Division of Health Service Regulation				1 Ordivi 7	APPROVED	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SU COMPLET	
		HAL035024	B. WING		R-C 12/08	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	ΓE, ZIP CODE		
FRANKLI	N MANOR ASSISTED LIV	ING CENTER	ISET DR SVILLE, NC 2759	6		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 000}	Initial Comments		{D 000}			
	The Adult Care Lices follow-up survey on December 8, 2021.	ure Section conducted a December 6, 2021 to				
{D 270}	10A NCAC 13F .0901 Supervision	I(b) Personal Care and	{D 270}			
		e supervision of residents in n resident's assessed needs,				
	This Rule is not met FOLLOWUP TO A TY	<u> </u>				
	Based on these findir Violation was not aba	ngs, the previous type A2 ted.				
	reviews, the facility fa supervision and imple anti-anxiety medication residents (#3) based symptoms, who exhibits behaviors and wander					
	The findings are:					
	09/30/21 revealed: -Diagnoses included fibrillation and chronic	3's current FL-2 dated vascular dementia, atrial c kidney disease. isoriented and verbally				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SU		
7.1.12 . 2.1.1	5. GG.W.EG.WG.	.52		A. BUILDING: _			
		HAL035024		B. WING		R-0 12/0	C 8/ 2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
FRANKLII	N MANOR ASSISTED LIV	ING CENTER	100 SUNSE YOUNGSVI	T DR LLE, NC 2759	96		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIEN Y MUST BE PRECEDED LSC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETE DATE
{D 270}	Continued From page -He was ambulatory a -He exhibited aggress personal care. -There was an order of tablet as needed (pagitation/aggression) -Resident #3 resided (SCU). Review of Resident # revealed: -He needed supervisite groomingHe needed limited as dressingHe was independent ambulationThe resident was vewandered, going in a rooms and was aggrestaffThe resident was predementia behaviors. Observation of Resides 1:46am revealed the and lying across his build limited as dressing across his build limited as a rooms and was aggrestaffThe resident was recommended as a resident was predementia behaviors. Observation of Resides 1:47am on 12/06/21 in the resident #3 had just up most of the nightResident #3 had der had been aggressive and residents during. Observation of Resides 1:47am on 12/06/21 in the resident #3 had der had been aggressive and residents during.	and wandered. sive behaviors and for alprazolam 0.5 rn) (to treat in the special care in the special care in the special care on with eating and essistance for bathing with toileting and robally abusive, respectively abusive, respectively abusive, respectively mental hear scribed medication ent #3 on 12/06/27 resident was fully bed asleep. In all care aide (PC revealed: Infallen asleep; hear mentia with behavious and argumentative the night.	mg., take e unit d 09/30/21 d ng and isted care, idents' ected by alth n for 1 at clothed EA) at had been ors and e with staff	{D 270}	DEFICIENCY)		
	3:50pm revealed he a locked, resident's roo	attempted to enter					

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NAME OF PROVIDER OR SUPPLIER A. BUILDING: R-C	2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	2021
FRANKLIN MANOR ASSISTED LIVING CENTER 100 SUNSET DR	
YOUNGSVILLE, NC 27596	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 270} Continued From page 2 {D 270}	
Observation of Resident #3 on 12/07/21 at 3:05pm revealed: -Resident #3 walked up the hall to the nurses' desk and asked for the slice of cake he did not eat at lunch. -He turned around to look at the residents seated in the common area. -When he turned back around, he appeared angry and demanded his slice of cake now. Review of Resident #3's progress notes revealed: -On 10/13/21 at 2:00pm, Resident #3 was punching a female resident in the chest; the female resident stated Resident #3 walked into her room, and when she asked him to leave, he began to punch her in the chest several times; the female resident was very scared and asked to sit at the nurses' desk because she was terrified to return to her roomOn 10/14/21 at 5:00pm, Resident #3 hit another resident and was placed on checks every 30 minutes for 3 daysOn 10/28/21 at 6:00pm, Resident #3 was aggressive when trying to get another resident out of his room; Resident #3 tried to fight with the staff and grabbed the other resident; staff talked to Resident #3 and he relaxed and went to his roomOn 10/30/21 at 6:00pm, Resident #3 was aggressive when the resident #3 was aggressive on another resident #3 was aggressive the Machalled and went to his roomOn 10/30/21 at 6:00pm, Resident #3 was aggressive with the Machalled	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ` COI		(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAL035024	B. WING		R-C 12/08/2021
					12/00/2021
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	
FRANKLI	N MANOR ASSISTED LIV	ING CENTER YOUNGSV	: I DK ILLE, NC 2759	16	
()(1) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES	· ·	PROVIDER'S PLAN OF CORRECTIO	N (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
{D 270}	Continued From page	e 3	{D 270}		
{D 270}	the rooms, he becam fight staffOn 11/03/21 at 3:00p physically violent tow to pull the resident ou grabbing another resi with him; Resident #3 another resident in ar trying to assist Reside staff was kicked by R-On 11/04/21 at 3:00p hitting, kicking and fighad a female resident would not let her go; I medication to calm hi-On 11/06/21 at 8:30p another resident's roc spouse; staff explainer resident was not his sfight the resident and staff separated Resid residentOn 11/07/21 at 8:00p told several times and spouse; Resident #3 resident when told an Resident #3 spit his in -On 11/11/21 at 4:30p another resident to the very agitated and was medication that was reformed to the resident, grabbin very agitated, grabbin very agitated, grabbin	e angry and violent, trying to om, Resident #3 was being ards another resident, trying at of their wheelchair and dent when she refused to go as was found in bed with nother resident's room; when ent #3 out of the room, the esident #3. om, Resident #3 had been at a physical hold and he was given a prn om. om, Resident #3 went into om, told her she was his ed to Resident #3 tried to refused to leave the room; ent #3 and the female om, Resident #3 had been other resident was not his tried to fight another resident was not his tried to fight another resident was not his spouse; nedications into the trash. om, Resident #3 pushed e floor; Resident #3 was a administered a prn	{D 270}		
	resident, trying to pull and saying she was h	medication. Dam, Resident #3 pulled on a I her out of her wheelchair nis spouse; staff tried to the wheelchair and Resident			
	#3 began swinging (h	is arms), trying to fight staff;			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	CONSTRUCTION	(X3) DATE	SURVEY PLETED
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COM	-LETED
		HAL035024	B. WING		l l	R-C / 08/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	TE, ZIP CODE		
FRANKLII	N MANOR ASSISTED LIV	/ING CENTER	NSET DR SSVILLE, NC 2759	6		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{D 270}	-On 11/25/21 at 10:30 very aggressive while another resident from thought the other res Resident #3 was gett on a female resident' Resident #3 was adm -On 12/05/21 at 11:56:30 am, Resident #3 spitting, kicking doors was administered programmer of the was no documentation from the exception of incredays on 10/14/21; the documentation the stalprozolam after each was having aggressive agitation. Review of Resident # medication administrative was an entry 1 tablet prn for agitational revealed: -There was an entry 1 tablet prn for agitation administrative was not administered for agitation administered for agitation administered for agitation. #3 demonstrated behavior aggressive was a demonstrated behavior aggressive was not administered for agitation administered for a	ninistered a prn medication. Opm, Resident #3 became e staff was trying to remove in his room; Resident #3 ident was his spouse; ting out of his clothes to put is black pants and shirt; ininistered a prn medication. Opm and 12/06/21 at was very combative, is and residents; Resident #3 in medication at 6:35am. Inentation the Mental Health inotified about these Inentation of any ented after the incidents with eased supervision for three ere was also no in fincident when the resident ive behaviors and/or #3's October 2021 attion records (MAR) for alprozolam 0.5 mg, take ion/aggression. documented as attion/aggression on or 10/30/21 when Resident	{D 270}			
	revealed:	for alprozolam 0.5 mg, take ion/aggression. documented as				

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	F OF DEFICIENCIES	(X1) PROVIDER/SU		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATIO	N NUMBER:	A. BUILDING: _		COMPLETED
						R-C
		HAL03502	4	B. WING		12/08/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ITE, ZIP CODE	
EDANKLII	N MANOD ACCICTED I IV	INC CENTER	100 SUNSE	T DR		
FRANKLII	N MANOR ASSISTED LIV	ING CENTER	YOUNGSV	ILLE, NC 2759	96	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIE Y MUST BE PRECEDE LSC IDENTIFYING INF	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
{D 270}	Continued From page	= 5		{D 270}		
(= =)	11/01/21, 11/03/21, 1 Resident #3 demonst	1/04/21, or 11/07	/21 when			
	Interview with a PCA on 12/08/21 at 7:50am revealed:					
	revealed: -He started working with Resident #3 about four weeks agoResident #3 had dementia with behaviors and would become agitated, aggressive and used foul language with residents in the hallways, the					
	common areas and residents' rooms.					
	-Resident #3 thought	•	•			
	and when corrected,					
	angry and attack other	er residents by sv	vinging his			
	arms and kickingIncidents would hap	nen in the hallwa	vs common			
	areas, dining room ar					
	-Staff would take other					
	rooms in order to try					
	-Staff were to "keep a					
	look for) Resident #3	to determine if h	ne was			
	becoming agitatedStaff were to observe	e all residents ev	ery 2 houre			
	-After Resident #3 ha		-			
	continue to be monit					
	supervision.	Ţ				
	-He had been assigne	ed to sit outside I	Resident			
	#3's room door today		1			
	monitoring to keep Ro					
	-He had been given a	•				
	observations; it was t asked to document r					
	-He was not aware of					
	for Resident #3 for pr	•	•			
	incidents with other re					
	Interview with a seco	nd PCA on 12/08	3/21 at			
	10:05am revealed:					
	-Resident #3 had a vi		re he would			
	have an outburst with	residents.				

