DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			<u> </u>	B NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		) DATE SURVEY COMPLETED
		345242	B. WING			01/23/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
THE FOUR	NTAINS AT THE ALBEMA	RLE		200 TRADE STREET TARBORO, NC 27886		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED <sup>-</sup> DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
E 000	Initial Comments		E OC	00		
	complaint investigation 1/21/2020 through 1/2 found in compliance of 483.73. Emergency F NEQ711.	23/2020. The facility was with requirement CFR Preparedness. Event				0/10/20
F 550 SS=D	Resident Rights/Exer CFR(s): 483.10(a)(1)	-	F 55	50		2/12/20
	self-determination, an access to persons an	Rights. ght to a dignified existence, nd communication with and d services inside and cluding those specified in				
	with respect and dign resident in a manner promotes maintenand	and in an environment that ce or enhancement of his or ognizing each resident's lity must protect and				
	access to quality care severity of condition, must establish and m practices regarding tr	cility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source.				
		right to exercise his or her f the facility and as a citizen				
LABORATORY	L DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE
Electroni	cally Signed					02/05/2020

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	-	D HUMAN SERVICES MEDICAID SERVICES			FORM A OMB NO. (	PPROVED
STATEMENT (	STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING			(X3) DATE SL COMPLE	JRVEY	
		345242	B. WING		01/23	s/2020
	ROVIDER OR SUPPLIER	RLE	2	TREET ADDRESS, CITY, STATE, ZIP CODE 200 TRADE STREET TARBORO, NC 27886	•	
(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	(X5) COMPLETION DATE
F 550	<ul> <li>§483.10(b)(1) The factor resident can exercise interference, coercion from the facility.</li> <li>§483.10(b)(2) The restore of interference, correprisal from the facility rights and to be supplexercise of his or her subpart.</li> <li>This REQUIREMENT by:</li> <li>Based on observation interviews the facility dignity and respect by required assistance wwas evidenced for two for dining. (Resident #2 was art 10/6/16. Her active di and anxiety disorder.</li> <li>Resident #2 's minim (MDS) dated 10/30/19 assessed as severely required extensive as</li> <li>Resident #2 's care p she was care planned meals.</li> <li>During observation or lunch Resident #2 was read to a many for the several means.</li> </ul>	cility must ensure that the his or her rights without a, discrimination, or reprisal sident has the right to be oercion, discrimination, and ty in exercising his or her orted by the facility in the rights as required under this is not met as evidenced an, record review and staff failed to treat residents with y referring to residents who yith meals as "feeders." This o of two residents observed #2, Resident #18) dmitted to the facility on agnoses included dementia, um data set assessment 9 revealed she was cognitively impaired. She	F 550	Inservice with 100% of skilled nursing clinical and dietary associates began 01/21/20 and will be completed by 02/12/20 covering treating residents v dignity by using the term residents requiring assistance with dining for residents that need assistance with meals. Meals in the dining room will be audite the DON or her designee weekly x 4 weeks and monthly x 2 months to ens associates are treating residents with dignity and respect by referring to the residents needing assistance with me as residents requiring assistance with dining and not using the term feeders Findings of Dining Room audits will be presented to the QAPI Committee monthly for three months with any changes to plan made as needed.	on vith ed by sure als	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		COMP	LETED
		345242	B. WING			01/	23/2020
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE FOUNTAINS AT THE ALBEMARLE					200 TRADE STREET TARBORO, NC 27886		
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 550	the surveyor was star There were multiple of residents within an au Nurse #1. During an interview of MDS Nurse #1 stated the term "feeder." He just not thinking and s residents needed ass nurse concluded "feed and there were alert a who were able to hea have used it. During an interview of Nurse Aide #1 stated the term "feeders." SH "feeders" MDS Nurse Resident #2 and Resi "feeders" meant the re during meals. When a "feeders" was a term those residents. During an interview of Director of Nursing stated stated staff were to sa assistance with meals begin in-services imm 2. Resident #18 was a 6/6/14. Her active dia Resident #18 's minin (MDS) dated 12/18/19	This was audible from where hading two tables away, other alert and oriented udible distance from MDS In 1/21/2020 at 12:47 PM The should not have used continued to state he was should have said the istance with meals. The ders" was a derogatory term and oriented people in room r him, and he should not In 1/21/2020 at 1:13 PM the staff at the facility used he further stated the #1 was asking about were ident #18. She stated sidents needed staff help asked again, she reiterated used by staff to describe In 1/21/2020 3:21 PM the ated staff should not use the nity concerns. She further ay residents required s. She concluded she would hediately. admitted to the facility on gnoses included dementia. mum data set assessment 9 revealed she was	F	550			
	(MDS) dated 12/18/19						

