STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056001	A. BUILDING: _____ B. WING _____	R-C 06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW MANOR CARE CENTER	150 CRISP STREET FRANKLIN, NC 28734

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D 000	Initial Comments The Adult Care Licensure Section and the Macon County Department of Social Services conducted a followup survey and a complaint investigation on 06/04/24 and 06/05/24.	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: Based on observations, interviews, and record reviews, the facility failed to provide supervision to a resident with a history of wandering and elopement for 1 of 5 sampled residents (#3). The findings are: Review of Resident #3's current FL2 dated 05/29/24 revealed: -Diagnoses included schizophrenia and tardive dyskinesia (a disorder resulting in repetitive body movements). -Recommended level of care was documented as rest home. -The resident was ambulatory. -There was no documentation regarding his orientation. Review of Resident #3's current care plan dated 05/31/24 revealed: -There was no documentation of wandering.	D 270		

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D 270	Continued From page 1	D 270		

-Under "Social and Mental Health History" a diagnosis of schizophrenia was documented.
-There was documentation Resident #3 was sometimes disoriented, forgetful and needed reminders, and had delusional thoughts.
-There was no documentation of history of elopement.

Review of nurses notes for 05/29/24 revealed:
-Resident #3 returned to the facility from a short-term psychiatric facility on 05/29/24 at 6:13pm.
-The Resident Care Coordinator (RCC) documented he "will need close supervision, no going outside after dark, and watch him for night wandering."

Review of nurses notes for 05/30/24 revealed:
-Resident #3 had been up all night.
-He was found outside, but did come back in the facility when asked to by the medication aide (MA).
-The staff would continue to monitor him.
-He went to bed at 7:00am on 05/30/24.
-The staff would continue to monitor him.

Interview with a personal care aide (PCA) on 06/04/24 at 2:25pm revealed Resident #3 would often "take off on his own" and go outside.

Telephone interview with Resident #3's Care Manager on 06/04/24 at 3:24pm revealed:
-She was contacted by the RCC on 04/03/24 that Resident #3 had been sent to the emergency room (ER) on 03/31/24 after being accidentally locked outside the facility at night for an unknown length of time.
-She was concerned that he may need a higher level of care than could be provided at the facility and had discussed this with the RCC on

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D 270	Continued From page 2 04/03/24. -The RCC said Resident #3 enjoyed his freedom and wanted to go in and out and wander around the building on the property. -After his hospitalization, he was transferred to a short-term psychiatric facility until he was discharged back to the facility on 05/29/24. -She had not been made aware that he was outside again in the early morning hours on 05/30/24. -Resident #3 had continuous delusions and generalized paranoia. -She was concerned that he needed increased supervision that was not being provided at the facility. Telephone interview with a medication aide (MA) on 06/05/24 at 8:30am revealed: -She was working 3rd shift on the evening of 03/31/24 when Resident #3 was outside the building during the night. -The front doors were always unlocked between 11:00pm and 1:00am because this was the time the pharmacy delivered medications. -Around 12:00am, a PCA told her that Resident #3 had been outside and "just came in stumbling through the front door." -She and the PCAs working that night were not aware he was outside. -She immediately went to see him and took his vitals. -He had on two long sleeve shirts, two pairs of pants, socks, shoes and a toboggan. -His oxygen saturation was in the 80's and she started Resident #3 on oxygen at two liters per facility protocol. -He was very pale and complaining of chest pains. -She called Emergency Medical Services (EMS) and the Administrator.	D 270		

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D 270	Continued From page 3 -Since Resident #3 was his own Guardian, there was no one to call on his behalf. -He remained at the hospital for a few weeks, then went to an inpatient psychiatric facility for treatment. -He returned to the facility on 05/29/24. -She was working the night of 05/29/24. -She was told by the off going MA on 05/29/24 that Resident #3 had returned from the hospital, and they needed to do two hour checks on him and make sure he did not go outside after dark. -She was in the hallway sometime between 12:00am and 1:00am on 05/30/24 and saw Resident #3 exit the front of the building. -She went to the door and asked him to come back inside. -Resident #3 came back in the building but was up all night wandering the halls. -He did not go to bed until the next morning at 7:00am. -They did not increase supervision on Resident #3 after he came back in the building. Interview with the RCC on 06/05/24 at 9:31am revealed: -Resident #3 returned from his hospitalization on 05/29/24. -She made a nurses' note and told the MA on duty that Resident #3 needed close supervision, could not go out at night and to observe Resident #3 for wandering. -She defined close supervision as "every couple of hours." -The MA on duty was responsible to pass on to the oncoming staff that Resident #3 needed close supervision, could not go out at night and to observe him for wandering. -Resident #3 had the right to go outside and he had never wandered off the property.	D 270		