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	OF DEFICIENCIES	(X1) PROVIDER/SUP		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION	NUMBER:	A. BUILDING: _		COMPLE	= IED
				B. WING		R-	-
		HAL035024		5:		12/0	8/2021
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
FRANKLI	N MANOR ASSISTED LIV	ING CENTER	100 SUNSE				
			YOUNGSVI	LLE, NC 2759	96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIEN Y MUST BE PRECEDED LSC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
{D 270}	Continued From page	e 6		{D 270}			
	-Resident #3 would h curse when he had ar -Resident #3 thought facility were his spous -Resident #3 would w grab her arm or hand his spouse's nameWhen Resident #3 h to redirect himThe staff would remote wards the resident -Resident #3 would laresidentThere was one femal his spouseResident #3 saw a fethe living room with her sesident #3 pushed -The female resident anyone; she was only with her walker.	it, kick, throw thing noutburst. the female reside se. valk up to a female and say "come or ad an outburst the ove residents from ents' safety when showing aggressical in bed with a felle resident who locemale resident amer walker. eee you talking to the resident to the was not speaking	nts in the e resident, n" and say e staff tried Resident he was ion male oked like bulating in hat man".				
	Interview with a MA on 12/08/21 at 9:40am revealed: -She was familiar with Resident #3.						
	-Resident #3 had bee than 6 months (02/24	•					
	stayed the same sinc		o nau				
	-He was constantly lo		se who				
	was not at the facility.						
	-If he could not find he	•					
	agitated, curse and s	wing his arms to h	it staff or				
	residents.	ld radiract Dasida	ot #2 by				
	-Staff sometimes cougiving him snacks.	iu redirect Residel	iii #3 by				
	-On 11/11/21, Reside		resident				
	and pushed her back	wards.					

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMI LETED
		HAL035024	B. WING		R-C 12/08/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
== 4 .		100 SUNS	SET DR		
FRANKLII	N MANOR ASSISTED LIV	YOUNGS	VILLE, NC 2759	96	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
{D 270}	O} Continued From page 7		{D 270}		
	-The resident tried to down to the floor unhulf a resident was in the checked on every 2 hulf a resident was in the checked on every 30. There were log sheet every 30 minutes and After a resident had monitor the resident a monitoring sheets or staff. -The Resident Care Ewhen a resident was every 2 hours. -She did not know which were kept. -She had not seen an until this morning (12). The facility must have 1:1 supervision for Resident with a second 2:44pm revealed:	balance herself but slid urt. he common room, they were hours. heir room, they were minutes. Its for checks every hour, devery 15 minutes. an incident, staff were to and document on the go on 1:1 supervision from Director (RCD) determined to be monitored more than here the monitoring forms by resident on 1:1 monitoring (708/21). The had enough staff to have desident #3 today (12/08/21). The had on 12/08/21 at			
	-Resident #3 could be -On 10/31/21, Reside	e aggressive with residents. ent #3 grabbed a resident by			
	the wrist and staff had -Routine monitoring vevery 2 hours.	d to redirect him. vas checking on residents			
	and 3:33pm revealed -Resident #3 would g find his spouseResident #3 would a thinking they were his -Resident #3 would reresident's hand and to	et upset when he could not pproach female residents, s spouse.			

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intervene.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	•
			7 50.12510.		R-C	
		HAL035024	B. WING		12/08/202	:1
NAME OF PF	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
FRANKLIN	I MANOR ASSISTED LIV	ING CENTER 100 SUNS		•		
			ILLE, NC 2759			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE CON	(X5) MPLETE MATE
{D 270}	Continued From page	e 8	{D 270}			
	when he would get up -The MA saw Resider seated on the couch i Resident #3 attempte to lie down on the cou -The MA removed the situationResident #3 became at the MAThe MA would call R could speak to herResident #3 would ca his spouse.	nt #3 and a female resident n the living room and d to get the female resident				
	revealed: -Resident #3 would be residents and the staft -When Resident #3 grand verbally curseResident #3 thought his spouseThere was one femal cuddleWhen the staff would at times with hitting, kender would administe every morning so here. The alprazolam was but an as needed mendershe had spoken with changing Alprazolam but the PCP wanted it medicationThe staff had to check minutes.	e aggressive toward the ff. ot mad he would hit, kick the female residents were le resident that he liked to d intervene, he would react cicking or cursing. er alprazolam to Resident #3 would be less aggressive. not a scheduled medication, dication.				

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HAL035024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596 100 SUNSET DR YOUNGSTON SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DRAFT DR	STATEMEN [*]	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER REGULATORY OR LSC IDENTIFYING INFORMATION) (A) JD SUMMARY STATEMENT OF DEFICIENCIES TAGGE SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (B) ZOTO) (B) ZOTO) (B) ZOTO) (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (B) ZOTO) (B) ZOTO) (B) ZOTO) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE DEFICIENCY) (B) ZOTO) (B) ZOTO) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE DATE DATE DATE DATE DATE D				A. BOILDING			
CALC DEFICIENCY			HAL035024	B. WING			2021
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (D 270) Continued From page 9 -Resident #3 would wander into the female residents' bedrooms. -The staff had to constantly keep Resident #3 away from all female residented the whenever he was bothering other residents; he bothered female residents the most. -On 11/06/21 Resident #3 went into a female residents's room and she wanted him out of her room. -It took two PCAs to redirect Resident #3 and take him out of the female resident #3 went back into the female resident #3 went back into the female resident #3 was mad or upset, the staff had to let him calm down; he did not like anyone to	EDANIZI I	N MANOD ACCIETED I IV	(INC CENTER 100 SUNS	ET DR			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCED TO THE APPROPRIATE DATE DATE	FRANKLI	N MANOR ASSISTED LIV	YOUNGS\	ILLE, NC 2759	96		
-Residents a would wander into the female residents' bedrooms. -The staff had to constantly keep Resident #3 away from all female residents because he thought they were his spouse. -She would redirect him whenever he was bothering other residents; he bothered female residents the most. -On 11/06/21 Resident #3 went into a female residents's room and she wanted him out of her room. -It took two PCAs to redirect Resident #3 and take him out of the female resident's room. -Resident #3 went back into the female resident's room; she and two other PCAs had to get him out again. -If Resident #3 was mad or upset, the staff had to let him calm down; he did not like anyone to	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE (COMPLETE
residents' bedrooms. -The staff had to constantly keep Resident #3 away from all female residents because he thought they were his spouse. -She would redirect him whenever he was bothering other residents; he bothered female residents the most. -On 11/06/21 Resident #3 went into a female residents's room and she wanted him out of her room. -It took two PCAs to redirect Resident #3 and take him out of the female resident's room. -Resident #3 went back into the female resident's room; she and two other PCAs had to get him out again. -If Resident #3 was mad or upset, the staff had to let him calm down; he did not like anyone to	{D 270}	Continued From page	e 9	{D 270}			
-If he was having a bad day, the best thing to do was to leave him alone. -On 11/15/21 there was an incident when Resident #3 grabbed a female resident by her wrist and was trying to pull her out of her wheelchair. -Resident #3 would get upset when he was separated from the female residents once he started to bother them. -Most of the time Resident #3 was up in the evenings and needed to be watched to make sure he did not go into the female residents' rooms. -He also would wander around and bother the residents; the staff had to separate him from the other residents when he wandered to keep an eye on him. -Resident #3 required extra supervision; staff had to really pay attention to him to keep him away	{D 210}	-Resident #3 would we residents' bedrooms. -The staff had to consaway from all female thought they were his -She would redirect hothering other residents the most. -On 11/06/21 Resident residents's room and room. -It took two PCAs to resident #3 went barroom; she and two of again. -If Resident #3 was nother let him calm down; he "holler" at him. -If he was having a bowas to leave him aloron 11/15/21 there work Resident #3 grabbed wrist and was trying to wheelchair. -Resident #3 would geparated from the festarted to bother theromost of the time Resevenings and needed sure he did not go introoms. -He also would wand residents; the staff had other residents when eye on him. -Resident #3 required	stantly keep Resident #3 residents because he is spouse. him whenever he was ents; he bothered female Int #3 went into a female she wanted him out of her redirect Resident #3 and emale resident's room. ack into the female resident's ther PCAs had to get him out mad or upset, the staff had to be did not like anyone to ad day, the best thing to do ne. It was an incident when If a female resident by her to pull her out of her spet upset when he was emale residents once he m. It is ident #3 was up in the did to be watched to make to the female residents' Iter around and bother the and to separate him from the land to separate to keep an land extra supervision; staff had	{D 2/0}			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAL035024	B. WING		R-C 12/08/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	,
		100 SUNSE	T DR		
FRANKLI	N MANOR ASSISTED LIV	ING CENTER YOUNGSV	ILLE, NC 2759	16	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
{D 270}	Continued From page	e 10	{D 270}		
{D 210}	Telephone interview of at 2:56pm revealed: -On 10/30/21 Resider when a female reside-Resident #3 jumped by her wrist and woul-She separated Resident and then mothe rest of her shiftResident #3 called the spouse's nameThe staff redirected hewent into other resider be want into other resider be want into other resider be was aggressive to resident #3's behaved discussed at shift change he was aggressive to resident #3's behaved into a shift change he was aggressive to resident #3's behaved into a shift change he was aggressive to resident #3's behaved into a shift change he was aggressive to resident #3's behaved into a shift change he was aggressive to resident #3's behaved into a shift change he was aggressive to resident #3's behaved into a shift change he was aggressive to resident was	with a sixth MA on 12/08/21 Int #3 was asleep in a chair ant tried to wake him up. Int and grabbed the resident Int do not let go. Ident #3 and the female Initiored the female resident Interest emale resident Interest ema	(0.270)		
	revealed: -Resident #3 went from 2-hour checks to 30-minute checks to 15-minute checks.				
	started. -She knew Resident #	#3 was on 30-minute checks			
	-She increased Resid	ks started on 12/07/21. lent #3's safety checks			
	-She could not recall from 10/13/21, 10/30/ -She could not recall	se in aggressive behavior. the incidents for Resident #3 /21 or 12/06/21. being notified or signing the I 10/13/21, 10/30/21 or			
		dent on 11/11/21 where a female resident.			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY IPLETED
		HAL035024		B. WING			R-C 2/08/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, STA	ΓE, ZIP CODE		
FRANKII	N MANOR ASSISTED LI	VING CENTER	100 SUNS	SET DR			
TIVALLI	N MANON AGGIOTED EI	VIIIO OLIVILIA	YOUNGS	VILLE, NC 2759	6		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENC CY MUST BE PRECEDED E LSC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
{D 270}	Continued From page -The facility would in 15-minutes with beh -The MHP was containcidentShe would call or fa needed for a resider -She could not recal the behavioral incide 10/13/21, 10/30/21 a -She would notify ma as the behavioral ep -Documentation of n would be in Residen record or the fax ser the confirmation she Resident #3's record -All incident reports the day the incident -She would receive a happened during he she was not in the fat them in her mailbox under her door.	crease safety check avioral incidents. acted after each beh in acted after each beh in acted after each beh in acted after each behavior in the safety of the MHP was not it if the alth on the safety is progress not eat to mental health being in the toward be placed if it. In were submitted to the occurred. In were submitted to the occurred. In the staff would be placed if it is the progress in the staff would be placed if it is the placed in the staff would be placed if it is the placed in the staff would be placed if it is the placed in the staff would be placed in the pl	avioral visit was rs. iffied after dated ame day notified s in his ong with n e RCC that ned. If	{D 270}			
	Interview with Resid 12:40pm revealed: -He was not aware of aggression being do Resident #3His office was called requesting an acute being combative and residentsResident #3 needed to be closely superviabusive behaviors.; all timesHe was not aware of into place to prevent and abusive behaviors and abusive behaviors.	of the instances of about the instances of about the too ther residents of yesterday (12/06/2 visit for Resident #3 diaggressive to other distribution of any facility measures Resident #3's aggressident #3's ag	ouse and s by 21) who was er e needed on of rvision at res put essive				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION N		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		HAL035024		B. WING			R-C 2/08/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
EDANIZIII	N MANOR ASSISTED I I	VINC CENTER	100 SUNSI	ET DR			
FRANKLI	N MANOR ASSISTED LI	VING CENTER	YOUNGSV	ILLE, NC 2759	06		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCI CY MUST BE PRECEDED B LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
	(POA) on 12/08/21 a -The POA was awar aggressive with othe settle down and wou -The POA asked abo had not been given a	e Resident #3 had be r residents; he was h ld argue. out the other resident	een nard to s but				
	requesting assistance behaviors and wand -The previous Admir months ago to notify other placement for behaviors with other -The previous Admir discharge/transfer at -The POA spoke with after the previous Admir after the previous Admir after the previous Admir after the previous Admir and the previous Admir after the previous Admir and the pre	te to assist in calming ering. istrator called her ab her they were lookin Resident #3 because residents. istrator left before rangements were man the current Administ liministrator left (did not schedule a meeting discharge, but she	g his out 2 ag for of his ade. strator out ag was not				
	3:39pm revealed: -Resident #3 had de could be aggressive staffThe previous Admir discharging Residen process did not cont was not having as m-The Administrator d Resident #3Resident #3 continuaggressive, argumen verbally abusive, and staff.	nistrator was in the price t #3 before he left, but inue because the restany behavioral incide id not want to dischalled being more confidence.	s and and occess of ut the sident ences. rge used, are, lents and				

