Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	04/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on April 18-19, 2023.	D 000	Administrator or designee will ensure that all therapeutic diets are being followed per physician orders. The Resident Care Director or designee will ensure that the dietary department has a signed copy of all residents' diet orders every 6 months and in the diet binder and in the event that a resident's diet changes, the Resident Care Director or designee will hand deliver the updated diet order to the Dining Service Food Manager or designee. The Administrator or designee will conduct weekly audits with the Dining Services Food Manager on the diet binder and also monitor resident's diets during meal services daily to ensure correct diet order including texture and dietary modifications per diagnosis are being served as ordered by the resident's physician to comply with rule 10ANCAC 13F.0904 Nutrition and Food Service.	5/2/23
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure therapeutic diets were served as ordered for 1 of 3 sampled residents (#6) who had physician orders for a low concentrated sweets (LCS) diet with puree texture. The findings are: Review of Resident #6's current FL-2 dated 02/27/23 and signed by the physician revealed: -Diagnoses included Alzheimer's disease, diabetes type II, dementia without behavioral disturbances, anxiety, hypertension, and chronic kidney disease stage III. -There was an order for a low concentrated sweets (LCS) diet with puree texture. Review of Resident #6's physician signed diet order dated 03/21/23 revealed Resident #6 had an order for a LCS diet with puree texture. Telephone interview on 04/19 23 at 11:06 with a licensed dietitian revealed: -A LCS diet replaces the regular diet having sugar and concentrated sweets using measured	D 310		

Received and Acknowledged on 05/15/23 Janet Thornburg

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D 310	Continued From page 1 portions. -Pureed foods were prepared to have a smooth pudding or fluffy mashed potato consistency that did not require chewing. Observation of the kitchen during the initial tour on 04/18/23 at 08:05am revealed: -There was a Food Diet Sheet posted on the wall listing residents having orders for regular diets. -There was a Food Diet Sheet posted on wall listing residents having orders for ground textured diets. -There was no time period, date or signatures on the documents. -There was no Food Diet Sheet for a LCS diet with puree texture for Resident #6. -There was no Food Diet Sheet listing for staff to review for a LCS diet with puree texture for Resident #6. -There was no therapeutic diet spreadsheet posted for staff to review. Interview with the Dining Services Manager (DSM) on 04/18/23 at 11:15am revealed: -There was a therapeutic diet spreadsheet that was kept in a binder in his office. -The therapeutic spreadsheet had not been posted in the kitchen for staff to review. -He and the cook were familiar with the residents' diets and plated meals from memory. Review of the contracted dietitian's therapeutic diet spread sheet for April 2023 revealed: -The spread sheet listed a LCS diet with puree texture instructions for breakfast, lunch and dinner meals. -The spread sheet listed a puree textured diet with instructions on how to prepare meals for breakfast, lunch and dinner.	D 310	Dining Service Food Manager or designee will ensure that the menu guide is available during the meal service for staff to view to ensure that residents are receiving the appropriate diet with all dietary modifications and preparation instructions as approved by the registered dietician. The Dining Service Food Manger or designee will conduct weekly audits ensure that the diet binder is in compliance to include all residents' diets orders with physician signatures and dates, and the food diet spread sheet. The Dining Service Food Manager or designee will ensure that the binder is available to staff during all meal services. The Dining Service Manager or designee will check daily to ensure that the therapeutic diet spreadsheet is posted in the kitchen and readily available for staff to review to ensure compliance with rule 10 NCAC 13F .0904(e)(4) Nutrition and Food Service. The Dietary Department to be retrained on therapeutic diets and the menu guide by our registered dietician.	5/2/23 5/5/23