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 02/25/2020 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION		(X3) DATE	
		345242	B. WING			_	01/	23/2020
NAME OF PI	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE FOUR	NTAINS AT THE ALBEMA	RLE			200 TRADE STREET TARBORO, NC 27886			
04015		ATEMENT OF DEFICIENCIES	10		,	S PLAN OF CORRECTION		()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	Continued From page	• 3	F	550				
	was totally dependent	t on staff for meals.						
	Resident #18 ' s care revealed she was car assistance with meals	e planned to require						
	MDS Nurse #1 was o lunch meals in the dir kitchen staff and audi getting food off the ca tray was brought from Resident #18. MDS N be heard from the far There were multiple o	n 1/21/2020 at 12:33 PM bserved helping pass out ning room. He turned to the bly stated a nurse aide was art for the "feeders." A meal in the cart and given to lurse #1's statement could corner of the dining room. other alert and oriented udible distance from MDS						
	MDS Nurse #1 stated the term "feeder." He just not thinking and s residents needed ass nurse concluded "fee and there were alert a	n 1/21/2020 at 12:47 PM I he should not have used continued to state he was should have said the istance with meals. The ders" was a derogatory term and oriented people in room r him, and he should not						
	Nurse Aide #1 stated the term "feeders." SH "feeders" MDS Nurse Resident #2 and Resi "feeder" meant the re during meals. When a "feeders" was a term those residents.	#1 was asking about were						

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						. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345242	B. WING		01/2	23/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	NTAINS AT THE ALBEMA			200 TRADE STREET		
				TARBORO, NC 27886		
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 550	Continued From page	e 4	F 55	50		
	term "feeders" for dig stated staff were to s assistance with meal	s. She concluded she would				
F 637 SS=D	begin in-services imn Comprehensive Asse CFR(s): 483.20(b)(2)	essment After Signifcant Chg	F 63	.7	:	2/12/20
	determines, or should there has been a sign resident's physical or purpose of this section means a major declin resident's status that itself without further in implementing standa interventions, that had one area of the reside requires interdisciplin care plan, or both.) This REQUIREMENT by: Based on record rev facility failed to perfore status Minimum Data following hospice enr (Resident #16) review The findings included Resident #16 was ad 12/5/2019 with diagn malignant neoplasm (a cancerous tumor to tissue such as muscl	r mental condition. (For on, a "significant change" ne or improvement in the will not normally resolve intervention by staff or by rd disease-related clinical s an impact on more than ent's health status, and hary review or revision of the T is not met as evidenced iew and staff interviews the rm a significant change in a Set (MDS) assessment follment for 1 of 1 residents wed for hospice care. d: imitted to the facility on oses which included of connective and soft tissue hat arises in the connective es, tendons, ligaments, fat, ispecified dementia without		Completion of Significant Changassessment for Resident #16 wa completed on 01/28/19 to capturenrollment. This assessment wa transmitted on 01/30/19. 100% audit of all residents on ho be conducted by DON and/or de 2/12/20 to ensure that all hospic residents had a significant changassessment completed at the tir hospice enrollment. Inservice with DON, and ADON 02/12/19 covering the need for co of significant change assessment following hospice enrollment by	as re hospice is ospice will esignee by e ge ne of by completion nt	

Event ID: NEQ711

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/25/2020 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		(X3) DATE	ESURVEY PLETED	
		345242	B. WING _			01	/23/2020
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
THE FOU	NTAINS AT THE ALBEMA	RLE		20	0 TRADE STREET		
				T/	ARBORO, NC 27886		
(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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 637	Continued From page	• 5	F 6	637	resident. MDS nurse resigned effectiv		
	12/11/2019 revealed status was unable to showed the resident I				02/05/20. Upon hire, new MDS nurse complete inservice. All MDS assessments for residents enrolling in hospice will be audited by DON or designee weekly x 4 weeks a monthly x 2 months to ensure comple of significant change assessment after hospice enrollment.	will Ind Ition	
	Resident #16 showed evaluate and provide Resident #16 ' s med	l an order for hospice to			Findings of MDS assessment audits be presented to the QAPI Committee monthly for three months with any changes to plan made as needed	vill	
	Resident #16 ' s MDS significant change as	assessments revealed a					
	change MDS was not admission MDS had j morning Resident #16 services. MDS Nurse the only thing that had #16. MDS Nurse #1 ft	ith MDS Nurse #1 on , he stated a significant completed because the ust been completed the 6 was admitted to hospice e #1 also stated hospice was d changed with Resident ' s urther stated that he should ignificant change MDS for					
F 758	at 1:00 pm revealed t responsible for compl change assessment a started, and the asses completed.	Administrator on 1/23/2020 he MDS Nurse was eting the MDS significant after hospice care had been ssment should have been chotropic Meds/PRN Use	F 7	'58			2/12/20