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	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION (IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED	
		HAL035024		B. WING		R-C 12/08/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE ZIP CODE	
NAME OF T	NOVIDER OR GOLF EIER		100 SUNSE		11 E, 211 GGBE	
FRANKLI	N MANOR ASSISTED LIV	ING CENTER		ILLE, NC 2759	96	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
{D 270}	box", being monitored days after incidents; to interventions put into -On 10/28/21, Reside the "hot box" and behinterventions such as reminiscing when the the incidentsIncidents of verbal alwith Resident #3 contagenession of Reside residentsStaff did not communin keeping her up to behaviorsResident #3 needed his behaviors before alresident #3 was plant.	d every 30 minutes for there were no more place. In the same and again place and aggressive tinued. In the same against other the same ag	eed in ees and on after ness eer the eal have t's control d.	{D 270}		
	yesterday (12/07/21). Based on observation reviews it was determ interviewable. The facility neglected supervision and imple alprozolam for Reside being aggressive, arg abusive, hitting and k wandering into other resulted in a resident and kicked in the leg having her wrist twist being pushed to the f neglect by not providi Resident #3's current aggression and agitat to be harmed which of	to provide adequate ement an order for ent #3 who had a hist gumentative, verbally icking residents and residents' rooms which being punched in the and foot, another residents. This failure resulting supervision according symptoms, including tion, causing other residents.	tory of ch e chest ident ent lited in rding to			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HAL035024	B. WING			R-C / 08/2021
NAME OF P	ROVIDER OR SUPPLIER		ET ADDRESS, CITY, STA	TE ZIP CODE		
		100 \$	SUNSET DR	11. ZII OODE		
FRANKLI	N MANOR ASSISTED LIV	ING CENTER YOU	NGSVILLE, NC 2759	06		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
{D 270}	Continued From page 14		{D 270}			
	Type A2 Violation.					
	The facility provided a accordance with G.S. this violation.	a plan of protection in 131D-34 on 12/07/21 for				
	Refer to tag D338, 10 Resident Rights [Type					
D 273	10A NCAC 13F .0902	(b) Health Care	D 273			
		Health Care assure referral and follow-up ad acute health care needs				
	reviews, the facility fa health provider (MHP residents (#3) who ex	is, interviews, and record iled to notify the mental) for 1 of 5 sampled				
	The findings are:					
	signed by the primary revealed: -Diagnoses included of fibrillation and chronic -He was constantly diabusiveHe was ambulatory a	d medication orders and care provider (PCP) vascular dementia, atrial kidney disease. soriented and verbally				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S			
AND PLAN (OF CORRECTION	IDENTIFICATION	N NUMBER:	A. BUILDING: _		COMPLI	ETED
						R-	.c l
		HAL035024	ı	B. WING		I	8/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
			100 SUNSE	T DR			
FRANKLII	N MANOR ASSISTED LIV	ING CENTER	YOUNGSV	ILLE, NC 2759	96		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIE	NCIES	ID	PROVIDER'S PLAN OF CORRECT	ON	(X5)
PREFIX TAG	,	Y MUST BE PRECEDE LSC IDENTIFYING INFO		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
D 273	Continued From page	- 1F		D 273	,		
D 213	Continued From page			0273			
	Review of Resident # revealed:	3's care plan date	ed 09/30/21				
	-He needed supervisi	ion with eating an	d				
	-He needed limited as	ssistance for bath	ing and				
	dressing.						
	-He was independent ambulation.	t with tolleting and	1				
	-The resident was ve	rbally abusive, re	sisted care,				
	wandered, going in a	nd out of other re	sidents'				
	rooms and was aggressive when redirected by		ected by				
	staff.	aciving montal bo	alth				
	-The resident was red services and was pre						
	dementia behaviors.	scribed medicalic)				
	Observation of Resid	ent #3 on 12/07/2	91 at				
	3:05pm revealed:	One 7/0 on 12/01/2	. r ut				
	-Resident #3 walked	up the hall to the	nurses'				
	desk and asked for th	ne slice of cake he	e did not				
	eat at lunch.						
	-He turned around to	look at the reside	ents seated				
	in the common area.						
	 -When he turned bac angry and demanded 						
	Dovious of Danidant #	101a nragrasa = -1-	o rovo alc d				
	Review of Resident # -On 10/13/21 at 2:00						
	punching a female re						
	female resident state						
	her room, and when						
	began to punch her in						
	the female resident w						
	sit at the nurses' desl	•					
	to return to her room.						
	-On 10/14/21 at 5:00	pm, Resident #3 ł	nit another				
	resident and was plac	ced on checks ev	ery 30				
	minutes for 3 days.						
	-On 10/28/21 at 6:00ր						
	aggressive when tryir	ng to get another	resident				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NU	IMRED:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL035024		B. WING		R-C 12/08/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STAT	TE, ZIP CODE	
ED ANIZI II	N MANOR ACCIOTER I II	VINO CENTED	100 SUNSET	DR		
FRANKLI	N MANOR ASSISTED LI	VING CENTER	YOUNGSVIL	LE, NC 2759	6	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 273	μ-19-1-0			D 273		
	aggressive to another wrist; the medication Resident #3 a prescribing, but the resident hitting her in the storkicking her; the MA with the resident. -On 11/01/21 at 3:00 to go into other resident.	e other resident; staff he relaxed and went to pm, Resident #3 was er resident by twisting aide (MA) tried to ad ribed prn medication was aggressive with nach and continuous called a family member pm, Resident #3 con ents' rooms and get if d to assist Resident # he angry and violent, pm, Resident #3 was wards another resider ut of their wheelchair dident when she refus was found in bed w	italked o his o his in her Iminister to calm the MA, ly er to talk itinued in their #3 out of trying to is being out, trying and sed to go with			
	hitting, kicking and find a female resider would not let her goOn 11/06/21 at 8:30	Resident #3. pm, Resident #3 had ghting other residents nt in a physical hold a pm, Resident #3 wer	been s; he and			
	fight the resident and staff separated Resident.	ed to Resident #3 the spouse; Resident #3 I refused to leave the dent #3 and the fema pm, Resident #3 had other resident was no tried to fight another	e female tried to room; lle been ot his			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND LEAN	J. JOHNLOHON	DENTI TOATION NOWDER.	A. BUILDING: _		COWIN ELTED
					R-C
		HAL035024	B. WING		12/08/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
ED ANIZI II	I MANOR ACCIOTER I IN	100 SUN	SET DR		
FRANKLII	N MANOR ASSISTED LIV	YOUNGS	VILLE, NC 2759	96	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE
D 273	Continued From page	e 17	D 273		
	Resident #3 spit his no-On 11/11/21 at 4:30p another resident to the On 11/12/21 at 1:00p very agitated, grabbir language at residents -On 11/15/21 at 11:30 resident, trying to pull and saying she was hassist the resident in #3 began swinging (he-On 11/25/21 at 10:30 very aggressive while another resident from thought the other resident #3 was gett on a female resident #3 on 12/05/21 at 11:59 6:30am, Resident #3 spitting, kicking doors	nedications into the trash. om, Resident #3 pushed e floor. om, Resident #3 had been ng residents and using foul s and staff. Oam, Resident #3 pulled on a l her out of her wheelchair nis spouse; staff tried to the wheelchair and Resident nis arms), trying to fight staff. Opm, Resident #3 became e staff was trying to remove his room; Resident #3 dent was his spouse; ing out of his clothes to put s black pants and shirt. Opm and 12/06/21 at was very combative, s and residents. nentation the Mental Health			
	Interview with a PCA on 12/08/21 at 7:50am revealed: -He started working with Resident #3 about four weeks agoResident #3 had dementia with behaviors and would become agitated, aggressive and used foul				
	language with resider common areas and re-Resident #3 thought and when corrected, angry and attack other arms and kickingIncidents would happareas, dining room ar-Staff would take other	nts in the hallways, the			