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D 310	Continued From page 2 Observation of the breakfast meal on 04/19/23 at 8:00am revealed: -Resident #6 was seated in the dining room holding her fork and picking at her plate of oatmeal, sausage and French toast with regular fruit juice and water. -The oatmeal had been scooped into a ball shape and placed on a plate; the oatmeal was not pureed. -The sausage patty was ground, not pureed. -The French toast was ground, not pureed and had streaks of maple syrup over the top. -The beverage was a red fruit juice. Review of the therapeutic diet spread sheet for the breakfast LCS diet with puree texture for Resident #6 revealed: -The French toast was to be pureed and served with diet syrup. -The beverage of choice was to be a sugar free. -Oatmeal was to be served 2 pureed scoops, 1 pureed scoop of sausage with French toast and diet syrup. Observation of the lunch meal on 04/19/23 at 12:25pm revealed: -Resident #6 was seated in the dining room receiving feeding assistance from staff. -The sweet potato, green vegetable and baked chicken foods were blended to the texture of cake frosting and placed flat on the plate. -Resident #6 was served water and regular tea with sugar. -Resident #6 was served a dessert bowl of regular baked fruit crumble with sugar that was a blended texture, not pureed. Review of the LCS diet with puree texture spread sheet for lunch for Resident #6 revealed: -The baked chicken, mashed potatoes, steamed	D 310		

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D 310	Continued From page 3 vegetables, dinner roll (no margarine) were to be pureed. -The dessert was to be fruit cocktail puree (no fruit crumble) and a diet beverage of choice. Interview with the dietary cook on 04/19/23 at 3:00pm revealed: -She started working as a dietary cook 3-4 weeks ago; she had previous experience as a personal care aide (PCA). -She was trained by the DSM on how to prepare puree texture and other diets. -Resident #6 had a diabetes diet with puree texture. -Physician diet orders were kept in a yellow binder under the plating table. -She knew the residents and their diet orders from memory and did not always need to review the therapeutic diet spread sheet for meal preparation information. Interview with the DSM on 04/19/23 at 3:35pm revealed: -He received changes in residents' diet orders from the Resident Care Director (RCD) and medication aides (MA). - Diet orders were often left on his desk by medication aides (MA) and the cook would place it in the yellow binder. -If there were additional changes in resident orders, he and the cook were to let each other know. -When he started working at the facility on 12/02/22, he was not aware there was a therapeutic spread sheet to review. -No one told him there was a therapeutic spread sheet prepared by the dietitian. -He was made aware Resident #6 had a diagnosis of diabetes about 3 weeks ago, but no changes were made in her meals except to give	D 310		

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D 310	Continued From page 4 her sugar free desserts. Interview with the Resident Care Director (RCD) on 04/19/23 at 2:30pm revealed: -When dietary orders for residents were received she or the medication aide (MA) receiving the order would deliver it to the DSM or the cook to place in the yellow binder and posted on the bulletin board in the kitchen. -She was not aware of a therapeutic diet spread sheet to be used as a guide for meal preparation for Resident #6. Interview with the Administrator on 04/19/23 at 3:15pm revealed: -The facility menus, including therapeutic menus, were provided by a contracted dietary management company for the facility. -The therapeutic diet spread sheet was kept in a binder in the DSM's office. -Physician's diet orders for residents were placed and kept in the binder in the DSM's office. -The DSM and cooks were to refer to the physicians' orders and the dietitian's therapeutic diet spread sheet when preparing meals for residents having therapeutic diet orders. -She was not aware Resident #6 was not receiving meals according to physician's orders for a LCS with puree texture diet. -The Administrator was responsible for making sure all residents were receiving their meals as ordered by the physician. -Audits needed to be made of all residents' dietary orders. Attempted interview with Resident #6 on 04/19/23 at 12:35pm was unsuccessful. Attempted interview with Resident #6's primary care provider (PCP) on 04/19/23 at 2:45pm was	D 310		

