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	HAL056006	A. BUILDING: _____ B. WING _____	C 02/23/2017

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D 000	Initial Comments The Adult Care Licensure Section and the Macon County Department of Social Services conducted an annual survey on February 21-22, 2017 with an exit conference via telephone on February 23, 2017.	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 adequate supervision at meals for 1 of 1 resident (Resident #3) with physician orders for honey thickened liquids. The findings are: Review of Resident #3's current FL2 dated 8/8/16 revealed: -Diagnoses included: Vascular dementia, hemiplegia/hemiparesis (paralysis of one side of the body), history of stroke, and dysarthria (unclear articulation of speech). -A physician's order for a mechanical soft diet with honey thick liquids. -The recommended level of care for the resident was documented Special Care Unit (SCU). Review of Resident #3's physician order dated 11/14/16 revealed mechanical soft diet with honey	D 270	Med Tech or staff designee on duty at each meal will provide one on one staff to resident supervision at and during each meal of the day to any/all resident requiring direct supervision starting on 02/23/2017. All staff informed by the Director of Resident Care and the facility Executive Director. Resident Care Director and/or Executive Director will monitor daily at each meal. Mandatory Med Tech meeting on 03/15/17 to emphasize personal care and supervision of the residents.	03/15/17

Reviewed and Accepted
Date: 3/24/17 cs

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D 270	Continued From page 1 thickened liquids were renewed for the resident. Review of Resident #3's Care Plan dated 12/5/16 revealed: -The resident was documented as non-ambulatory with use of wheelchair for ambulation, sometimes disoriented, forgetful-needs reminders, and having slurred speech. -The resident was documented as requiring limited staff assistance with eating. -The resident was documented as requiring extensive assistance with transfers. Observations of Resident #3 during the lunch meal service in the SCU dining room on 2/21/17 from 11:55am to 12:15pm revealed: - At 11:55am, the resident was sitting at the dining room table with a 4 oz. cup of water with ice, a 4 oz. cup of honey thickened water and an 8oz. cup of nutritional supplement in the place setting in front of him. - At 12:00pm, the resident picked the 4 oz. glass of water with ice up and proceeded to drink it, then returned it to the left side of the his place setting. - At 12:00pm, no coughing was observed immediately after the resident consumed the water with ice. -At 12:01pm, the resident was served a plate with chopped oriental chicken, fried rice, cooked carrots, and a cut up veggie egg roll. -At 12:02pm, there was a 3/4 full 4oz. cup of water with ice in it sitting on the left side of the resident's place setting. -At 12:04pm, the resident coughed loudly while he was eating. -At 12:05pm, the resident was observed to cough again. -At 12:10pm, the resident had consumed 100% of	D 270		

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D 270	Continued From page 2 the chopped oriental chicken, 75% of the fried rice, 0% of the carrots and veggie egg roll, 3/4 of the 8 oz. chocolate nutritional shake, 1 oz. of the thickened water, and 50% of the cooked apples he had received for dessert. -At 12:15pm, the resident wheeled himself out of the dining room in his wheelchair. Observations of Resident #3 in the SCU dining room on 2/21/17 from 4:45pm to 5:03pm revealed: -At 4:46pm, Resident #3 received an 8oz. cup of nutritional supplement. -At 4:50pm, staff served Resident #3 was served an 8oz. cup of honey thickened cranberry juice. -At 4:52pm, a Personal Care Aide (PCA) verbally redirected Resident #3 when he attempted to take the cup of ice water from the resident sitting to his immediate left. -At 4:53pm, a PCA once again verbally redirected Resident #3 when he attempted to take the cup of ice water from the resident sitting to his immediate left. -At 4:55pm, a PCA poured Resident #3 an 8oz. cup of commercially prepared chilled lemon flavored honey thickened water. -At 5:02pm, Resident #3 took the 4oz. cup of ice water from the resident seated to his immediate left and drank the water in the cup. Resident #3 immediately coughed loudly then placed the empty cup back in front of the resident to his left place setting. -At 5:03pm, a PCA was informed by the observing Surveyor what had occurred. Staff in the dining room were unaware Resident #3 had drank the other residents ice water. Review of Resident #3's Nurse Practioner note dated 7/25/16 revealed: -"Facility staff report the resident has been known	D 270		