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D 1/1/10	R-C (08/2021
D 1/1/10	
HAL035024 B. WING 12	OU/LUL!
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
FRANKLIN MANOR ASSISTED LIVING CENTER 100 SUNSET DR	
FRANKLIN MANOR ASSISTED LIVING CENTER YOUNGSVILLE, NC 27596	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273 Continued From page 18 D 273	
Interview with a second PCA on 12/08/21 at 10:05am revealed: -Resident #3 had a violent streak where he would have an outburst with residentsResident #3 would hit, kick, throw things and/or curse when he had an outburstResident #3 thought the female residents in the facility were his spouseResident #3 would walk up to a female resident, grab her arm or hand and say "come on" and say his spouse's nameThe staff would remove residents from Resident #3 for the other residents' safety when he was having an outburst or showing aggression towards the residentsResident #3 would lay in bed with a female residentThere was one female resident who looked like his spouseResident #3 saw a female resident ambulating in the living room with her walkerResident #3 apid "I see you talking to that man"Resident #3 pushed the resident to the floorThe female resident was not speaking to anyone; she was only walking in the living room with her walker. Interview with a MA on 12/08/21 at 9:40am revealed: -She was familiar with Resident #3Resident #3 had been at the facility for more than 6 months (02/24/21); his behaviors had stayed the same since admissionHe was constantly looking for his spouse who was not at the facilityIf he could not find her, he would become agitated, curse and swing his arms to hit staff or	

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-Staff sometimes could redirect Resident #3 by

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAI 025024	B. WING			R-C
		HAL035024			14	2/08/2021
NAME OF P	ROVIDER OR SUPPLIER	STF	REET ADDRESS, CITY, STAT	E, ZIP CODE		
FRANKLII	N MANOR ASSISTED LIV	/ING CENTER	SUNSET DR			
		YO	UNGSVILLE, NC 27596	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	e 19	D 273			
	giving him snacksOn 11/11/21, Reside and pushed her back	nt #3 walked by a resident wards. balance herself but slid				
	and 3:33pm revealed -Resident #3 would g find his spouseResident #3 would a thinking they were his -Resident #3 would re resident's hand and ti -Resident #3 would g interveneResident #3 would get up -The MA saw Resident seated on the couch	pproach female residents, s spouse. each for the female ry to get them to go with hir let mad when the staff would urse at the other residents poset. In #3 and a female resident in the living room and led to get the female resident	m. d			
	on 12/08/21 at 2:35pr -She could not recall from 10/13/21, 10/30/ -She could not recall incident reports dated 12/06/21She recalled the inci Resident #3 pushed a -The facility would ind 15-minutes with beha -The Mental Health P contacted after each -She would call or fay needed for a resident	the incidents for Resident # /21 or 12/06/21. being notified or signing the d 10/13/21, 10/30/21 or dent on 11/11/21 where a female resident. crease safety checks to avioral incidents. Provider (MHP) was behavioral incident. c mental health if a visit was	#3 e			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2)			(X3) DATE SURVEY COMPLETED		
		HAL035024		B. WING			R-C 2/08/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	·	
ED A NIZI II	N MANOR AGGICTER I II	"NO OFNITED	100 SUNSE	T DR			
FRANKLI	N MANOR ASSISTED LIV	ING CENTER	YOUNGSV	ILLE, NC 2759	06		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	10/13/21, 10/30/21 ai	nd 11/11/21.		D 273			
	-She would notify mental health on the same day as the behavioral episodeDocumentation of mental health being notified would be in Resident #3's progress notes in his record or the fax sent to mental health along with the confirmation sheet would be placed in Resident #3's record.						
	Interview with Reside 12:40pm revealed: -He was not aware of aggression being dor Resident #3His office was called requesting an acute wheing combative and residentsResident #3 needed to be closely supervisabusive behaviors.; hall timesHe was not aware of into place to prevent and abusive behavior residents.	ent #3's MHP on 12 If the instances of alto the to other residents If yesterday (12/06/2) If yester	ouse and s by 21) who was er e needed on of rvision at res put essive				
	Interview with the Adi 3:39pm revealed: -Resident #3 had der could be aggressive vistaffThe previous Adminidischarging Resident process did not contil was not having as ma-The Administrator did Resident #3Resident #3Resident #3 continue aggressive, argumen	mentia with behavio with other residents istrator was in the part #3 before he left, because the reany behavioral incided not want to discharged being more confident.	rs and and rocess of out the sident lences. arge				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			71. 501251110.		R-0	C
		HAL035024	B. WING		1	8/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
FRANKLI	N MANOR ASSISTED LIV	ING CENTER 100 SUNSE				
040.45	CLIMMADV CT		LLE, NC 2759		N	0.50
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	21	D 273			
{D 358}	staffIncidents of verbal al with Resident #3 contBehavioral intervent incidents occurred di aggression of Reside residentsStaff did not communin keeping her up to obehaviors. Based on observation	ions put into place after the d not stop the physical nt #3 against other nicate as they should have late with Resident #3's ns, interviews and record nined Resident #3 was not	{D 358}			
ני פייטיין	Administration 10A NCAC 13F .1004 (a) An adult care hor preparation and admi prescription and non-by staff are in accorda (1) orders by a licens which are maintained (2) rules in this Section and procedures. This Rule is not met Based on observation reviews, the facility farmedications as order residents (#1) including the control of the control o	Medication Administration ne shall assure that the nistration of medications, prescription, and treatments ance with: sed prescribing practitioner in the resident's record; and on and the facility's policies as evidenced by: ns, interviews, and record illed to administer ed for 1 of 5 sampled ng errors with medications ocemia, rash, constipation,	[5 550]			

