PRINTED: 12/04/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345335	B. WING			C 11/08/2018		
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
ED ANIZI II	I OAKS MUDSING AND I	DELIABILITATION CENTED		1	704 NC HIGHWAY 39 N			
FRANKLII	N UAKS NURSING AND I	REHABILITATION CENTER		L	OUISBURG, NC 27549			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE	
TAG	AG INEGGENTON ON ESCRIPTING INFORMATION)		TAG		DEFICIENCY)			
E 607	Camanahanaiya Aasa	agreement After Cigniferent Char		CO7			10/0/10	
F 637		ssment After Signifcant Chg	-	637			12/6/18	
SS=D CFR(s): 483.20(b)(2)		(II <i>)</i>						
	§483.20(b)(2)(ii) With	nin 14 days after the facility						
		I have determined, that						
	there has been a sign	ificant change in the						
	resident's physical or	mental condition. (For						
		n, a "significant change"						
		e or improvement in the						
		will not normally resolve						
		ntervention by staff or by						
	. •	d disease-related clinical						
		s an impact on more than ent's health status, and						
		ary review or revision of the						
	care plan, or both.)	ary review or revision or the						
		is not met as evidenced						
	by:	is not met as evidenced						
	_	ew and staff interviews the			Franklin Oaks Nursing and Rehabilitat	ion		
		ete a significant change			Center acknowledges receipt of the			
	Minimum Data Set As				Statement of Deficiencies and propose	s		
	residents that had a s	ignificant change is status			this Plan of Correction to the extent that	at		
	(Resident #76).				the summary of findings is factually			
					correct and in order to maintain			
	The findings included	:			compliance with applicable rules and			
					provisions of quality of care of resident			
		mitted to the facility on			The Plan of Correction is submitted as	а		
		agnosis of dementia with			written allegation of compliance.			
	behavioral disturband	e.			Franklin Oaks Nursing and Bahahiliteti	on		
	The Care Plan for Po	sident #76 dated 7/2/18			Franklin Oaks Nursing and Rehabilitati Center's response to this Statement of			
		indered and was at risk for			Deficiencies does not denote agreeme			
		n the facility. The Care Plan			with the Statement of Deficiencies nor			
	did not list other beha				does it constitute an admission that an	V		
					deficiency is accurate. Further, Frankli	-		
	The Admission Minim	um Data Set (MDS)			Oaks Nursing and Rehabilitation Center			
		6/18 revealed the resident			reserves the right to refute any of the			
	had severe cognitive	impairment, required			deficiencies on this Statement of			
		with activities of daily living			Deficiencies through Informal Dispute			
		ragement and cueing with			Resolution, formal appeal procedure			
ADODATODY	DIDECTOR'S OR DROVINER	SUPPLIER REPRESENTATIVE'S SIGNATUR			TITI F		(X6) DATE	

11/21/2018 **Electronically Signed**

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345335	B. WING			l	C 08/2018
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	00/2010
	10115211 011 001 1 2.2.1				704 NC HIGHWAY 39 N		
FRANKLI	OAKS NURSING AND	REHABILITATION CENTER			OUISBURG, NC 27549		
	OLIMANA DV OT	ATEMENT OF REFIGIENCIES					2.5
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 637	Continued From page	e 1	F	337			
	eating. It was noted the 173 pounds.	he resident ' s weight was			and/or any other administrative or lega proceeding.	l	
	Review of the resident 's weights revealed the resident weighed 170 pounds on 7/25/18 and 8/1/18. A nursing progress note dated 8/6/18 revealed the resident was anxious/agitated and pacing and hollering at the staff and other residents. A nursing progress note dated 8/14/18 at 2:44 PM				F 637 The process that lead to the deficiency was the Minimum Data Set (MDS) Nurse failed to complete a significant change assessment for resident # 76. On 11/21/2018 the MDS nurse complete a significant change assessment in the	se ted	
	had a poor PO (by modated 8/24/18 at 3:48 anxious and pacing a	e resident was pacing in the hallway and por PO (by mouth) intake. A nurse 's note 24/18 at 3:48 PM noted the resident was and pacing and refused breakfast and d snacks were given in between meals.			area of weight loss and increased behaviors for resident # 76. MDS for Resident # 76 was transmitted and accepted into the National Repository (11/21/2018.	on	