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D 270	Continued From page 3 to take other residents thin liquids and begin to drink them before they have the opportunity to sit down and begin their meal." -"He ends up coughing a lot as a result." -"He is supposed to be on thickened liquids." -"Dysphagia-the resident does not apparently like thickened liquids. These are required to help with the swallowing difficulties that proceeded following his CVA." -"Perhaps the resident could be the last person who is brought into the dining room where there are regular thin liquids being left on the table in preparation for the meal." Interview with the Memory Care Manager on 2/21/17 at 5:05pm revealed: -Resident #3 has right sided hemiplegia, post stroke, and dysphagia. -He was aware Resident #3 frequently took thin liquid drinks from the residents seated around him at meal times and drank them. -"He steals cups off the med cart to drink water out of the sink in his room." -"We have reported it to the Nurse Practitioner and Doctor about him stealing drinks and cups." -"We have had conversations with the family about it." -"The doctor and Nurse Practitioner do not want to change his [thickened liquid] order." -"All the staff are aware and we all watch him very closely but he still does it." -"The family brings him food he's not supposed to have and we have asked them to sign a release to release us from the liability." Interview with the Executive Director on 2/21/17 at 5:10pm revealed: -He was aware of Resident #3's behaviors including taking other resident's thin liquid drinks at meals and taking cups to drink water from the	D 270		

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D 270	Continued From page 4 sink in his room. -"All the staff are aware and we watch him." -"For example, today a family member saw [Resident #3] take some med cups off the med cart as it went by him..." -The family member immediately reported it to the Executive Director and he immediately went to Resident #3 and asked him if he had cups. Resident #3 denied he had taken any cups. -Then another staff member asked him about the cups and Resident #3 denied it again and "then we found the cups behind his back in his wheelchair." -The resident's Physician and Nurse Practitioner have been made aware of the resident's noncompliant behaviors. -The resident's Power of Attorney had been made aware of the resident's noncompliant behaviors. Interview with Staff F, Medication Aide (MA), on 2/22/17 at 11:06am revealed: -"We remind the resident he's on thickened liquids." -"We keep the med cart locked up." -All the staff know "no cups" are allowed to be in his room. -"He sleeps in the morning. Comes out early for lunch and socializes" in the common areas. -"We lay eyes on him every 30 minutes to 1 hour while he's in his room." Interview with Staff B, MA, on 2/22/17 at 11:20am revealed: -Resident #3 "stays in his room for the most part, but if he sees the snack cart he will try to sneak the liquids." -"We usually have to supervise him around that and in the dining room." -"We do check him in his bedroom to make sure he's okay. We are in there every hour checking	D 270		

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D 270	Continued From page 5 him." Interview with Staff E, Personal Care Aide (PCA), on 2/22/17 at 11:27am revealed she checked on Resident #3 if he was in his room "every 30 minutes unless he's calling" meaning had put his call light on to alert staff he needed assistance. Telephone interview with Resident #3's Nurse Practitioner on 2/22/17 at 2:45pm revealed: -She was aware Resident #3 had an order for honey thickened liquids and was noncompliant with the order at times. -"He's obviously with it enough to do this behind everybody's back." -"He hasn't had any cases of pneumonia. No trips to the emergency room for aspiration." -"I don't think the thin liquids over the long-term have been detrimental to him." Telephone interview with Resident #3's Power of Attorney on 2/22/17 at 2:40pm revealed: -She described the care Resident #3 received as "overall pretty good." -She had been made aware Resident #3 was sometimes noncompliant with his honey thickened liquids order. -"It worries me. I tell him he can choke." -"He just says 'no'. I don't know if he just doesn't comprehend or he's just stubborn." -Resident #3 had not been to the hospital for treatment for pneumonia. -She did not hear from staff a lot about his noncompliance, "but I'm there about every other day" to visit. -"Overall, I think they do a pretty good job to stay on top of it" in reference to managing Resident #3's noncompliant behaviors.	D 270		

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D 283	Continued From page 6	D 283		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews and record review the facility failed to assure food items stored in the kitchen were stored in a manner as to protect from contamination. The findings are: A review of the "Food Establishment Inspection Report" dated 1/18/17 revealed: - "Protection from Contamination-out of compliance" and circled for "food separated and protected". - Observations and corrective actions section noted "Ready to eat potentially hazardous foods shall be date marked after opening." - "The opened containers of beef and chicken base had the date when they were received rather than when they were opened." - "No points taken." Observation on 2/21/17 between 9:40am and 10:00am of the dry and cold storage areas in the facility kitchen revealed: - A 5 lb. bag of grits half full, opened, with masking tape on the partially rolled bag, not dated. - A 5 lb. bag of powered buttermilk, half full, that had been opened and tied back but not dated. - A 5 lb. bag of pancake batter mix, ¼ full, had	D 283	All dietary staff informed that all food and beverage items will be marked with the date opened at the time of opening. All opened items marked with the date opened on 02/23/2017. Signs posted in kitchen area that items opened must be marked with the date opened. Dietary Manager and Executive Director will monitor daily to insure compliance.	03/15/17