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
				B. WING		R-C
		HAL035024		B. WING		12/08/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDF	RESS, CITY, STA	TE, ZIP CODE	
FRANKLII	N MANOR ASSISTED LIV	/ING CENTER	100 SUNSE	T DR		
			YOUNGSVII	LLE, NC 2759	96	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
{D 358}	Continued From page 22			{D 358}		
	1. Review of Resider 09/30/21 revealed dia Alzheimer's disease, hypoglycemia, diabe hypertension and and	senile dementia, tes mellitus type 2,	red			
	a. Review of Resident #1's Primary Care Provider (PCP) orders dated 09/30/21 revealed: -There was an order for Lantus 10 units daily. Hold if fingerstick blood sugar (FSBS) is less than 140. Give half a dose if FSBS is between 140 and 160There was an order for FSBS four times daily.		illy. ss than 140 and			
	physician's orders da -There was an order	#1's Hospice Provider ated 11/10/21 revealed for Lantus 12 units da for FSBS checks before.	l: illy.			
	revealed: -There was an entry Hold if blood sugar is dose if FSBS is betw -There was an entry -There was documer	l (MAR) for November for Lantus 10 units da s less than 140. Give h	ily. nalf a aily. units			
	revealed: -There was an entry Hold if blood sugar is dose if FSBS is betw -There was an entry -There was documer	for Lantus 10 units da s less than 140. Give heen 140 and 160. for FSBS four times datation that Lantus 10 ily at 8:00pm from 12/	ily. nalf a aily. units			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			74. BOILBING.		R-C	
		HAL035024	B. WING		12/08/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
FRANKI II	N MANOR ASSISTED LIV	ING CENTER 100 SUNSI				
TOTAL	T MARKOT AGGIOTED EIV	YOUNGSV	ILLE, NC 2759	06		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
{D 358}	Continued From page	e 23	{D 358}			
	to 12/08/21.					
	Attempted interview v 12:20pm was unsucc	vith the PCP on 12/06/21 at essful.				
		with the medical assistant ary care provider's office on				
	•	terview with the Clinical s office on 12/07/21 at				
		e interviews with a nurse tracted hospice provider on and 3:00pm.				
		e interview with the facility's st on 12/06/21 at 3:50pm				
	Refer to the interview (MA) on 12/06/21 at 1	with the medication aide 12:05pm.				
		s with the Resident Care n 12/07/21 at 9:30am and				
	Refer to the interview at 9:35am.	with the RCC on 12/08/21				
	Refer to the interview Nurse on 12/07/21 at	with the facility's Regional 11:20am.				
	Refer to the interview 12/07/21 at 4:21pm.	with the Administrator on				
	(PCP) orders dated 0	t #1's Primary Care Provider 9/30/21 revealed there was 100000 units/1gm apply a day.				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL035024	B. WING		l l	R-C 2/ 08/2021
	ROVIDER OR SUPPLIER	100 S	ET ADDRESS, CITY, STATE	E, ZIP CODE		
FRANKLII	N MANOR ASSISTED LIV	YOUN	NGSVILLE, NC 27596			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
{D 358}	Continued From page	e 24	{D 358}			
	physician's orders da was an order for Nyst topically to rash twice Review of Resident # administration record revealed: -There was an entry f units/1gm apply topic -There was documen units/1gm was admin	f1's medication (MAR) for November 2021 for Nystatin 100000 ally to rash twice a day. tation that Nystatin 100000				
	revealed: -There was an entry f units/1gm apply topic -There was documen units/1gm was admin 8:00am and 8:00pm	ally to rash twice a day. tation that Nystatin 100000 istered twice a day at 12/01/21 to 12/08/21. with the PCP on 12/06/21 at				
	Refer to the interview at Resident #1's prim 12/07/21 at 8:59am. Refer to telephone in Manager at the PCP's 1:32pm.	with the medical assistant ary care provider's office on terview with the Clinical s office on 12/07/21 at				
	from the facility's con 12/07/21 at 10:39am Refer to the telephon	e interviews with a nurse tracted hospice provider on and 3:00pm. e interview with the facility's on 12/06/21 at 3:50pm				

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COMI LETED	
		HAL035024	B. WING		R-C 12/08/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
FRANKLII	N MANOR ASSISTED LIV	ING CENTER 100 SUNS YOUNGS	ET DR /ILLE, NC 2759	96		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
{D 358}	Continued From page	25	{D 358}			
	Refer to the interview (MA) on 12/06/21 at 1	with the medication aide 12:05pm.				
		s with the Resident Care n 12/07/21 at 9:30am and				
	Refer to the interview with the RCC on 12/08/21 at 9:35am.					
	Refer to the interview Nurse on 12/07/21 at	with the facility's Regional 11:20am.				
	Refer to the interview 12/07/21 at 4:21pm.	with the Administrator on				
		t #1's Hospice Provider 1 revealed there was an g-50mg one daily as				
	and December 2021	1's medication (MAR) for November 2021 revealed there was no entry ng one daily as needed.				
	on 12/07/21 11:43am	ent #1's medication on hand revealed there was no available for administration.				
	Attempted interview v 12:20pm was unsucc	vith the PCP on 12/06/21 at essful.				
	Refer to the interview with the medical assistant at Resident #1's primary care provider's office on 12/07/21 at 8:59am.					
		terview with the Clinical s office on 12/07/21 at				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		D.	CONSTRUCTION		E SURVEY PLETED
	HAL035024	B. WING		l l	R-C 2 /08/2021
NAME OF PROVIDER OR SUPPL	ER	STREET ADDRESS, CITY, STATI	E, ZIP CODE		
FRANKLIN MANOR ASSIST	ED LIVING CENTER	100 SUNSET DR YOUNGSVILLE, NC 27596	3		
PREFIX (EACH DEI	ARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FUL RY OR LSC IDENTIFYING INFORMATIO	1 1121 171	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
from the facility 12/07/21 at 10: Refer to the tel contracted phate Refer to the int (MA) on 12/06/ Refer to the int Coordinator (R 11:20am. Refer to the int at 9:35am. Refer to the int Nurse on 12/07/21 at 4:2 d. Review of Resident order for anti-funder of a second of the company of th	ephone interviews with a nurse is contracted hospice provider 39am and 3:00pm. ephone interview with the facility macist on 12/06/21 at 3:50pm erview with the medication aid 21 at 12:05pm. erviews with the Resident Care CC) on 12/07/21 at 9:30am an erview with the RCC on 12/08/erview with the facility's Region 21 at 11:20am. erview with the Administrator of 1pm. esident #1's Hospice Provider 1/10/21 revealed there was an ngal 2% topical cream to skin en twice a day. dent #1's medication record (MAR) for November 20/2021 revealed there was no expressed to the skin folds of the	on ity's e e d 21 nal on			