	pounds on 8/30/18. A progress note by the 8/30/18 revealed the significant weight loss percent) in 30 days a desired. Diet-changed Average PO (by mou meals with 4 meals do 7.5mg started on 8/29 Recommendations: 6 (nutritional supplement med pass. A nursing behavior no noted the resident was the shift. Unsuccessful.	the Registered Dietician dated following: Resident had a sof 37 pounds (21.8 and the weight loss was not do to finger foods 8/29/18. The intake 55 percent of eclined in 7 days. Remeron 19/18 to increase appetite. To milliliters Resource 2.0 and three times a day with the dated 8/30/18 at 8:04 PM alked the hallways most of ully redirected to sit to rest.			A 100% audit of all residents□ current MDS assessment was initiated on 11/19/2018 by the Director of Nursing (DON), Assistant Director of Nursing (ADON), Registered Nurse (RN) Unit Managers to include Resident # 76 to identify any significant changes in residuatus. This audit will be completed by DON, ADON, RN Unit Managers using resident census. A significant change assessment will be completed by the MDS nurse during the audit for any identified areas of concern with the oversight from the DON to be completed 11/30/2018. An in-service was completed on 11/19/2018 for the MDS nurses by the Registered Nurse MDS Consultant regarding the definition of a significant	the a	
		weight due to decreased			change, how to identify a significant change in resident status. All newly him	ired	

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NAME OF D		345335	B. WING	OTDEET ADDRESS SITV STATE ZID SOE	•	11/08/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL)E		
FRANKLI	N OAKS NURSING AND	REHABILITATION CENTER		1704 NC HIGHWAY 39 N			
		NEW CENTER		LOUISBURG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY 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) COMPLETION DATE	
F 637	Continued From pag	e 2	F 63	37			
	supplements.			MDS nurses will be provided	the		
	Саррістістіс.			in-service during orientation b			
	A Weight review note	e dated 9/6/18 revealed the		Facilitator (SF) regarding the			
		y being reviewed by the		a significant change, how to i			
		weight loss and revealed		significant change in resident			
	•	ody weight 130-145. Usual					
		weight 135. Diet changed to		10% of completed residents I	MDS□s to		
	_	o her behaviors of constant		include Resident # 76, will be			
	activity and pacing. F	Registered dietician has		the DON, ADON and RN Uni	t Managers		
	seen. Placed on Ren	neron and then changed to		to ensure significant changes	are		
	Marinol (appetite stin	nulant) and 2 mighty shakes		identified and a significant ch	ange		
	with meals.			assessment was completed v			
				identified utilizing an MDS Ac			
		ht was documented as 135		Tool weekly for 8 weeks and			
		36 pounds on 9/12/18 and		month. Any identified areas of			
	137 pounds on 9/19/	18.		be immediately addressed by include additional training and			
		imum Data Set (MDS)		modifications to the MDS ass	essment as		
		rly) dated 9/24/18 revealed		indicated. The Administrator			
	-	extensive assistance with		and initial the MDS Accuracy			
		g except for eating with		weekly for eight weeks and the			
	-	upervision and cueing to eat.		for one month for accuracy a			
		ht was documented as 136		all areas of concerns have be	en		
		lent had not experienced a		addressed.			
	significant weight los	s in the past month.		The Administrator will forward	d the results		
	A physician 's progre	ess note dated 10/30/18		of the MDS Accuracy QI Tool			
		ported the resident had a		Executive QI Committee mor			
		e over the weekend. The		months. The Executive QI Co	•		
	note revealed the res	sident remained incoherent,		meet monthly x 3 months to r	eview the		
	not agitated and was	cooperative at that time.		audit results of the MDS Accu	ıracy QI Tool.		
				Any issues, concerns, and/or	trends		
	On 11/6/18 at 1:57 P			identified will be addressed b			
	conducted with Nurse			implementing changes as ne			
		stated she was responsible		include continued frequency	of		
		n the resident 's chart and		monitoring.			