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345242	B. WING			01/	23/2020	
NAME OF PF	ROVIDER OR SUPPLIER	I		5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
THE FOUN	DUNTAINS AT THE ALBEMARLE				200 TRADE STREET TARBORO, NC 27886			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 758 SS=D	affects brain activities processes and behave but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehe resident, the facility m §483.45(e)(1) Reside psychotropic drugs ar unless the medication specific condition as of in the clinical record; §483.45(e)(2) Reside drugs receive gradua behavioral interventio contraindicated, in an drugs; §483.45(e)(3) Reside psychotropic drugs pu unless that medicatio diagnosed specific co in the clinical record; §483.45(e)(4) PRN of	(e)(1)-(5) ppic Drugs. hotropic drug is any drug that associated with mental ior. These drugs include, drugs in the following ensive assessment of a hust ensure that nts who have not used re not given these drugs is necessary to treat a diagnosed and documented It swho use psychotropic I dose reductions, and ons, unless clinically effort to discontinue these Its do not receive ursuant to a PRN order n is necessary to treat a ondition that is documented and rders for psychotropic drugs 5. Except as provided in attending physician or	F	758				

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TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE C	CONSTRUCTION	(X3) DATE	D. 0938-039 SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		345242	B. WING _			01/	/23/2020
NAME OF P	ROVIDER OR SUPPLIER	-		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
	NTAINS AT THE ALBEM		200 TRADE STREET		) TRADE STREET		
				TA	RBORO, NC 27886		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 758	Continued From pag	e 7	F7	759			
1 700				50			
		RN order to be extended or she should document their					
		ent's medical record and					
	indicate the duration						
	§483.45(e)(5) PRN o	orders for anti-psychotic					
	drugs are limited to 1	l4 days and cannot be					
		attending physician or					
		er evaluates the resident for					
	the appropriateness						
		T is not met as evidenced					
	by:	on, staff interviews and			The prescriber (Nurse Practitioner)		
		and record reviews, the			documented a rationale in resident #1	6's	
		the duration of the use of an			medical record for an extension of the		
	-	ychotropic drug to 14 days or			Ativan 0.5 mg for 45 days on 01/22/20		
		cument a rationale in the				-	
		ecord for an extension of the			An audit was completed by the DON a	ind	
	drug 's use beyond '	14 days for 1 of 1 residents			ADON on 01/24/20 of all resident's with		
	(Resident # 16) revie	ewed for unnecessary			orders for PRN psychotropic medication	ons	
	medications.				to ensure that each had a stop date to		
					limit the duration of the use to 14 days		
	Findings included:				had a prescriber documented rational	in	
	Desident #40 ····				the resident's medical record for an		
		Imitted to the facility on			extension of the drug's use beyond 14		
	12/5/2019 with diagn	of connective and soft tissue			days.		
		that arises in the connective			Inservice with all nursing staff to be		
		les, tendons, ligaments, fat,			completed by 02/12/20 covering obtain	nina	
		nspecified dementia without			a stop date for all PRN pychotropic dru		
	behavioral disturband	•			to limit the duration of the use to 14 da	-	
					or having a prescriber document a		
		Resident #16 that was dated			rationale in the resident's medical reco		
		Ativan 0.5 milligrams (mg) by			for an extension of the drug's use bey	ond	
		as needed for anxiety with			14 days.		
	no stop date indicate	ed.					
					All PRN psychotropic medication orde	rs	
		um Data Set (MDS) dated			will be audited by DON or designee	a the a	
		Resident #16 cognitive			weekly x 4 weeks and monthly x 2 mo	nuns	1