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	SI CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		OOMI LETED	
		HAL035024	B. WING		R-C 12/08/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
FRANKLI	N MANOR ASSISTED LIV	ING CENTER 100 SUNS YOUNGS	ET DR /ILLE, NC 2759	96		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
{D 358}	Continued From page	27	{D 358}			
	Attempted interview v 12:20pm was unsucc	vith the PCP on 12/06/21 at essful.				
		with the medical assistant ary care provider's office on				
	Refer to telephone interview with the Clinical Manager at the PCP's office on 12/07/21 at 1:32pm.					
	Refer to the telephone interviews with a nurse from the facility's contracted hospice provider on 12/07/21 at 10:39am and 3:00pm.					
		s with the Resident Care n 12/07/21 at 9:30am and				
		e interview with the facility's on 12/06/21 at 3:50pm				
	Refer to the interview (MA) on 12/06/21 at 1	with the medication aide 2:05pm.				
	Refer to the interview at 9:35am.	with the RCC on 12/08/21				
	Refer to the interview Nurse on 12/07/21 at	with the facility's Regional 11:20am.				
	Refer to the interview 12/07/21 at 4:21pm.	with the Administrator on				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		D.		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL035024		B. WING		R-C 12/08/2021
NAME OF P	ROVIDER OR SUPPLIER	:	STREET ADDRE	ESS, CITY, STAT	TE, ZIP CODE	
FRANKLI	N MANOR ASSISTED LIV	ING CENTER	100 SUNSET YOUNGSVIL	DR LE, NC 2759	6	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULI LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
{D 358}	Continued From page	e 28		{D 358}		
	and December 2021 for morphine concent 0.25ml/5mg every 4 h Observation of Resid on 12/07/21 11:43am morphine 0.25ml/5mg administration. Attempted interview v 12:20pm was unsucce Refer to the interview at Resident #1's prim 12/07/21 at 8:59am.	(MAR) for November 20 revealed there was no er rate 0.25ml, 100mg/5ml, nours as needed. ent #1's medication on he revealed there was no g available for	and I at			
		s office on 12/07/21 at				
	-	e interviews with a nurse tracted hospice provider and 3:00pm.				
	-	e interview with the facilit st on 12/06/21 at 3:50pm	•			
	Refer to the interview (MA) on 12/06/21 at 1	with the medication aidenter with the medication aidenter aidenter with the with the medication aidenter with aidenter with the medication aidenter with the medi				
		rs with the Resident Care n 12/07/21 at 9:30am and				
	Refer to the interview at 9:35am.	with the RCC on 12/08/2	21			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED	` '			
		HAL035024		B. WING		R-C 12/08/2021	
	ROVIDER OR SUPPLIER	/ING CENTER	100 SUNSE	RESS, CITY, STA T DR ILLE, NC 2759			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCI Y MUST BE PRECEDED B LSC IDENTIFYING INFORM	ES Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE COMPLE	ETE
{D 358}	Continued From page Refer to the interview Nurse on 12/07/21 at Refer to the interview 12/07/21 at 4:21pm. f. Review of Resident orders dated 11/10/2 order for Levin 0.125 needed. Review of Resident # administration record and December 2021 for Levin 0.125mg ev Observation of Resid on 12/07/21 at 11:43a Levin 0.125mg availa Attempted interview at Resident #1's prim 12/07/21 at 8:59am. Refer to the interview at Resident #1's prim 12/07/21 at 8:59am. Refer to the telephone from the facility's con 12/07/21 at 10:39am Refer to the telephon contracted pharmacis Refer to the interview (MA) on 12/06/21 at 2	with the facility's Ref. 11:20am. with the Administra the #1's Hospice Provide 1 revealed there was might every 6 hours as the facility of t	tor on der san ser 2021 no entry led. on hand ras no en. 06/21 at esistant office on lical at enurse vider on facility's form	{D 358}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL035024	B. WING			R-C 2/08/2021
NAME OF P	ROVIDER OR SUPPLIER	STF	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
FRANKLI	N MANOR ASSISTED LIV	/ING CENTER	SUNSET DR UNGSVILLE, NC 275	96		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
{D 358}	Continued From page	e 30	{D 358}			
		vs with the Resident Care n 12/07/21 at 9:30am and				
	Refer to the interview at 9:35am.	with the RCC on 12/08/21				
	Refer to the interview Nurse on 12/07/21 at	with the facility's Regional 11:20am.				
	Refer to the interview 12/07/21 at 4:21pm.	with the Administrator on				
	at Resident #1's prim 12/07/21 at 8:59am r -When a resident was family decided wheth along with hospice or providerResident #1's PCP a were both servicing F	s accepted into hospice, the er to keep their PCP working go entirely with the hospice and the hospice provider	g			
	the PCP's office on 1 -The family had the co PCP once the resider -Resident #1 was beithe hospice providerThe hospice nurse s	with the Clinical Manager at 2/07/21 at 1:32pm revealed option to continue with the nt was admitted to hospice. Ing followed by the PCP and hould be faxing orders to the PCP would decide which	: d e			
	Telephone interview of facility's contracted heat 10:39am and 3:00	ospice provider on 12/07/21				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
74121 2741	or connection	IBERTII IO/KIIO	TO TO MELICE	A. BUILDING: _				
		HAL03502	4	B. WING			R-C 08/2021	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
FRANKLI	N MANOR ASSISTED LIV	ING CENTER	100 SUNSE	T DR LLE, NC 2759	ne.			
	CLIMMADY CT	ATEMENT OF DEFICIE		1		CTION	0.50	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIE Y MUST BE PRECEDE LSC IDENTIFYING INF	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
{D 358}	Continued From page	e 31		{D 358}				
	-The PCP and the ho collaboration to care in All medication orders provider should by foll should be readily available. Resident orders were facility was responsible faxing the orders to the pharmacy. -The only time the fact would fax orders to the pharmacy was when for refill of a medicating. The nurse should be relephone interview with pharmacist on 12/06/. -The facility would fax pharmacy. -The PCP would send script at times. -The pharmacy did not dated 11/10/21 for Reference in the care in the pharmacy of the pharmacy of the pharmacy did not dated 11/10/21 for Reference in the provided in the pharmacy did not dated 11/10/21 for Reference in the provided in the pharmacy did not dated 11/10/21 for Reference in the provided in the pharmacy did not dated 11/10/21 for Reference in the provided in the pharmacy did not dated 11/10/21 for Reference in the provided in the pharmacy did not dated 11/10/21 for Reference in the provided in the pharmacy did not dated 11/10/21 for Reference in the provided in the provided in the pharmacy did not dated 11/10/21 for Reference in the provided in the provided in the pharmacy did not dated 11/10/21 for Reference in the provided in the pharmacy did not dated 11/10/21 for Reference in the provided in the pharmacy did not determine the provided in the pharmacy did not determine the pharmacy did not deter	spice provider was for the resident. It is written by the hallowed and the mailable if needed. It is face to the face the facility's contracted the facility is c	ospice nedication cility. The ne PCP and neted hospice neted as needed facility staff.					
	Interview with the me 12:05pm revealed: -The MA's or the RCG from the faxThe new orders are filled. Interview with the Rec (RCC) on 12/07/21 at revealed: -When a resident on PCP and the hospice follow orders from bo-The PCP signed the ordersThe hospice provide	dication aide on C will retrieve new faxed to the phare sident Care Coor 9:30am and 11: hospice was follow provider, the fact th providers. FL2 and the star	w orders macy to be rdinator 20am owed by the cility would					

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DIVISION	n nealth Service Regu	lialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
			1		_	_
				R-		
		HAL035024	B. WING		12/0	8/2021
NAME OF D	20//DED OD OUDDUED	OTDEETAD	DDE00 0ITV 0T4	TE 710 000E		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	I E, ZIP CODE		
EDANKI IN	N MANOR ASSISTED LIV	ING CENTER 100 SUNS	ET DR			
INAME	WANTE ASSISTED LIV	YOUNGS	/ILLE, NC 2759	96		
(V4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ı	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE	DATE
			1	DEFICIENCY)		
(5,050)	<u> </u>		(0.050)			
{D 358}	Continued From page	e 32	{D 358}			
	and the facility staff w	ould notify the PCP of the				
	new orders.	rodic flotily the FCF of the				
		Idea Afficial - DOD affica				
	-	Id notify the PCP of the new				
	-	e provider by faxing or calling				
	the PCP.					
		ew order, the facility staff				
	would notify the hosp					
	-New orders from the	facility's contracted hospice				
	were faxed to the faci	ility.				
	-The RCC would retri	eve the faxed orders, review				
	them then fax to the p	oharmacy.				
		ad not discussed any new				
	orders for Resident #	•				
		all hospice orders to the				
	pharmacy if she was					
	priarriacy ii one was	aware or mem.				
	Interview with the PC	C on 12/08/21 at 9:35am				
	revealed:	O 011 12/00/21 at 9.55am				
		the beauties and an				
		w the hospice orders were				
		record without being faxed				
	to the pharmacy.					
		these orders from the fax.				
	-	n initialed all orders she				
	faxed.					
		ility's Regional Nurse on				
	12/07/21 at 11:20am	revealed:				
	-All orders written for	hospice residents should be				
	followed, whether writ	tten by the PCP or the				
	hospice provider.					
		hould discuss all new orders				
	for the hospice reside					
		hould be communicating all				
	orders with the RCC.	20 communicating an				
		e notifying the PCP of all				
		the hospice provider.				ļ
	new orders writteri by	ilie nospice provider.				
	Indometric control de la A. I.	iniatuatan an 40/07/04 -+				
	Interview with the Adr	ministrator on 12/07/21 at				
	π. / IDM te//σσίσα.		1	1		

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-The facility followed the PCP orders.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL035024	B. WING		R-C 12/08/2021
NAME OF PE	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA	TE ZIP CODE	, .=.00:=0=:
NAME OF T	TOVIDER OR OUT FEEL		INSET DR	12, 211 0002	
FRANKLIN	N MANOR ASSISTED LIV	ING CENTER	GSVILLE, NC 2759	96	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
{D 358}	Continued From page	: 33	{D 358}		
	-When orders written faxed to the facility, th would fax them to the -The order with the fa placed in the resident -She did not know how	by the hospice provider are the medication aide or RCC PCP and the pharmacy of x confirmation would be selected by the hospice orders were the record without being			
D 394	10A NCAC 13F .1008 Substance	(c) (d) Controlled	D 394		
	10A NCAC 13F .1008	Controlled Substance			
	shall be returned to the of the expiration or discontrolled substance resident. The facility resident's name; the resident name; the resident name; the resident name; the pharmacy we controlled substance; administrator's design controlled substance or following. The destruction shall pharmacist, dispension of a licensed pharmacist, dispension of a licensed pharmacist, name; the destructioner. The destructioner. The destructioner. The destructioner name, away the controlled substances	ager required for a resident the pharmacy within 90 days scontinuation of the profollowing the death of the shall document the name, strength and dosage substance; and the amount also be documentation by eccipt or return of the strength and dosage substance; and the amount also be documentation by eccipt or return of the strength and the administrator or the strength and the administrator or the strength and th			

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET DR YOUNGSVILLE, NC 27596 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	R-C 2/08/2021 (X5) COMPLETE DATE
FRANKLIN MANOR ASSISTED LIVING CENTER 100 SUNSET DR YOUNGSVILLE, NC 27596 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE
FRANKLIN MANOR ASSISTED LIVING CENTER YOUNGSVILLE, NC 27596 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	COMPLETE
DEFICIENCY)	
D 394 Continued From page 34 form of the controlled substance; the amount destroyed; the method of destruction; and, the signature of the administrator or the administrator's designee and the signature of the licensed pharmacist, dispensing practitioner or designee of the licensed pharmacist or dispensing practitioner.	
This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure an expired controlled substance (Morphine) was returned to the pharmacy to be destroyed or disposed of properly for 1 of 4 residents sampled (Resident #1).	
The findings are: Review of Resident #1's current FL-2 dated 09/30/21 revealed: -Diagnoses included Alzheimer's Disease, senile dementia, hypoglycemia, diabetes mellitus type 2, hypertension and anxiety disorderThere was no order for morphine (used for pain) 0.25mls sublingually every 4 hours as needed for shortness of breath or pain.	
Review of the hospital discharge dated 06/04/21 revealed an order to discontinue morphine 0.25mls. Observation of Resident #1's medications on	