	•	ed 9/24/18 for Resident #76.					
		resident was very active and					
	moving a lot with rep	etitive movements and this					

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		345335	B. WING			1	C 08/2018	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		1704	ET ADDRESS, CITY, STATE, ZIP CODE NC HIGHWAY 39 N ISBURG, NC 27549	1 11/	00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 637	Continued From page	e 3	F	537				
	was the reason for the Manager stated when MDS assessment the stabilized.	e weight loss. The Dietary n he coded the quarterly e resident 's weight had M, Nurse #3 stated in an						
	encourage her to eat	ve to sit with the resident and . The Nurse further stated ace around on the unit and						
	where Resident #76 the resident was gett appetite and she was of meals. The Nurse	M an interview was e #2 who worked on the unit resided. The Nurse stated ing medication for her s now eating 75-100 percent stated the only behavior she sident was her constant						
	conducted with Nurse resident 's weight los pacing on the unit an beginning was not so constant pacing. The the weight loss was r	M a second interview was e #1. The Nurse stated the ss was due to her constant d felt the issue in the much her not eating but the Nurse further stated when noted on 8/30/18 they interventions in place.						
	interview on 11/7/18 admitted the resident increased over time. admission the reside	nt was weighed weekly for 4 nt was stable so they went to						
		Consultant stated in an at 2:08 PM they had some						

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 637 F 641 SS=D	nurses fill in for the M further stated the res areas and a significate been done. The Cons MDS Nurse would not behaviors unless the problem was due to a Accuracy of Assessm	IDS Nurse. The Consultant ident had a change in two not change MDS should have sultant further stated the total the total the increased staff told her and felt the a communication issue.	F 6			12/6/18		
33-5	§483.20(g) Accuracy The assessment must resident's status. This REQUIREMENT by: Based on record rev facility failed to code (MDS) assessment a diagnoses (Resident Preadmission Screer (PASRR) (Resident # residents reviewed for The findings included 1. Resident #120 wa 2/19/2016. Her face diagnoses including redated for 2/19/2016. A review of Resident 10/16/2018 did not indepression. A review assessments dated 37/16/2018, did not indepression.	is not met as evidenced iew and staff interviews, the the Minimum Data Set ccurately in the areas of #120), and level II sing and Resident Review #89) for 2 of 25 sampled or MDS accuracy. : s admitted to the facility on sheet listed multiple major depressive disorder #120's annual MDS dated clude a diagnosis of of previous MDS /19/2018, 6/17/2018 and		F 641 The process that led to this de was Minimum Data Set Nurse failed to code diagnosis in secresident # 120. MDS Nurse fa Level 2 Preadmission Screeni Resident Review (PASRR) in resident # 89. Resident # 120, Minimum Data assessment was modified by the nurse on 11/9/2018 to reflect a coding of the diagnosis of dep Resident # 89, MDS assessment was modified by the MDS nurse or to reflect level 2 PASRR. MDS Resident #120 was transmitted accepted into the National Rep 11/9/2018 and the MDS for Rewas transmitted and accepted National Repository on 11/8/20	(MDS) tition I for illed to code ng and section A for a Set (MDS) the MDS an accurate ression. ent was a 11/7/2018 S for d and pository on esident # 88 into the	or S)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	(X3) DATE SURVEY COMPLETED	
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		345335	B. WING			11/08/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	10	
IVAIVIL OF T	NOVIDEN ON OUT FEEL			1704 NC HIGHWAY 39 N	=		
FRANKLII	N OAKS NURSING AN	ND REHABILITATION CENTER		LOUISBURG, NC 27549			
	I			· · · · · · · · · · · · · · · · · · ·			
(X4) ID PREFIX TAG	(EACH DEFICI	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMP	X5) PLETION PATE	
F 641	Continued From p	age 5	F 6	641			