Facility ID: 953485

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A. BUILDING     O1/23/202       A. BUILDING     O1/23/202       B. WING     O1/23/202       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       THE FOUNTAINS AT THE ALBEMARLE     STREET       (X4) ID PREFIX     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL     ID PREFIX     PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE     (COMP	STATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPI	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
Image of PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         2017 TADDE STREET       2017 TADDE STREET         741 Dimensional Control of Component Control Contrection Construct Contrection Constitutes Stric Control Control Co	IND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i	COMPLETED	
THE FOUNTAINS AT THE ALBEMARLE         20 TRADE STREET TABORO, NC 27885           (PHER) TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (PACH CORRECT A CTORY SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY)         0.0 (PACH CORRECTION ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY)         0.0 (PACH CORRECTION ACTION PRV DRYCONTOPIC AUGE OF AN (PACH CORRECTION ACTION ACTION DATE TO A DECEMBER 2019 AND ACTION ATTION ACTION ACTION ACTION ATTION ACTION ACTION ACTION ATTION ACTION			345242	B. WING		01/23/2020	
THE FOUNTIAINS AT THE ALBEMARLE       TARBORO, NC 27865         (M) D FRETX TAG       SUMMARY STATEMENT OF DEFICIENCIES. (EACH DEFICIENCY MUST BE PRECEDE BY FULL REGULATIONY OR LSC DERITIFYING INFORMATION)       D D (EACH DEFICIENCIES) (EACH DEFICIENCY MUST BE PRECEDE BY FULL REGULATIONY OR LSC DERITIFYING INFORMATION)       D D D D D D D D D D D D D D D D D D D	NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PHEFIX TAG         CEAH CORRECTIVE ACTION SHOULD BE CROSS-RETERENCE OF DIFLATION OF LAPPROPRIATE         COME DEFICIENCY           F 758         Continued From page 8 status was unable to be assessed. The MDS showed the resident had no moods or behaviors. The resident received no anti-anxiety medication during the assessment 's look back period.         F 758         to ensure there is a stop date for all PRN pychotropic drugs to limit the duration of the use to 14 days or prescriber documentation of a rationale in the resident received no anti-anxiety medication during the month of December 2019 and received Ativan six times during the month of January 2020. The January 2020 MAR reflected that Resident #16 received PRN Ativan in January on the following dates: 1/17/2020, 1/18/2020, 1/19/2020, 1/20/2020.         F 758           A nobservation on 1/22/2020 at Resident #16 's primary care physician revealed a recommendation which stated Resident #16 had a PRN lativan order without a stop date. To discontinue or provide a rationale for continued use or provide a duration of therapy.         F 758           An observation on 1/22/2020 at 2:10 pm, he stated the physician #1 on 1/22/2020 at 2:10 pm, he stated the physician #1 on 1/22/2020 at 2:10 pm, he stated the physician #1 on 1/22/2020 at 2:10 pm, he stated the physician #1 as ostated the mistakenly thought Resident #16 was being followed by the psychiatrist and psychotropic medications are normally deferred to the Nurse Practitioner. Physician #1 also stated the mistakenly thought Resident #16 was being followed by the psychiatrist and psychotropic medications are normally deferred to the psychiatrist. The physician also stated the mistakenly thought Resident #16 was being followed by the psychiatrist and psychotropic medications are normally deferred to the psychiatrist. The physician #1 also stated	THE FOUI	NTAINS AT THE ALBEMA	ARLE				
<ul> <li>status was unable to be assessed. The MDS showed the resident and no moods or behaviors. The resident received no anti-anxiety medication during the assessment 's look back period.</li> <li>Resident #16 's medication administration records revealed the resident received no Ativan during the month of December 2019 and received Ativan six times during the month of January 2020. The January 2020 MAR reflected that Resident #16 received PNA thivan in January on the following dates: 1/17/2020, 1/18/2020, 1/18/2020, 1/18/2020, 1/18/2020, 1/19/2020, 1/20/2020.</li> <li>A pharmacist consultant recommendation dated 1/16/2020 addressed to Resident #16 's privation are provide a duration of therapy.</li> <li>An observation on 1/22/2020 at 4:00 pm with Nurse #2 revealed Resident #16 had a package and a bottle of Ativan 0.5 mg tablets in the narcotic box on the west hallway medication cart.</li> <li>During an interview with Physician #1 on 1/22/2020 at 2:10 pm, he stated the pharmacist recommendation dated haracotic box on the west hallway medication cart.