with the RCD on 09/02/21 at 10:34am revealed: -Residents' temperatures were taken twice daily. -Checking residents' temperatures began on 09/01/21. -There were no screening questions asked regarding symptoms. -Temperatures and screening had not been done for residents until 09/01/21 since there were residents diagnosed with COVID-19 in the building months ago. Interview with the RDCS on 09/02/21 at 5:24pm revealed: -The dietary manager (DM) for the facility tested positive for COVID-19 on 08/02/21. -MAs were asked to begin taking daily temperatures of the residents on Monday, 08/30/21, after a second dietary staff tested positive for COVID-19; temperature checks were then increased to every shift. -Daily temperature checks should have begun when the DM tested positive on 08/02/21 and did not know why they were not.	D 612			
D912	G.S. 131D-21(2) Declaration of Residents' Rights	D912			

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D912	Continued From page 109 G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration and resident rights. The findings are: 1. Based on observations and interviews, the facility failed to ensure the residents were treated with respect and dignity by not providing adequate furnishings for residents to eat in their rooms when communal dining was stopped due to COVID 19 and residents were forced to lock the doors to their rooms to keep other residents who wandered from coming in and out of their rooms. [Refer to Tag D338, 10A NCAC 13F .0909 Resident Rights (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 4 residents (#3, #10, #11) observed during the morning medication pass including errors with a thyroid medication (#10, #11); a vitamin supplement (#11); omission of an eye drop for dry eyes (#3); omission of a pain medication, a laxative and a topical cream (#10); and for 4 of 5 residents sampled for record review including errors with a	D912	- In Service on Residents Rights Started on 9/3, 9/4, 9/5, and will be 100% complete by 10/3/21 - Tables were purchased for the residents and chairs are used from dining room to ensure all residents are provided w/adequate furnishings during in room dining due to Covid 19. - ED, RCD or designee will ensure all new staff have Residents Rights training at hire and all staff will be retrained biannually and CQ needed. - Facility identified all wanderers and residents w/ behaviors on 9/3/21. Behavior care plans will be completed/ followed after each behavior. - all care plans w/ identified wanderers/behaviors have been updated to capture wandering and behaviors and to include referrals to Psys Services	10/3/21 9/10/21 ongoing 10/1/21	

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D912	Continued From page 110 medication for blood pressure (#3 and #8); a medication for sleep and medication used to treat high blood sugar (#8); a pain medication and an iron supplement (#3); a medication used to treat atrial fibrillation, a medication used to treat hypothyroidism, and a medication used to treat insomnia (#7); and an antidepressant (#5). [Refer to Tag D358, 10A NCAC 13F .1004a Medication Administration (Type B Violation)].	D912	- For hospice residents w/ behaviors or wandering - Hospice was contacted on 10/1/21 for additional support and/or interventions from interdisciplinary team. - completed new FL-2's on all wanderers/ behaviors and early risers to capture this information.	10/1/21	
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents were free of neglect as related to supervision. The findings are: Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#2) who was known to wander into other residents' rooms, causing the other residents to become agitated resulting in two separate altercations with other residents and the resident being injured.. [Refer to Tag D0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)].	D914	- RCS logs updated on all residents w/ wandering and behaviors and early risers. - In service on wandering started on 9/3/21. Continued through 9/4, 9/5, and completed 100% by 10/3/2021. - ED & RCD will discuss all behaviors/wanderers during morning meetings and daily files meetings. ED, RCD or designee are to report behaviors by way of incident reports + sent to RDCS after discussing in morning meeting. - Behavior care plan process will be initiated by ED, RCD, or designee. Behaviors will be reviewed weekly to ensure processes are followed and interventions are effective.	10/1/21 10/1/21 10/1/21 10/3/21 ongoing ongoing	
D935	G.S. § 131D-4.5B(b) ACH Medication Aides; Training and Competency	D935			

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D935	Continued From page 111 G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in	D935	- 2 med techs were immediately removed off med cart and retrained on NC DSS med administration course - med tech refresher course of medication administration was completed. - all med techs attended a 15 hour med. administration training, new order tracking, meds not available, Coumadin, diabetes proper transcription of orders to MAR, proper use of BS flow sheets, proper time FSBs checks, calibration of glucometers following all parameters - such as meds given on empty stomach or w/ foods, high or low BS, timely administration of meds, Procedures for med errors, Clarification of orders, Reordering medications, Components of complete medication orders, proper documentation, follow up to PRN meds and 6 rights of medication administration. Addendum 10/04/21: Rule Area Completed	9/2/21 9/10/21 10/1/2021 10/01/21