	milligrams (mg) every review of a Physic documented Effexton On 11/6/2018 at 1 conducted with the nurse #1 stated Reserved.	or (an anti-depressant) 150 very morning for depression. A ian order dated 9/19/2018 or 220 mg daily for depression. 1:49 AM, an interview was e MDS nurse #1. The MDS esident #120 had a diagnosis of		A 100% audit of all residents current MDS assessments was on 11/19/2018 by the Director (DON), Assistant Director of N (ADON), Registered Nurse (R Managers to include Resident resident # 89 to ensure all cor MDS assessments are coded to include diagnosis of depresents.	s initiated of Nursing lursing N) Unit # 120 and npleted accurately		
		as not sure how it was not listed sments. The MDS nurse		to include diagnosis of depres level 2 PASRR. This audit will			
		make a modification.		completed by the DON, ADON Managers using a resident ce	I, RN Unit		
	conducted with the who stated the dia identified from a P 3/24/2016, and the	:06 AM, an interview was e Director of Nursing (DON) egnosis of depression was first sychiatric Physician note dated e face sheet with the date of orrect. The DON stated she		Modifications will be complete MDS nurse during the audit for identified areas of concern will oversight from the DON to be 11/30/2018.	r any h the		
	expected the MDS	6 to be coded correctly.		An in-service was completed 11/19/2018 for the MDS nurse Registered Nurse MDS Const	s by the ultant		
	with diagnoses ind depressive disord dementia. Resider indicated identificated resident identified	lad been admitted on 11/4/15 cluding bipolar disorder, major er, unspecified psychosis and ht #89's admission forms ation as a Level II PASRR (a las having a serious mental		regarding the proper coding of assessments as indicated in the Assessment Instrument (RAI) emphasis that all MDS assess completed accurately and coordinates and alignosis of deprint and accurate to include a diagnosis of deprint and accurate the accura	ne Resident manual with ments are ed correctly ession and		
	and federal guidel	·		level 2 PASRR. All newly hire nurses will be provided the induring orientation by the Staff (SF) regarding the proper cod	service Facilitator		
	A review of Resident #89's most recent comprehensive MDS assessment dated 1/6/18 did not indicate identification as a Level II PASRR.			assessments as indicated in t manual with emphasis that all assessments are completed a and coded correctly to include	ne RAI MDS ccurately		
	Social Worker (SV	24 PM an interview with the V) was conducted. The SW ssion, Resident #89 had been II PASRR.		of depression and level 2 PAS 10% of all current residents or MDS assessments to include	ompleted		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345335	B. WING _			1	C 08/2018
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 704 NC HIGHWAY 39 N DUISBURG, NC 27549		00/2010
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From page 6 On 11/07/18 at 11:33 AM an interview with MDS nurse #1 was conducted. MDS nurse #1 stated Resident #89 had a Level II PASRR identification. MDS nurse #1 also stated Resident #89's most recent comprehensive assessment had not been coded correctly. On 11/08/18 at 9:05 AM an interview was conducted with the Administrator (AD). The AD stated resident #89 had been identified as a Level II PASRR. She stated the MDS should have been coded correctly and reflected the Level II PASRR identification.		F6	120 and resident # 89, will be the DON to ensure accurate MDS assessments, including diagnosis of depression and PASRR utilizing an MDS Act Tool weekly for 8 weeks and month. Any identified areas a be immediately addressed be include additional training an modifications to the MDS as indicated. The Administrator and initial the MDS Accuracy weekly for eight weeks and the for one month for accuracy all areas of concerns have be addressed. The Administrator will forward of the MDS Accuracy QI Toolexecutive QI Committee months. The Executive QI Comeet monthly x 3 months to audit results of the MDS Accuracy Any issues, concerns, and/oridentified will be addressed be implementing changes as neinclude continued frequency monitoring.		the (1 will to as / ly ure Its	
F 657 SS=D	Care Plan Timing and CFR(s): 483.21(b)(2)		F 6	657	monitoring.		12/6/18
	be- (i) Developed within 7 the comprehensive as	orehensive care plan must days after completion of seessment. Territorial days after care plan must days after completion of seessment.					