</li> <li>During an interview with Physician #1 on 1/22/2020 at 2:10 pm, he stated the pharmacist recommendation dated haracotic box on the west hallway medication cart.</li> <li>During an interview with Physician #1 on 1/22/2020 at 2:10 pm, he stated the pharmacist recommendation dated he narcotic box on the west hallway medication cart.</li> <li>During an interview with Physician #1 on 1/22/2020 at 2:10 pm, he stated the pharmacist recommendation dated he nistakenly thought Resident #16 was being followed by the psychiatrist and psychotropic medications are normally defered to the psychiatrist and psychotropic medications are normally defered to the psychiatrist and psychotropic medication also stated the resident 's PRN Ativan order should have had a</li> </ul>	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE COMPLETIO	
<ul> <li>status was unable to be assessed. The MDS showed the resident nearbident hand no moods or behaviors. The resident received no anti-anxiety medication during the assessment 's look back period.</li> <li>Resident #16 's medication administration records revealed the resident received no Ativan during the month of December 2019 and received Ativan six times during the month of January 2020. The January 2020 MAR reflected that Resident #16 received PA thivan is January 2020, 11/19/2020, 11/18/2020, 11/18/2020, 11/19/2020, 11/19/2020, 11/19/2020, 11/19/2020, 11/19/2020, 11/19/2020, 11/19/2020, 11/19/2020, 11/18/2020, 11/19/2020, 1</li></ul>	F 758	Continued From page	e 8	F 75	8		
		status was unable to showed the resident The resident received during the assessme Resident #16 ' s med records revealed the during the month of E Ativan six times durin 2020. The January 22 Resident #16 receive the following dates: 1 1/19/2020, 1/20/2020 A pharmacist consult 1/16/2020 addressed care physician reveal stated Resident #16 without a stop date. T rationale for continue of therapy. An observation on 1/2 Nurse #2 revealed Re and a bottle of Ativan narcotic box on the w During an interview w 1/22/2020 at 2:10 pm recommendation of 1 Nurse Practitioner. P mistakenly thought R followed by the psych medications are norm psychiatrist. The phys- resident ' s PRN Ativa	be assessed. The MDS had no moods or behaviors. d no anti-anxiety medication nt's look back period. lication administration resident received no Ativan December 2019 and received og the month of January 020 MAR reflected that ed PRN Ativan in January on /17/2020, 1/18/2020, ). ant recommendation dated I to Resident #16 's primary led a recommendation which had a PRN ativan order To discontinue or provide a ed use or provide a duration 22/2020 at 4:00 pm with esident #16 had a package 0.5 mg tablets in the vest hallway medication cart. with Physician #1 on h, he stated the pharmacist /16/20 was reviewed by the hysician #1 also stated he resident #16 was being niatrist and psychotropic hally deferred to the sician also stated the		<ul> <li>to ensure there is a stop date for a pychotropic drugs to limit the durat the use to 14 days or prescriber documentation of a rationale in the resident's medical record for an ex of the drug's use beyond 14 days. PRN psychotropic medication order also be conducted by Pharmacy consultant monthly with recomment given to DON to complete.</li> <li>Findings of PRN Psychotropic aud be presented to the QAPI Committed monthly for three months with any changes to plan made as needed.</li> <li>This Plan of Correction has been submitted to meet the requirement established by state/federal law. The of Correction constitutes this facilit demonstration of compliance for the deficiencies cited. Submission of the stables of</li></ul>	ion of tension Audit of ers will idations its will ee s his Plan y's e nis Plan hat a	
The Administrator stated during an interview on		The Administrator sta	ated during an interview on				

If continuation sheet Page 9 of 10

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	: 02/25/2020 APPROVED . 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345242	B. WING				01/2	23/2020
NAME OF PI	ROVIDER OR SUPPLIER		ł		STREET ADDRESS, CITY, STATE, ZIF	P CODE		
THE FOUN	THE FOUNTAINS AT THE ALBEMARLE				200 TRADE STREET FARBORO, NC 27886			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN (	OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF	IX	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	O THE APPROPRIA		COMPLETION DATE
F 758	1.0		F	758				
		, upon Resident #16 ' s ity, the nurses should have						
	caught that the reside	ent ' s PRN Ativan order had						
	no stop date and calle clarification order.	ed the physician to obtain a						
	clamication order.							

Event ID: NEQ711

Facility ID: 953485

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