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D 310	Continued From page 5 unsuccessful.	D 310	Resident Care Director requested physician to change medication order from Aspirin EC 81mg to a chewable Aspirin 81 mg which can be crushed. Resident Care Director or designee will conduct weekly crushed med audits to ensure that the medications are being administered per physician orders. Resident Care Director or designee to provide quarterly training to medication aides on medication administration. Resident Care Director or designee to conduct a medication review on all meds in the cart with a do not crush order monthly to ensure that the order is conducive for correct administration and preparation to meet the resident needs and physician orders without causing pain or discomfort to the resident. In the event that the medication prescribed does not meet the resident's needs, the Resident Care Director or designee will notify the physician to ask for another medication to meet those needs to comply with rule 10A NCAC 13F.1004(a) Medication Administration.	4/19/23
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: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 6 residents (#7, #8) observed during the 8:00am morning medication pass including a medication that could not be crushed (#7); and a medication to be given on an empty stomach (#8). The findings are: The medication error rate was 7% as evidenced by the observation of 2 errors out of 26 opportunities during the 8:00am medication pass on 04/19/23. 1. Review of Resident #7's current FL-2 dated 03/28/23 revealed diagnoses included dementia, coronary artery disease, gastro-esophageal reflux disease, polyneuropathy, insomnia, depression, Alzheimer's disease, and hypertension. Review of Resident #7's signed six-month physician's orders dated 03/2/23 revealed an	D 358		

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D 358	Continued From page 6 order for aspirin enteric coated (EC) 81mg (used to prevent blood clots) one tablet daily do not crush. Observation of the morning medication pass on 04/19/23 8:31am revealed: -The medication aide (MA) was standing at the medication cart, outside the dining room, administering medications as the residents were leaving the dining room after breakfast. -The MA stopped Resident #7 as she was leaving the dining room to administer her morning medications. -The MA prepared Resident #7's aspirin EC 81mg for administration by crushing the tablet and placing it in yogurt. -She administered the crushed medication in yogurt to Resident #7. Interview with the MA on 04/19/23 at 10:47am revealed: -She had worked as a MA for 8 years. -She assisted in training the new MAs when hired. -She knew Resident #7's aspirin order read "do not crush". -Resident #7 would only take her medications if they were crushed and placed in yogurt. -Resident #7 would spit her medication out if it was not crushed and placed in yogurt. -She had not spoken to the Primary Care Physician (PCP) about changing the medication to something that could be crushed. -She would notify the PCP and discuss changing aspirin EC to something that could be crushed. Review of Resident # 7's electronic medication administration record (eMAR) for April 2023 revealed: -There was an entry for aspirin 81mg daily, do not	D 358		

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D 358	Continued From page 7 crush, scheduled for administration at 8:00am. -There was documentation that aspirin was administered at 8:00am on 04/19/23. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 04/19/23 at 11:32am revealed: -The pharmacy had an order for aspirin EC 81mg daily do not crush. -Resident #7 had a diagnosis of coronary artery disease and aspirin was used as a preventive measure to promote blood flow. -Aspirin EC could not be crushed because it would destroy the coating on the medication and increase the chance of abdominal discomfort. -The prescription label on the bubble pack indicated the aspirin EC was not to be crushed. -If Resident #7 required medications to be crushed, the pharmacy would need an order for chewable aspirin 81mg, which could be crushed without causing abdominal discomfort. -The facility had not contacted the pharmacy regarding the need to crush the aspirin. Interview with Resident #8's PCP on 04/19/23 at 12:16pm revealed: -Resident #7 had an order for aspirin 81mg daily. -She knew Resident #7's medications were crushed for administration. -She did not realize Resident #7 was receiving aspirin EC 81mg instead of the chewable aspirin that could be crushed. -The facility had not reached out to her to have the order for aspirin changed from EC to chewable. -Resident #8 could have increased abdominal discomfort by consuming aspirin EC 81mg after it was crushed. -She expected the MAs to administer the medications as ordered.	D 358	Resident Care Director completed an in-service for Med Aides on Medication administration and storage. Med Aides received a copy of the medication administration and storage policy. Med Aides are to administer medications as prescribed and to ensure that the resident receives the right medication at the right time with the right documentation. Med aides are to complete an occurrence report when a resident receives the wrong dose, wrong time, wrong drug, wrong resident, or a missed dose and will notify the residents responsible party, the physician, and the Resident Care Director or designee when a resident. If the Med Aide could not administer medications as ordered, the physician will be notified. Administrator or designee will review all occurrence reports within 24 hours and will provide an intervention and or follow up with the physician. In the event that the med aide receives a medication that is not conducive for the preparation to meet the residents' orders and or needs, they are to notify the Resident Care Director, pharmacy, and the physician immediately and request that an alternative medication to be prescribed. The Resident Care Director or designee will conduct weekly cart and chart audits to ensure that the preparation and administration of medications, prescriptions and non-prescription, and treatments by staff are in accordance with orders by a licensed prescribing practitioner which are maintained in the resident record and the rule for section 10A NCAC 13F.1004(a) Medication Administration.	4/26/23