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D 270	Continued From page 4 Interview with a MA on 06/05/24 at 11:44am revealed: -Resident #3 preferred to do most of his care independently. -When she worked, she checked on Resident #3 every two hours. -Other than a change in medications, she had not been made aware of anything being done differently for Resident #3 since his return from the hospital. -She was not aware of any increase in supervision for Resident #3. -She was not aware Resident #3 could no longer go outside at night. Interview with a PCA on 06/05/24 at 1:56pm revealed: -She was working on 05/29/24 when Resident #3 returned to the facility. -She was not told anything different about what to do for him. -She sees all the residents every two hours when she works. -There was no increase for Resident #3 that she had been made aware of. -She was not aware he could no longer go outside at night. Interview with the Administrator on 06/05/24 at 4:23pm revealed: -There had been no indication for the psychiatrist at the inpatient facility where Resident #3 was that he had any increase in wandering. -She expected staff to observe him to ensure he did not go outside at night after he returned from the hospital. -He should not have gone outside on the facility grounds at night when he returned from the hospital. -There should have been an increase in	D 270		

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D 270	Continued From page 5 supervision from staff upon his return from the hospital.	D 270		
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 ensure medications were administered as prescribed for 1 of 1 sampled resident (#5) related to medications used to treat constipation. The findings are: Review of Resident #3's current FL2 dated 05/29/24 revealed diagnoses included constipation. Review of Resident #3's hospital discharge summary dated 05/29/24 revealed: -There was an order for polyethylene glycol (used to treat constipation) 17 grams daily. -There was an order for psyllium (used to treat constipation) 1 packet twice daily. Review of Resident #3's electronic medication administration record (eMAR) for May 2024 revealed:	D 358		

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D 358	Continued From page 6 -There was not an entry for polyethylene glycol 17 grams daily listed on the eMAR. -There was not an entry for psyllium 1 packet twice daily listed on the eMAR. Review of Resident #3's electronic medication administration record (eMAR) for June 2024 revealed: -There was not an entry for polyethylene glycol 17 grams daily listed on the eMAR. -There was not an entry for psyllium 1 packet twice daily listed on the eMAR. Observation of Resident #3's medications on hand for 06/05/24 at 2:28pm revealed: -There was no polyethylene glycol available for administration. -There was no psyllium available for administration. Interview with the medication aide (MA) on 06/05/24 at 2:28pm revealed: -Resident #3 returned to the facility from a recent hospitalization last week. -She was not aware of an order for Resident #3 to have polyethylene glycol or psyllium. -There was no polyethylene glycol or psyllium available on the medication cart to administer to Resident #3. Interview with a second MA on 06/05/24 at 2:35pm revealed: -The MA Supervisor was responsible to fax orders from the hospital to the pharmacy upon Resident #3's return to the facility. -The pharmacy would electronically enter the medications on the eMAR. Interview with the Resident Care Coordinator (RCC) on 06/05/24 at 3:11pm revealed:	D 358		

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D 358	Continued From page 7 -When a resident returned from a hospitalization, the hospital discharge summary was faxed to the pharmacy. -The MA Supervisor was responsible to fax the hospital discharge summary to the pharmacy. -If the MA Supervisor was not working, the MA responsible for administering the resident's medications was responsible to fax the hospital discharge summary to the pharmacy. -A pharmacy technician entered the orders on the eMAR and the pharmacist was supposed to review it before electronically sending the updated eMAR to the facility. -Resident #3 returned from the hospital around 6:00pm on 05/29/24. -The MA Supervisor was already off work for the day. -The MA responsible for Resident #3's medications faxed the hospital discharge summary to the pharmacy on 05/29/24. -She called the pharmacy on 06/05/24 to inquire about Resident #3's medications. -After review, the pharmacy representative realized the polyethylene glycol and psyllium should have been on the eMAR but were not. -Once the eMAR was received from the pharmacy, the MA supervisor or the MA should have rechecked to verify the medications were correct, before medications were administered. Telephone interview with a representative from the facility's contracted pharmacy on 06/05/24 at 3:34pm revealed: -The pharmacy received a fax from the facility on 05/29/24 with medications listed on a hospital discharge report. -The pharmacy technician placed the orders on the eMAR for Resident #3. -The pharmacist reviewed the eMAR before it was electronically sent to the facility.	D 358		

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D 358	Continued From page 8 -The pharmacist did not catch the error of the two medications being left off the eMAR for Resident #3. Interview with the Administrator on 06/05/24 at 4:23pm revealed: -Resident #3 returned to the facility from a hospitalization after 6:00pm on 05/29/24. -The MA supervisor was responsible for faxing the hospital discharge report to the pharmacy. -When the MA supervisor was not working it was the responsibility of the MA to send the hospital discharge report to the pharmacy. -Once the medications were placed on the eMAR by a pharmacy representative, the MA had to approve the medications were correct according to the hospital discharge orders. -This was an MA oversight for the two medications that had not been placed on the eMAR for Resident #3.	D 358		