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D 283	Continued From page 7 been opened and tied back but not dated. - A 16 oz. bag of potato chips, in a white bag, half full, had been opened and masking tape had been used to seal it but it was not dated. - A 35 oz. bag of frosted flakes, half full, had been opened and masking tape had been used to seal it but it was not dated. - A 16 oz. bag of raisin bran, 1/4 full, had been opened and masking tape had been used to seal it but it was not dated. - A large round container, 11.35 liters, of chocolate ice cream with a package date of 9/9/16 had been opened and not dated. - A large round container, 11.35 liters, of strawberry ice cream with a package date of 11/21/16 had been opened and not dated. - Near an unopened white round container of blueberries was a sandwich size freezer bag with blueberries that was not labeled or dated. - A 16 oz. opened, bag of whipped topping, with a metal tip covered in topping, lying on top of 4 unopened whipped topping bags. Observation on 9/21/17 at 10:00am of the clean storage area for pans revealed: - A fully opened bag containing bread, had a resident name written in black on the bag, with crumbs on the tray was not dated. - A regular, clear bag of loaf bread with seven pieces remaining, was lying on the clean tray not dated with crumbs to the left side of the bag. - Observed cook remove loaf of bread with a resident's name on it from the tray in the clean storage area to the prep area. Interview on 2/21/17 at 10:03am with the facility Cook revealed: -She had laid the bread out for use. -"Bread is kept in the dry storage area". -The bread she moved to the prep area did	D 283		

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D 283	Continued From page 8 belong to a resident and they kept it for the resident in the kitchen. Interview on 2/21/17 at 10:05am with the Dietary Manager revealed: -She had been the Dietary Manager for about a year. -She dated the food items when the food came in from the truck. - "I would have expected the staff that opened it to label and date it." - She was unable to explain why the opened food items were not stored, dated and labeled. Interview on 2/21/17 at 12:40pm with the Executive Director revealed: - He had assisted the Dietary Manager in dating items when they arrived from the delivery truck. - He was unable to explain why the opened food items were not stored, dated and labeled.	D 283		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of 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: Based on observation, interview and record review the facility failed to assure the right for each resident to be treated with respect, consideration, dignity and full recognition of his or her individuality. The findings are:	D 338	Med Tech on duty or designee at each meal time will provide supervisory monitoring to assure that each and every residents rights are maintained through the care staff helping, prompting, and guiding the resident with respect, consideration, and dignity while recognizing the residents' individuality. The Resident Care Director and/or the Executive Director will monitor each day starting 02/23/2017. Mandatory Med Tech meeting/training on 03/15/2017 to emphasize residents rights.	03/15/17

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D 338	Continued From page 9 Based on observations, interviews and record reviews the facility failed to treat 1 of 8 residents with respect, consideration, dignity, and with full recognition of his or her individuality as evidenced by the staff failing to assist with the silverware for her meal resulting in the resident eating her meals with her fingers (Resident #7). [(Refer to Tag G.S. 131-D-21, Declaration of Resident's Rights.)]	D 338		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to treat 1 of 8 residents with respect, consideration, dignity, and with full recognition of his or her individuality as evidenced by the staff failing to assist the resident with taking the silverware out of the package resulting in the resident eating her meals with her fingers (Resident #7). A review of the FL2 dated 1/10/17 for Resident #7 revealed: - Diagnosis included Alzheimer's disease, dysphagia, seizures, osteoarthritis and history of lumbar fracture. - Diet ordered chopped meats. A review of the Resident Register for Resident #7 revealed she was admitted on 1/26/15.	D911		