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL035024		B. WING		R-C 12/08/2021
	PROVIDER OR SUPPLIER N MANOR ASSISTED LIV	ING CENTER	100 SUNS	DRESS, CITY, STA ET DR ILLE, NC 2759		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY .SC IDENTIFYING INFORM	S FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE
D 394	Continued From page hand on 12/06/21 rev Morphine 0.25mls rer dispensed on 01/31/2 Based on observation reviews it was determinerviewable. Telephone interview of facility's contract phath 4:04pm revealed: -There was no order the morphine 0.25mls hospital discharge daroll discontinued medicate pharmacy to be destroited back to the pharmacy discontinued medicate pharmacy to be destroited by the pharmacy to be destroited by the pharmacy to be destroited by the order was written provider (PCP)She completed the "The pharmacy" discontinued medicate interview with the Refunction (RCC) on 12/08/21 at 10:33pm discontinued medicate interview with the Refunction (RCC) and the pharmacy of the discontinued medicate interview with the Refunction of the pharmacy to be described by the MA would pull the once the order was well-the MA would pull the once the order was well-the MA completed the form.	ealed 20 syringes of mained that were original. Ins., interviews, and remained Resident #1 was with the pharmacist at macy on 12/06/21 at for the morphine 0.25 als was discontinued ted 06/04/21. Ilications need to be soft, wery driver would pick ion and return it to the oyed. Idication aide (MA) or revealed: Ilications were sent be estroyed. Is is continued medication by the Primary Care return to pharmacy are would scan the conform and take the ion. Is ident Care Coordinal to 10:43 am revealed: Ilications were sent be estroyed. In the conform and take the ion. In the coordinal to 10:43 am revealed: Ilications were sent be estroyed. In the conformal the conformal take the ion.	ginally cord as not t the t fomls. on the sent k up the e ack to on once form. mpleted ator ack to cation	D 394		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R-C
		HAL035024	B. WING		12/08/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE	
TO WILL OF TH	to vibert of tool i eleft	100 SUN		, 2.11 0052	
FRANKLI	N MANOR ASSISTED LIV	ING CENTER	VILLE, NC 2759	96	
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	· ·	PROVIDER'S PLAN OF CORRECTION	N (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 394	Continued From page	e 36	D 394		
	sealed bag -The pharmacy's drive "return to pharmacy" discontinued medicat -The medication carts RCC and the License twice a weekWhen auditing medication medicationsShe used the MAR to were on the cart for a -The MA should remo medications the day to discontinued. Interview with the LHI 10:46pm revealed: -She audited the medication expired and discontin -She compared the M cart to ensure that all for administration.	sion. So were monitored by the sed Health Professional Nurse cation carts the RCC looked and and discontinued continued contin			
	Interview with the Administrator on 12/08/21 at 10:49pm revealed: -The RCC and LHPS nurse will audit the medication carts twice a week. -The last cart audit was completed on 12/02/21				
	to the pharmacy.	dications should be returned cotics should be returned to stroyed.			
D 611	10A NCAC 13F .1801 Control Program (terr	1 (b) Infection Prevention & np)	D 611		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	4	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLI	ETED
						R-	c l
		HAL035024		B. WING		1	8/2021
NAME OF PI	ROVIDER OR SUPPLIER	Sī	FREET ADDI	RESS, CITY, STA	TE, ZIP CODE		
		10	00 SUNSE	T DR			
FRANKLI	N MANOR ASSISTED LIV	/ING CENTER		LLE, NC 2759	96		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
					22.10.2.10.1		
D 611	11 Continued From page 37		D 611				
	10A NCAC 13F .1801	1 INFECTION					
		CONTROL PROGRAM					
		ssure the following policie	s				
		established and implement					
	consistent with	'					
	the federal CDC publ	ished guidelines, which are	е				
	hereby incorporated by	by reference including					
	subsequent						
	amendments and editions, on infection control that are accessible at no charge online at						
	https://www.cdc.gov/i						
	addresses the followi						
	(1) Standard and tran		. n				
	the CDC	h guidance can be found o	on				
	website at						
		infectioncontrol/basics,					
	including:	in i da a i i a a a a a a a a a a a a a a					
	•	ne and cough etiquette;					
		eaning and disinfection;					
	(C) reprocessing and	disinfection of reusable					
	resident medical equi	ipment;					
	(D) hand hygiene;						
	. ,	proper use of personal					
	protective equipment						
		sion-based precautions an	a				
	when each type is inc						
		droplet precautions, and					
	airborne precautions;	report to the local health					
	department when the						
	confirmed						
	reportable communic	able disease case or					
	-	nicable disease outbreak ir	1				
		e .1802 of this Section;					
	(3) Resident care who	en there is suspected or					
	confirmed communication	able disease in the facility,					
		ated, isolation of infected					
	residents, limiting or s	stopping group activities a	nd				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N			CONSTRUCTION	(X3) DATE SU	
74101244	or contraction	IBENTI IOMITONI	OWIDEI C	A. BUILDING: _			
		HAL035024		B. WING		R-0 12/0 8	C 8/ 2021
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
FRANKLIN	N MANOR ASSISTED LIV	ING CENTER	100 SUNSE		ac.		
	CLIMMA DV CT	ATEMENT OF DEFICIENC		LLE, NC 2759		N	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENC Y MUST BE PRECEDED B .SC IDENTIFYING INFORI	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 611	Continued From page	÷ 38		D 611			
	communal dining, and transmission, use of siby the residents. Source face coverings for restransmission is through (4) Procedures for sciand criteria for restricting signs of illness, as well as pregarding screening at (5) Procedures for scienteria for restricting sillness from working; (6) Procedures and sistaffing issues and erneeds of the residents during outbreak; (7) The annual review IPCP to be consistent guidance on infection control; at (8) a process for upday procedures to reflect recommendations by CDC, local health dep Carolina Department Services (NCDHHS) during a procedured by the Unite North Carolina or a prodeclared by the State	d based on the mode source control as told control includes the sidents when the mode of a respiratory path reening visitors to the ting visitors who extracted a sident of the staff who exhibit signals are trategies for address a suring staffing to make the staff who exhibits and update of the twith published CD and atting policies and guidelines and the coartment, and North of Health and Human public health emerged States and that a public health emerged	e use of ode of nogen; ne facility hibit visitors edures; and ns of sing leet the disease facility 's C				
	This Rule is not met Based on record revie facility failed to ensure	ews and interviews,					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SI COMPLE	
		HAL035024		B. WING		R-0	C 8/2021
NAME OF P	ROVIDER OR SUPPLIER	111/1200021	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	1 12/0	0/2021
EDANKIII	N MANOD ACCICTED I IV	INC CENTED	100 SUNSE	T DR			
FRANKLII	N MANOR ASSISTED LIV	ING CENTER	YOUNGSV	ILLE, NC 2759	96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 611	Continued From page guidance established Control (CDC), and the Department of Health DHHS) were implement provide protection to a Special Care Unit (SC global coronavirus (Corelated to the proper control) by staff. The findings are: Review of the Centers Prevention (CDC) Interested to the proper control (CDC) Interested to the	by the Centers for Die North Carolina and Human Services ented and maintained Assisted Living (AL) a CU) residents during to OVID-19) pandemic ause of facemask (sour services of facemask (sour services) spread in Nursim Care Facilities date of should wear source in areas of the health ald encounter resident be worn under the notations to prevent of the properties of the health and the counter resident be worn under the notations of COVID-19 in LTC accility staff should we facility. The cial Care Unit (SCU and to 3:29pm revealed: ent Care Director (RC survey team with her whin, her nose and motonal care aides (PCA noses; they were interested and the content of the content	and tion and ti	D 611	DEFICIENCY)		
	-The RCD moved her and pulled it away fro		nose				