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(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 657	resident. (C) A nurse aide weresident. (D) A member of for the extent puther resident and the resident and the resident resident and their resident not practicable for resident's care play (F) Other appropridisciplines as deteor as requested by (iii) Reviewed and team after each as comprehensive ar assessments. This REQUIREME by: Based on record facility failed to up reflect weight loss pacing for 1 of 2 rechange in status (failed to update the peripherally insert of 2 residents reviewed and #278). The findings included the peripherally insert of 2 residents reviewed and #278). The findings included the peripherally insert of 2 residents reviewed and #278 and #278 and had a behavioral disturbent for the resident #76 we 6/29/18 and had a behavioral disturbent for the resident #76 we 6/29/18 and had a behavioral disturbent for the resident #76 we 6/29/18 and had a behavioral disturbent for the resident #76 we 6/29/18 and had a behavioral disturbent for the resident #76 we 6/29/18 and had a behavioral disturbent for the resident #76 we 6/29/18 and had a behavioral disturbent for the resident #76 we 6/29/18 and had a behavioral disturbent for the resident for t	physician. urse with responsibility for the with responsibility for the ood and nutrition services staff. practicable, the participation of the resident's representative(s). ust be included in a resident's the participation of the resident representative is determined the development of the the the development of the the the development of the the the the development of the the the the development of the	F	F657 The process that led to this of was Minimum Data Set Nurse failed to update a Residents a significant change in status # 76. MDS Nurse failed to ucare plans for care of a periginserted central catheter (Plot Residents # 124 and Resident # 1278 care pla	se (MDS) care plan for s for Resident update the oherally CC) for ent # 278 with s reviewed reflect ght loss and tre identified dent # 124		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
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NAME OF DE	ROVIDER OR SUPPLIER	04000	1	STREET ADDRE	ESS, CITY, STATE, ZIP CODE	11	/08/2018	
NAME OF T	TOVIDER OR SOLT EIER							
FRANKLIN	OAKS NURSING AND	REHABILITATION CENTER		1704 NC HIGH				
				LOUISBURG	i, NC 27549			
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F 657	Continued From page	e 8	F 6	57				
	noted the resident wandered and was at risk for unsupervised exits from the facility related to cognitive impairment. There was not a care plan for other behaviors or for nutrition.			reflect th Catheter	d and revised on 11/9/2018 to nat Peripherally Inserted Cen r (PICC) were identified by the of Nursing.	itral		
	had severe cognitive extensive assistance except for supervision cueing for eating. It w weight was 173 poun Review of the resider resident weighed 170 8/1/18. A nursing progress not the resident was anxi hollering at the staff a nursing progress not noted the resident was anxinoted the re	6/18 revealed the resident impairment, required for activities of daily living n, encouragement and vas noted the resident's		initiated of Nursing (RN) Unifor resident loss, behat all aresident with area reflect the care of remarks of resident loss.	audit of all care plans was on 11/19/2018 by the Director (DON), Assistant Director of (ADON) and Registered Nur it Managers, including care plents # 76, resident # 124 and # 278 and residents with we haviors and PICC lines to en areas of the care plan reflect is individual needs to be ed by 11/30/2018. Any care plans of concerns will be updated as of concerns will be updated as esignificant change in statutes in the significant change in statutes with oversight from the of Nursing.	rse plans d eight sure the plans ed to is and		
	dated 8/24/18 at 3:48 PM noted the resident was anxious and pacing and refused breakfast and lunch and snacks were given in between meals. The resident's weight was documented as 133 pounds on 8/30/18. A progress note by the Registered Dietician dated 8/30/18 revealed the following: Resident had a significant weight loss of 37 pounds (21.8 percent) in 30 days and the weight loss was not			Consulta plan tear (MDS) C of Nursin RN Unit (DM), So Director completin each res	218 by the Registered Nurse ant with the interdisciplinary of members: Minimum Data Coordinator, MDS nurse, Director of Nurse, Assistant Director of Nurse, Dietary Managers, Dietary Manager ocial Worker (SW) and Activity on the requirements for ing a comprehensive care placed and to review and review of the reach resident change as	ed Nurse MDS ciplinary care um Data Set urse, Director or of Nursing, Manager and Activities s for e care plan for and revise the		
	Average PO (by mou meals with 4 meals d 7.5mg started on 8/29	d to finger foods 8/29/18. th) intake 55 percent of eclined in 7 days. Remeron 9/18 to increase appetite. 0 milliliters Resource 2.0		resident	t will be completed of 10% of □s care plans to include care r resident # 76, resident # 12	е		