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D911	Continued From page 10 A review of the "Pre/Re-Assessment Service Plan" dated 2/13/17 for Resident #7 revealed: - She required extensive assist with cutting food. - She required limited assist with eating. - She required supervision assistance with utensil usage. Observations of Resident #7 during the lunch meal service in the Special Care Unit (SCU) dining room on 2/21/17 from 12:15pm to 12:27 pm revealed: - At 12:15 pm, the resident had been served a plate with chopped oriental chicken, fried rice, cooked carrots, and a cut up veggie egg roll and her dessert of cooked apples was already at her plate. - A place setting consisted of a fork, knife and spoon in white paper sleeve, a napkin, glass of tea and a glass of water. - The resident was eating the shredded chicken, cooked carrots, fried rice and a cut up veggie egg roll with her fingers as the silverware remained in the white paper sleeve. - She would lick her fingers after every couple of bites. - At 12:27pm, Staff A, Personal Care Aide (PCA) assisted the resident by taking her silverware out of the white paper sleeve and the resident immediately picked up her fork and used it to finish eating her meal. - At 12:30pm resident had finished eating with her fork. Observations of Resident #7 during the dinner meal service in the SCU dining room on 2/21/17 from 4:45pm to 5:25pm revealed: - At 4:47pm, resident was sitting in her wheelchair at the dinner table with a place setting in front of her that included tea, coffee and cranberry juice,	D911		

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D911	Continued From page 11 a napkin and a white paper sleeve with silverware inside. - At 5:12pm, resident was served a breaded fish filet, baked fried potatoes, and a salad. - Resident began eating her fried potatoes with her fingers. - Staff D put tartar sauce on her fish and ketchup on her potatoes but did not take silverware out for resident. -Same staff member stated "she eats with her fingers sometimes" when asked if she knew resident was eating with her fingers. - Resident broke some of the fish apart eating it with tartar sauce and began wiping her fingers (that were covered in tartar sauce) with her roll. - At 5:16pm the resident continued to eat her fish with tartar sauce, salad with dressing, and potatoes with ketchup using her fingers. - At 5:20pm Staff gave her ice cream for dessert but still did not assist her with her silverware. - At 5:23pm the residents daughter arrived and pulled up a chair to assist but assisted another family member to the bathroom before she could sit down to assist the resident. - At 5:25pm the resident put her fingers in the vanilla ice cream and then in her mouth. - At 5:26pm a female staff person walking through the dining room assisted the resident with taking the silverware out of the white paper sleeve and placing it beside her plate. - At this point the resident began eating her ice cream with her spoon. Interview on 2/21/17 at 12:47pm with Personal Care Aide (PCA), first shift revealed: - Resident #7 was able to eat on her own. - "I happened to see her not eating her food so I walked over and noticed her silverware wasn't out." - She took the silverware out of the white paper	D911		

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D911	Continued From page 12 sleeve and placed it beside her plate. - "She will eat just fine if you take her silverware out." - "We just need to cue her." Interview on 2/22/17 at 10:15am with Medication Aide (MA) for first shift revealed: - Resident #7 required chopped meat to eat. - "You have to give her the silverware and then she can eat on her own." - Resident #7 was "stable" with "not really any changes." - "Sometimes she will use her fingers but we try to encourage her to use her silverware," Interview on 2/22/17 at 11:38am with the Memory Care Coordinator revealed: - He had observed Resident #7 eating with her fingers before. - "Staff should be directing her to eat with her fork." - "She has no problems eating if she has her fork." - The resident does get a supplement just in case of any weight loss. - "She would do well with finger foods but we don't have an order for that." - "Staff should be taking the silverware out of the package and she will eat fine." Telephone interview on 2/22/17 at 2:18pm with Resident #7's family member revealed: - The family member visits almost daily. - The resident had been declining for the past couple of months cognitively. - Sometimes when the family members have visited the silverware is in the white package. - They thought the staff had already picked up the silverware many times as resident was finished eating.	D911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056006	A. BUILDING: _____ B. WING _____	C 02/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN HOUSE	186 ONE CENTER STREET FRANKLIN, NC 28734

(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
D911	Continued From page 13 - "I hate she uses her fingers to eat her meal with because you know they don't wash their hands before they eat." Interview on 2/22/17 at 3:00pm with MA, second shift, revealed: - Resident eats independently and does not require assistance. - She has not noticed resident eating with her fingers. Interview on 2/22/17 at 3:05pm with PCA, second shift, revealed: - Resident ate independently but had to be told to eat with silverware at times. - She had noticed resident eating with her fingers. - She would assist the resident as needed. Interview on 2/22/17 at 5:20pm with the Executive Director revealed: - He was aware of residents on the SCU eating with their fingers. - "Staff should be assisting her to eat with her silverware."	D911		