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		D.C.
		HAL035024	B. WING		R-C 12/08/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
FRANKLII	N MANOR ASSISTED LIV	ING CENTER 100 SUNSE YOUNGSV	ET DR ILLE, NC 2759	96	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 611	dining room that disple proper wearing of factors and mouth. -The housekeeper mouse the chin while he spoke to the chin while she spoke nose. Observation of a med 3:05pm revealed: -She was seated at a residents playing bing the chin the covered. -She did not social distribution of the Ad 3:05pm revealed: -She was playing bing the facemask covered. Observation of the Ad 3:05pm revealed: -She was playing bing the facemask covered. Observation of a facil 3:07pm revealed she room while residents facemask below her company to the control of the RC on 12/06/21 at 3:11pm they exited the RCD's hallway toward the diffacemask were under	ation screen in the resident ayed instructions for the emask including covering oved his facemask under his o another staff. (IA) had her facemask below oved at 11:11am and 3:29pm. In cemask to the side of her exposing her mouth and her exposing her mouth and her exposing her mouth and her exposing her mouth. Her nose was estance from the three her same table. (It is the interior of 12/06/21 at each her mouth. Her nose was estance from the three her same table. (It is the interior of 12/06/21 at each her mouth. Her nose was estance from the three her same table. (It is the interior of 12/06/21 at each her mouth. Her nose was estance playing bingo with her chin. (It is the interior of 12/06/21 at each her mouth. Her nose was estance playing bingo with her chin. (It is the interior of 12/06/21 at each her mouth. Her nose was estance playing bingo with her chin. (It is the interior of 12/06/21 at each her mouth. Her nose was estance playing bingo with her chin. (It is the interior of 12/06/21 at each her mouth. Her nose was estance from the three each her mouth. Her nose was estance from the three each her mouth. Her nose was estance from the three each her mouth. Her nose was estance from the three each her mouth. Her nose was estance from the three each her mouth. Her nose was estance from the three each her mouth. Her nose was estance from the three each her mouth. Her nose was estance from the three each her mouth. Her nose was estance from the three each her mouth. Her nose was estance from the three each her mouth her mouth. Her nose was estance from the three each her mouth her	D 611		
		sident living area with his			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7.1. 20122.110.		R-C
		HAL035024	B. WING		12/08/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
FRANKLII	N MANOR ASSISTED LIV	ING CENTER YOUNGSV	ET DR TILLE, NC 2759	16	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 611	1 Continued From page 41		D 611		
	facemask under his c	hin.			
		ond PCA on 12/07/21 at was in resident living area der her chin.			
	Observation of the SCU on 12/07/21 from 10:15am to 12:38pm revealed: -A PCA had her facemask on under her chinA MA had her facemask on under nose. Observation of a facility staff on 12/07/21 at 11:15am revealed she wore her facemask under her chin. Observation of four facility staff in the resident's dining room on 12/07/21 at 3:41pm revealed: -Three facility staff were seated at the dining room tableOne facility staff was standing at the dining room table.				
	his chin.	aff had his facemask under ted a resident in sitting in a			
	chair at the same dini with his facemask stil -There was no social				
	-	me MA on 12/07/21 at had her facemask below r mouth covered.			
	revealed: -The facility required	on 12/06/21 at 11:15am the staff to wear KN95			
	and mouth.	upposed to cover her nose			
	-The only place staff of facemask was in the	breakroom while eating.			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B WING		R-C	
		HAL035024	b. WING		12/08/2021	\dashv
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
FRANKLI	N MANOR ASSISTED LIV	ING CENTER 100 SUNSI				
		YOUNGSV	ILLE, NC 2759	96		_
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
D 611	1 Continued From page 42		D 611			
	-The staff had been required to continuously wear their facemask for about three months.					
	revealed:	n 12/06/21 at 3:55pm				
	facemask while worki	S .				
		vearing facemask since one				
	of the staff tested pos	sitive about three months				
	-She was supposed to wear the facemask above					
	her nose, but it was h	ot and hard to breath in, so				
	she pulled it down be mouth covered.	low her nose but kept her				
	12/07/21 at 3:32pm re					
	in the facility.	ed to wear a facemask while				
	nose.	uired to be worn above the				
		allowed to be lowered at any				
	time; not even to spear- -She was surprised to					
	•	cemask below their noses				
		ey were pulling them away				
	from their face to talk	ave reminded the staff to				
		on their face when speaking				
	·	ut she never saw staff				
	wearing their facemas					
		SCU, so she walked around tobserve staff improperly				
	wearing their facemas					
		operly wear their facemask				
	because they were tra	ained to wear them when				
	-	here were signs posted				
		remind them; also, the ded for the staff to wear.				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NU		' '	CONSTRUCTION		E SURVEY PLETED
		HAL035024		B. WING			R-C 2/08/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
FRANKLI	N MANOR ASSISTED L	IVING CENTER	100 SUNS YOUNGSV	ET DR /ILLE, NC 2759	96		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCII CY MUST BE PRECEDED B' R LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 611	2:48pm revealed sh facemask when she and around the residence of the Additional staff were instruated all times. -The staff were instruated all times. -The staff did not has facemask. -The only time staff was when they left to the staff would were anywhere in the the staff had been regarding wearing the staff had been staff had been survey team staff had been on 12/06/21 at 8:45a with the survey team without the survey team without the staff had between 9:20am to the room with the staff had between 9	dministrator on 12/06/e made sure to wear was in the resident adents. dministrator on 12/07/cted to wear their face we problems wearing could remove their face he building. ar their facemask where facility. worn correctly when it and nose. in-serviced multiple time in facemask correctly desire facemask correctly. Resident Care Director am revealed she was in with her mask under mouth were not covered administrator on 12/06/e was meeting with the a mask. Administrator on 12/06/e. Administrator on 12/06	her ireas /21 at emask their cemask en they it imes ly. st wear or (RCD) meeting r her ed. 6/21 at he 6/21 entered without	D 611	DEFICIENCI)		
	3:05pm revealed:	edication aide on 12/0 a dining room table an					

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R-C	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
HALU35U24 S. VING			HAL035024	B. WING		R-C 12/08/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	NAME OF PROVIDER	DER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
FRANKLIN MANOR ASSISTED LIVING CENTER 100 SUNSET DR YOUNGSVILLE, NC 27596	FRANKLIN MANO	ANOR ASSISTED LIVING CE	CENTER		96	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	PREFIX	(EACH DEFICIENCY MUST E	ST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLET
D 611 Continued From page 44 Her mask covered her mouth. Her nose was not covered. -She did not social distance from the three residents seated at the same table. Observation of the Activity Director on 12/06/21 at 3:05pm revealed: -She was playing bingo with the residentsHer mask covered her mouth. Her nose was not covered. Observation of a facility staff on 12/06/21 at 3:07pm revealed she walked through the dining room while residents were playing bingo with her mask below her chin. Observation of the RCD and another facility staff on 12/06/21 at 3:11pm revealed they exited the RCD's office and walked into the hallway toward the dining room, both with their mask under their chin. Observation of a PCA on 12/07/21 at 7:35am revealed he was in resident living area with his mask under his chin. Observation of a facility staff on 12/07/21 at 7:40am revealed she was in resident living area with her mask under her chin. Observation of a facility staff on 12/07/21 at 11:15am revealed she wore her mask under her chin. Observation of a 12/07/21 at 3:41pm revealed: -Three facility staff in the resident's dining room on 12/07/21 at 3:41pm revealed: -Three facility staff were seated at the dining room table.	-Her n covered resides of resides	er mask covered her mout vered. he did not social distance is sidents seated at the same operation of the Activity D D5pm revealed: he was playing bingo with er mask covered her mout vered. Deservation of a facility staff D7pm revealed she walked om while residents were plask below her chin. Deservation of the RCD and 12/06/21 at 3:11pm revealed ye exited the RCD's office Ilway toward the dining rocask under their chin. Deservation of a PCA on 12/06/24 was in resident bask under his chin. Deservation of a second PCA on 12/06/25 was under his chin. Deservation of a facility staff ther mask under her chir deservation of a facility staff there facility staff were sear the did not prove the facility staff were sear the did not prove the facility staff were sear the did not prove	ce from the three me table. Director on 12/06/21 at ith the residents. bouth. Her nose was not aff on 12/06/21 at sed through the dining e playing bingo with her and another facility staff yealed ce and walked into the room, both with their 12/07/21 at 7:35am and living area with his PCA on 12/07/21 at in resident living area chin. aff on 12/07/21 at re her mask under her we staff in the resident's at 3:41pm revealed:	D 611		

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL035024	B. WING		R-C 12/08/2021
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	12/00/2021
FRANKLII	N MANOR ASSISTED LIV	/ING CENTER 100 SUNS			
		YOUNGS	VILLE, NC 2759	96	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE COMPLETE
D 611	Continued From page	e 45	D 611		
	chinThe same staff assis chair at the same dini with his mask still bel-There was no social Observation of the sa 4:30pm revealed she nose with only her more	distancing. Ime MA on 12/07/21 at had her mask below her outh covered.			
	Interview with the Administrator on 12/07/21 at 4:25pm revealed: -All staff were instructed to wear their mask at all timesThe staff did not have problems wearing their maskThe only time staff could remove their mask was when they left the buildingThe staff would wear their mask when they were anywhere in the facilityThe mask was worn correctly when it covered the mouth and noseThe staff had been in-serviced multiple times regarding wearing their mask correctlyManagement reminds staff that they must wear their mask and wear it correctly.				
{D912}	G.S. 131D-21 Declar Every resident shall h 2. To receive care an adequate, appropriate relevant federal and s regulations.	e, and in compliance with state laws and rules and	{D912}		
	This Rule is not met Based on observation	as evidenced by: ns, interviews and record			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		HAL035024		B. WING		R-	.C 08/2021
NAME OF PI	ROVIDER OR SUPPLIER	HALOGOLT	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	1 12/0	70/2021
	N MANOR ASSISTED LIV	ING CENTER	100 SUNSE				
FRANKLII	WANOK ASSISTED LIV	ING CENTER	YOUNGSVI	LLE, NC 2759	96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENC Y MUST BE PRECEDED E .SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
{D912}	Continued From page 46		{D912}				
	reviews, the facility no residents received ca adequate, appropriate relevant federal and s regulations related to	re and services whe e and in compliance state laws and rules	ich were with				
	The findings are: Based on observations, interviews, and record reviews, the facility failed to provide adequate supervision and implement an order for an anti-anxiety medication for 1 of 5 sampled residents (#3) based on the resident's current symptoms, who exhibited verbal and aggressive behaviors and wandered into other residents' rooms, resulting in distress and injuries to other residents.Refer to Tag 273 10A NCAC 13F .0901(b) Personal Care and Supervision (Unabated Type A2 Violation).]						
{D914}	G.S. 131D-21(4) Dec	laration of Resident	s' Rights	{D914}			
	G.S. 131D-21 Declar Every resident shall h 4. To be free of menta neglect, and exploitat	ave the following ri	ghts:				
	This Rule is not met Based on observatior reviews, the facility fa were free of mental a to resident rights.	ns, interviews, and rillied to ensure resid	ents				
	The findings are:						
	Based on observation	ns, interviews and re	ecord				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			SURVEY PLETED	
		HAL035024		B. WING			R-C /08/2021
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDI	RESS, CITY, STA	TE, ZIP CODE		
FRANKLI	N MANOR ASSISTED LIV	ING CENTER	100 SUNSE YOUNGSVI	T DR LLE, NC 2759	96		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
{D914}	reviews the facility fai residents (#1, #5 and (SCU) were protected fear of physical abuse who resided in the SC	led to ensure 3 of 3 sam #6) in the Special Care If from physical harm and from another resident (CU. [Refer to Tag 338 10 sident Rights. (Type A2	Unit d (#3)	{D914}			

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