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				1704 NC	HIGHWAY 39 N			
FRANKLI	N OAKS NURSING AN	ID REHABILITATION CENTER		LOUISE	BURG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 657	Continued From page	age 9	F 6	657				
F 057	(nutritional suppler med pass. A nursing behavior noted the resident the shift. Unsuccess A physician's prog the resident had lo oral intake and was upplements. A Weight review no resident was curre weight committee the following: Idea Usual weight 170. Changed to finger of constant activity dietician has seen changed to Marino mighty shakes with The resident's weighounds on 9/5/18, 137 pounds on 9/1 The most recent M Assessment (Quanthe resident required activities of daily limited which she required The resident's weighounds and the resident required and the resident's weighounds and the resident required the resident required the resident's weighounds and the resident required	ment) three times a day with Innote dated 8/30/18 at 8:04 PM walked the hallways most of asfully redirected to sit to rest. The stress note dated 9/4/18 noted st weight due to decreased as given nutritional The dated 9/6/18 revealed the ntly being reviewed by the for weight loss and revealed a body weight 130-145 pounds. Current weight 135. Diet foods related to her behaviors and pacing. Registered and Placed on Remeron and then all (appetite stimulant) and 2 an meals. Sight was documented as 135 and pounds on 9/12/18 and and 9/18. Itinimum Data Set (MDS) terly) dated 9/24/18 revealed and extensive assistance with a supervision and cueing to eat. and ght was documented as 136 and sident had not experienced a	F6	residence more RN plan utilization interests will revision for a second confusion for the community of the execution care and, interests were determined interests with the community of the execution care and the confusion care and the confusion for the care and the confusion	dent # 278 weekly x 8 weeks the othly x 1 month by the DON, ADO Unit Managers to ensure that the instance accurately reflects the resident instance and the care plan audit Tool. Tools in the care plan were plan team ment be retrained and the care plan were dimmediately by Director of Nany identified areas of concern. Administrator will review and initially a care plan audit Tool weekly a care plan audit areas of concern have been addressed. Administrator will present the firm of the QI care plan audit tool to the cautive Quality Assurance (QA) in mittee monthly for 3 months. The cautive QA Committee will meet in the plan audit tool to determine the plan audit tool to determine treator issues that may need further reventions put into place and to the plan audit tool to determine the need for further frequency in the plan audit tool to determine the need for further frequency in the plan audit tool to determine the need for further frequency in the plan audit tool to determine the need for further frequency in the plan audit tool to determine the need for further frequency in the plan audit tool to determine the need for further frequency in the plan audit tool to determine the need for further frequency in the plan audit tool to determine the need for further frequency in the plan audit tool to determine the need for further frequency in the plan audit tool to determine the need for further frequency in the plan audit tool to determine the need for further frequency in the plan audit tool to determine the need for further frequency in the plan audit tool to determine the need for further frequency in the plan audit tool to determine the need for further frequency in the plan audit tool to determine the need for further frequency in the plan audit tool to determine the need for further frequency in the plan audit tool to determine the need for further frequency in the plan audit tool to determine the need for further frequency in the plan audit tool to determine the need for further frequency in the plan audit	ON or e care t The object of the care triple of		
	The resident's Car reflect the weight le	e Plan was not updated to oss and interventions or of the od behavior of pacing on the						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345335	B. WING _	C 			
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZII 1704 NC HIGHWAY 39 N LOUISBURG, NC 27549	P CODE	11700/2010	