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D 358	Continued From page 8 Interview with the Resident Care Director (RCD) on 04/19/23 at 11:10am revealed: -The MA should not crush a medication that reads "do not crush". -If Resident #7 required her medications to be crushed, the MA should have notified the PCP to see if the order could be changed. -The MA should have called the pharmacy to see if the medication could be dissolved in water or came in a liquid form. -She was not informed by the MA staff that Resident #7 had a medication that should not be crushed, but needed to be crushed, for Resident #7 to take her medications. Interview with the Administrator on 04/19/23 at 12:33pm revealed: -The MAs should not be crushing a medication that reads "do not crush". -The MAs should have notified the RCD that they needed to crush a medication that could not be crushed for Resident #7 to take her medications. -The MAs should have contacted the pharmacy to see if another medication could be substituted and did not have to be crushed. Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable. 2. Review of Resident #8's current FL2 dated 08/18/22 revealed: -Diagnoses included dementia, hyperlipidemia, anxiety disorder, Alzheimer's disease, osteoarthritis, and chronic kidney disease stage 3. -There was an order for omeprazole DR 20 mg 30 minutes before breakfast.	D 358		4/19/23

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D 358	Continued From page 9 Review of Resident #8's signed six-month physician orders dated 02/17/23 revealed an order for omeprazole DR 20mg (used to treat heartburn) one 30 minutes before breakfast. Observation of the morning medication pass on 04/19/23 8:20am revealed: -The medication aide (MA) was standing at the medication cart, outside the dining room, administering medications as the residents were leaving the dining room after breakfast. -The MA stopped Resident #8 as he was leaving the dining room to administer his morning medications. -The medication aide pulled four bubble packs from the medication cart drawer and placed them on top of the medication cart. -One of the bubble packs was for omeprazole DR 20mg; the prescription label read take one capsule 30 minutes before breakfast. -The MA compared each bubble pack with the entry on the eMAR and popped the medication into a souffle cup. -The MA prepared 4 pills for administration to Resident #8, including omeprazole 20mg. -The MA administered the 4 pills to Resident #8 with a cup of water, including omeprazole 20mg. Review of Resident #8's electronic medication administration record (eMAR) for April 2023 revealed: -There was an entry for omeprazole DR 20mg 30 minutes before breakfast with a scheduled administration time of 7:30am. -There was documentation that omeprazole was administered at 7:30am on 04/19/23. Interview with the MA on 04/19/23 at 10:47am revealed: -She knew Resident #8's omeprazole was to be	D 358		

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D 358	Continued From page 10 given before breakfast. -She had gotten busy and distracted with other things this morning and did not administer Resident #8's omeprazole before breakfast. -She tried to administer Resident #8's omeprazole before breakfast but there were days that he did not receive it before breakfast. -She had not notified Resident #8's Primary Care Provider (PCP) the resident received omeprazole after eating breakfast. -She would notify the PCP to see if the time of administration could be changed. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 04/19/23 at 11:32am revealed: -The pharmacy had an order for omeprazole DR 20mg 30 minutes before breakfast. -Omeprazole was used to decrease the amount of acid in the stomach. -Omeprazole was to be administered on an empty stomach to maximize the absorption of the medication. -When omeprazole was administered after a meal, there was a reduction in the absorption of the medication, causing the medication to be less effective. -Resident #8 could have an increase in symptoms of reflux if the medication was not administered before the meal. Interview with Resident #8's PCP on 04/19/23 at 12:18pm revealed: -Omeprazole was ordered to be administered before food. -Omeprazole was to be administered before food to decrease the acid in the stomach. -When omeprazole was administered with or after food, the food would decrease the effectiveness of the omeprazole.	D 358		