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D935	Continued From page 112 accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure 1 of 2 sampled staff (A) who administered medications, had employment verification or completed the 5, 10, or 15-hour medication aide training courses, and completed a medication administration clinical skills competency validation prior to administering medications. The findings are: Review of Staff A's personnel record revealed: -Staff A was hired on 09/14/20 as a medication aide. -There was no documentation Staff A completed the 5, 10 or 15-hour medication administration training. -There was no documentation of employment verification showing Staff A worked as a medication aide within the last 24 months. -There was no documentation Staff A had completed the medication administration clinical skills competency validation checklist. Interview with Staff A on 09/01/21 at 4:40pm revealed: -She took a medication aide class about "eight years ago". -A Registered Nurse (RN) taught the 15-hour medication aide training at her previous employment. -She did not recall receiving a certificate upon completion of the medication aide training. -She had taken the medication aide test offered by the state of North Carolina -She had passed the written medication aide test on 10/19/17.	D935	- ED is to complete all new hire processes w/ the exception of onboarding which is the responsibility of the BOM. The BOM has been provided w/ auditing tools as well as a tickler in order to monitor due dates of employee requirements. - ED will review the tickler monthly.	<i>ongoing</i> <i>ongoing</i>	

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D935	Continued From page 113 -A RN completed the medication administration clinical skills competency validation checklist in October 2020. -She did not know why it was not in her personnel record. Interview with the Regional Director of Clinical Services on 09/03/221 at 4:30pm revealed: -The former Director was responsible for all new hire documentation. -The former Director should have verified Staff A completed the 5, 10, or 15 hours medication administration training. -The former Director should have verified that Staff A worked as a medication aide within the previous 24 months of employment. -The Licensed Health Professional Support (LHPS) Nurse should have completed and documented the medication administration clinical skills competency validation checklist. -The Business Office Manager (BOM) would maintain the employee personnel record. -The BOM would audit the employee personnel record for completion. Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).	D935		
D992	G.S. § 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled	D992	- For staff that doesn't have examination/screening of the presence of controlled substance in their employee file, a drug test will be administered by 10/7/21. - Prior to hiring new staff member a drug screening will be	10/7/21

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/03/2021
NAME OF PROVIDER OR SUPPLIER FRANKLIN MANOR ASSISTED LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596		
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D992	Continued From page 114 substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure examination and screening for the presence of controlled substances was completed upon hire for 2 of 3 staff sampled (A, B) who were hired after 10/01/13. The findings are: 1. Review of Staff A's personnel record revealed: -Staff A was hired on 09/14/20 as a medication aide. -There was no documentation of a controlled	D992	Administered. ED or designee will review all new hire files prior to scheduling staff member for assignment. Addendum 10/04/21: Rule Area Completed	<i>ongoing</i> 10/07/21	

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D992	Continued From page 115 substance screening prior to hire. Interview with Staff A on 09/01/21 at 4:40pm revealed: -She had been employed about "a year". -She did not remember having a controlled substance screening prior to hire. -She was employed as a medication aide (MA) and personal care aide (PCA). Refer to the interview on 09/03/21 at 1:30pm with the Regional Director of Clinical Services. 2. Review of Staff B's personnel record revealed: -Staff B was hired on 05/28/21 as a medication aide. -There was no documentation of a controlled substance screening prior to hire. Interview with Staff B on 09/03/21 at 1:25pm revealed: -She had been employed since May 2021. -She did not recall having a controlled substance screening. -She did not know if she signed a consent to have a controlled substance screen. -She was employed as a MA and PCA. Refer to the interview on 09/03/21 at 1:30pm with the Regional Director of Clinical Services. Interview with the Regional Director of Clinical Services on 09/03/21 at 1:30pm revealed: -She was the facility representative for the facility because the Administrator was unavailable. -Staff A and B worked as a MA and PCS. -She did not know why Staff A or B did not have a controlled substance screening. -The Business Office Manager (BOM) was responsible for the controlled substance	D992			

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D992	Continued From page 116 screening. -The BOM was hired in May 2021. -The previous Administrator was responsible for the controlled substance screening.	D992			