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F 657	revealed the staff rep decreased oral intake note revealed the res not agitated and was On 11/6/18 at 1:57 P interview the resident a lot with repetitive m reason for the weight On 11/6/18 at 3:02 P interview the staff has encourage her to eat the resident would pay would not sit down. On 11/7/18 at 8:25 A conducted with Nurse where Resident #76 the resident was gett appetite and she was of meals. The Nurse had seen from the repacing on the unit. On 11/7/18 at 9:57 A conducted with Nurse resident's weight loss pacing on the unit an beginning was not so constant pacing. The the weight loss was resident loss was resident.	as note dated 10/30/18 orted the resident had a e over the weekend. The ident remained incoherent, cooperative at that time. M Nurse #1 stated in an it was very active and moving ovements and this was the loss. M, Nurse #3 stated in an ive to sit with the resident and it. The Nurse further stated face around on the unit and M an interview was is #2 who worked on the unit resided. The Nurse stated fing medication for her is now eating 75-100 percent is stated the only behavior she is ident was her constant M a second interview was is #1. The Nurse stated the is was due to her constant id felt the issue in the in much her not eating but the Nurse further stated when inoted on 8/30/18 they interventions in place. AM an interview was	F	657			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL1 A. BUILDII	TIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED		
		345335	B. WING _			C 11/08/2018	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1704 NC HIGHWAY 39 N LOUISBURG, NC 27549	DE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 657	Continued From pa	-	F	957			
	resident's weight losit and put intervention. Manager stated who mid-September 201 weight loss and she weight range and hincreasing so he did loss to the resident. On 11/7/18 at 10:33 an interview they have tings and the did updates the care plathe weight loss should care Plan. The Director of Nurrinterview on 11/7/18 admitted the resident increased over time. On 11/7/18 at 1:45 conducted with the where the resident was part to the unit but her pure on 11/7/18 at 2:08. Consultant stated the resident had a charmal care to the unit but	AM MDS Nurse #1 stated in ave weekly weight loss etary manager is the one who can. The Nurse further stated all have been added to the unit manager is the pacing but her pacing but her pacing but Manager of the unit mesided. The Manager stated cing some when first admitted acing increased over time. PM the facility's MDS here were 2 areas in which the loge in status and a significant did have been done and these					
	7/3/2017. Resident	vas admitted to the facility on #124 was discharged to the 18 and re-admitted to the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		DNSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345335	B. WING				C 08/2018		
NAME OF PROVIDER OR SUPPLIER FRANKLIN OAKS NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1704 NC HIGHWAY 39 N LOUISBURG, NC 27549					
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F 657	infection to the right heripherally inserted (an intravenous line to antibiotics). Her Mini assessment dated 10 cognition to be intact intravenous antibiotic assessment date. A Physician order date for Vancomycin (an amilliliters (Sodium Chrintravenous (IV) ever Resident #124's care 10/4/2018 did not incobjectives and care to On 11/5/2018 at 9:51 conducted with Resident #124 line replaced on 11/3 On 11/7/2018 at 1:42 conducted with the Nowould have expected to the care plan, and On 11/8/2018 at 9:05 conducted with the Dana to be done line to be addressed	with diagnosis to include hip prothesis, and a central catheter (PICC) line used to administer mum Data Set (MDS) 1/10/2018 revealed her She had received s for 7 days prior to the sed 10/3/2018, was reviewed ntibiotic) 1.25 Grams in 250 loride) administered y day. plan last revised on lude a plan with measurable of address the PICC line. AM, an interview was lent #124 and an CC line in her right upper stated she just had the PICC //2018. PM, an interview was IDS nurse who stated she to see the PICC line added it was an oversight. AM, an interview was irector of Nursing (DON). as her expectation for the correctly, and for the PICC	F	557					
	10/12/2018, with diag								

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED		
345335			B. WING	B. WING			C 08/2018	
NAME OF PROVIDER OR SUPPLIER FRANKLIN OAKS NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1704 NC HIGHWAY 39 N LOUISBURG, NC 27549				
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F 657	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	657				

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NAME OF PROVIDER OR SUPPLIER FRANKLIN OAKS NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1704 NC HIGHWAY 39 N LOUISBURG, NC 27549	1 11133,2310
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODER OF T	JLD BE COMPLETION
F 657	On 11/8/2018 at 9:05 AM, an interview was conducted with the Director of Nursing (DON). The DON stated it was her expectation for the care plan to be done correctly, and for the PICC		F 65	7	
F 761 SS=D	line to be care planne Label/Store Drugs ar CFR(s): 483.45(g)(h)	nd Biologicals	F 76	1	12/6/18
	Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the applicable.	y and cautionary			
	Federal laws, the fac biologicals in locked	ordance with State and ility must store all drugs and compartments under proper , and permit only authorized cess to the keys.			