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D 358	Continued From page 11 -Resident #8 could have an increase in gastric reflux or esophageal discomfort. -She expected omeprazole to be administered as ordered to Resident #8. Interview with the Resident Care Director (RCD) on 04/19/23 at 11:10am revealed: -The MA should read the instructions carefully and administer the medications as ordered. -Resident #8 should be administered omeprazole before breakfast as ordered. -She had not been notified of Resident #8 receiving his omeprazole after breakfast instead of before breakfast, as ordered. Interview with the Administrator on 04/19/23 at 12:33pm revealed: -She expected the MAs to administer medications as ordered. -If the MAs could not administer the medication as ordered, the PCP should be notified. Based on observations, interviews, and record reviews, it was determined Resident #8 was not interviewable.	D 358		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by:	D 378		

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D 378	Continued From page 12 Based on observations, interviews, and record reviews, the facility failed to ensure medications left on top of a medication cart were locked when not under the direct physical supervision of a medication aide observed during the 8:00am medication pass on 04/19/23. The findings are: Review of the facility's current license effective 01/01/23 revealed the facility was licensed for a capacity of 54 with 54 Special Care Unit (SCU) beds. Review of the facility's resident census report dated 04/18/23 revealed there was a census of 32 residents. Review of the facility's medication storage policies and procedures revealed all prescription and non-prescription medications stored by the facility should be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration. Observation of a medication aide (MA) administering medications on 04/19/23 from 8:20am - 8:55am revealed: -The MA prepared 6 oral medications for a resident at 8:28am. -The MA could not locate another medication on the medication cart. -The MA left the medication cart and went to the medication room to look for the medication, leaving a souffle cup containing 6 oral medications, unsecured, on top of the medication cart. -Oral medication in the souffle cup included atenolol 25mg (used for high blood pressure), daily-vite (a supplement), gabapentin 300mg	D 378		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	04/19/2023

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

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D 378	Continued From page 13 (used to treat nerve pain), famotidine 20mg (used to treat heartburn), risperdal 0.25mg (used to treat anxiety), and amlodipine 2.5mg (used to treat high blood pressure). -The medication room was 25 feet from the medication cart. -The MA entered the medication room at 8:31am, leaving the door propped open, with her back to the medication cart. -Another staff member approached the MA in the med room in need of supplies. -The MA closed the medication room door at 8:36am and remained inside the medication room to retrieve supplies for the staff member. -The MA returned to the med cart at 8:37am, placed the cup of pills in the top drawer of the medication cart and locked the medication cart, and proceeded to assist the staff member. -The MA returned to the medication cart at 8:46am and administered six oral medications to a resident. -There was no staff in view of the medication cart while the MA was in the medication room. Interview with the MA 04/19/23 at 10:47am revealed: -She did not realize she left a cup of oral medications on top of the medication cart unattended. -She went to the medication room to look for medication she could not locate on the medication cart. -A staff member came to the medication room and needed supplies for a skin tear. -She should not allow interruptions to stop her from administering medications unless it was an emergency. -Another resident could have walked by the medication cart and taken the medications that were left on top of the medication cart.	D 378	Resident Care Director completed an in-service for Med Aides on Medication administration and storage. Med Aides reviewed and received a copy of the medication administration and storage policy. Resident Care Director or Designee will observe 2 med passes daily to ensure that medication administration and storage policies are being adhered to. Resident Care Director or designee will have quarterly in-services on Medication administration and storage. Med Aides are to administer all medication immediately after preparation. All medications that have been prepared or stored in the facility will be maintained under locked security except when under direct physical supervision of staff in charge of medication administration to ensure the safety of residents and to comply with rule 10A NCAC 13 F. 1006 (b) Medication Storage.	4/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	04/19/2023

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D 378	Continued From page 14 Interview with the Resident Care Director (RCD) on 04/19/23 at 11:10am revealed: -The MA must have been nervous; it was not typical of the MA to leave medications on the medication cart. -Medications should be administered immediately after the medications were prepared. -The MA should have administered the medications she had prepared and then looked for the one medication missing from the medication cart. Interview with the Administrator on 04/19/23 at 11:24am revealed: -Medications should be administered to the residents immediately after preparation. -Medications that have been prepared for administration should be placed in the medication cart and locked in case of an emergency. -Medications should always be secured for residents' safety.	D 378		