	locked, permanently storage of controlled the Comprehensive I Control Act of 1976 a abuse, except when package drug distribut quantity stored is mirribe readily detected. This REQUIREMENT by: Based on observation facility failed to store	cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the nimal and a missing dose can If is not met as evidenced on and staff interviews the un-opened vial of insulin in ailed to remove an expired		F 761 The process that lead to the deficient the facility failed to remove expired	-

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			A. Boilbling		С		
		345335	B. WING			11/08/2018	
NAME OF P	ROVIDER OR SUPPLIER		•	S1	TREET ADDRESS, CITY, STATE, ZIP CODE		
EDANKIII	I OVKS NIIBSING VND I	REHABILITATION CENTER		17	704 NC HIGHWAY 39 N		
INAME	TOARS HURSING AND I	KEHABIEHAHON GENTEK		L	OUISBURG, NC 27549		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	medication from the r	nedication cart for 1 of 4	F	761	Glucagon and unopened Lantus from 1 4 medication carts.	of	
	The findings included 1. The manufacturer's Insulin, under drug st insulin vials in the refidegrees Fahrenheit." An observation of the store medications for was conducted with the (DON) on 11/7/18 at 2 of unopened, undated the cart. The DON stathave been stored in the cart. The DON stathave been stored in the term of the cart on the outside of the expiration date of the in the box read 10/20 medication given by i situation when a resident mouth. The DON statfrom the pharmacy at	The manufacturer's package insert for Lantus sulin, under drug storage read: "Store unused sulin vials in the refrigerator between 36 to 46			The unopened vial of Lantus and out dated Glucagon were removed, discard and reordered from the pharmacy on 11/7/2018 by the Director of Nursing. 100% audit of all medication carts and medication rooms was completed on 11/7/2018 by the Registered Nurse (RN Unit Managers to ensure that medications requiring storage in refrigerator until opened were not on medication carts of medication was immediately removed, discarded and reordered from pharmacy Director of Nursing. 100% in-servicing was initiated on 11/7/2018 by the Staff Facilitator (SF) wall licensed nurses and medication aid regarding medications must be stored in refrigerator until opened to be completed by 11/30/2018. All newly hired licensed nurses and medication expirated ates and which medications must be stored in refrigerator until opened. The RN Unit Managers will monitor medication carts and medication rooms for expired medications and medication requiring refrigeration are refrigerated to requiring refrigeration are refrigerated.	N) ons or in Ey with es and ed d ve	

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345335 B. WING					C 11/08/2018			
NAME OF P	ROVIDER OR SUPPLIER	0.0000	<u> </u>	STREET AT	DDRESS, CITY, STATE, ZIP CODE	117	06/2016	
TO THE OT 1	NOVIDEN ON OUT FEEL				HIGHWAY 39 N			
FRANKLIN OAKS NURSING AND REHABILITATION CENTER					JRG, NC 27549			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 761	`		F 7	Expir 8 were Licen will be for an the a will re Expir 8 were completed to the control of the I QI Au Media Assu mont meet QI Au Media issue put in	red\Unopened Medications weekly eks and monthly x 1 month. All ased Nurses and Medication Aides are re-educated by the Staff Facilitary identified areas of concern duritudit. The Director of Nursing (DOI eview and initial the QI Audit tool red\Unopened Medications weekly eks then monthly x 1 month for oletion and to ensure all areas of ern were addressed. DON will present the findings of the didit tool Expired\Unopened cations to the Executive Quality areas (QA) committee monthly for the Executive QA Committee monthly for 3 months and review addit tool Expired\Unopened cations to determine trends and/ones that may need further interventing to place and to determine the neutron frequency of monitoring.	s ator ng N) / x ne r 3 will the r ons		