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	345335	A. BUILDING _____ B. WING _____	C 05/08/2025

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FRANKLIN OAKS NURSING AND REHABILITATION CENTER	1704 NC HIGHWAY 39 N LOUISBURG, NC 27549

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 5/5/2025 through 5/8/2025. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 4RLJ11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 5/5/2025 through 5/8/2025. Event ID# 4RLJ11. The following intake was investigated: NC00230078 1 of 1 complaint allegation did not result in a deficiency.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information	F 585		6/5/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/29/2025

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.

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F 585	Continued From page 1 on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;	F 585		

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F 585	Continued From page 2 (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with residents and staff, the facility failed to notify residents and resident representatives of the results of the investigation and any corrective	F 585	F585 Grievances On 5/28/2025, the Administrator completed a written grievance follow up	

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F 585	Continued From page 3 measures taken or to be taken by the facility as a result of the grievance. The facility also failed to ensure the residents' right to receive written notification of the decision regarding the grievance investigation and the date the decision was issued for 3 of 3 residents reviewed for the grievance process (Resident #42, Resident #52, Resident #95). The findings included: Review of the facility policy last revised 7/1/2018 titled "Resident Grievance Policy" read in part: The Administrator is responsible for overseeing, directing, and investigating grievances in a prompt manner. The Administrator will review the results of grievance investigations for conclusion, ensure confidentiality of grievance information and initiate corrective measures or actions in accordance with state law, state survey agency, quality improvement organization, or local law enforcement agency as indicated. The Administrator will assure the residents, or resident representatives, are notified timely of the results of the investigation, of any corrective measures taken, and notification will be documented. a. Resident #42 was admitted to the facility on 11/13/24. Review of the significant change Minimum Data Set assessment dated 4/11/25 revealed the resident was cognitively intact. Review of the grievances filed since the last standard survey on 4/18/24 revealed Resident #42 had filed a grievance with the facility on 2/14/25. The 2/14/25 grievance revealed	F 585	for resident #42 concern dated 2/14/25. A written follow-up will be provided to the resident/resident representative by 6/5/25. On 5/28/2025, the Administrator completed written grievance follow ups for resident #95 concerns dated 3/6/25 and 4/23/25. A written follow-up will be provided to the resident/resident representative by 6/5/2025. On 5/28/2025, the Administrator completed written grievance follow ups for resident #52 concerns dated 2/7/2025, 3/31/2025, 4/4/2025, and 4/10/2025. Written follow-ups will be provided to the resident/resident representative by 6/5/25. On 5/29/2025, the Social Worker and Assistant Administrator initiated an audit of all grievances for the past 30 days to ensure all grievances were investigated and that a Grievance Resolution Summary was reviewed with the resident and/or resident representative or a written copy of the grievance resolution was provided to the resident and/or resident representative when requested per the Resident Concern and Grievance guidelines. The Assistant Administrator will address all concerns during the audit to include completing an investigation as indicated and if requested providing a written Grievance Summary to the resident and/or resident representative. On 5/28/2025, the Social Worker initiated resident questionnaires with all alert and oriented residents regarding concerns.	

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F 585	Continued From page 4 Resident #42 complained of staff answering the call bell but did not assist her to the bathroom. The form had the Unit Manager #1 as the person receiving the grievance and the person responsible for completing the investigation. The area of outcome expectation of person voicing concern was not filled out. The grievance form investigation revealed staff went in to check on Resident #42 and told her she would be back because she was in the middle of providing care. Staff retraining was conducted was the action taken. The resolution section was checked no for investigation findings were reported to the person voicing concern and no written response was requested. There was no documentation for notification issuance of the decision regarding the grievance investigation. The Administrator signed off the grievance on 8/10/25. An interview was conducted with Resident #42 on 5/5/25 at 12:50 PM and she reported she had not received a written resolution regarding the outcome of the grievance she had reported and had not been informed verbally how the issue with staff answering the call bell and not assisting her was corrected. b. Resident #95 was admitted to the facility on 11/23/22. Review of the most recent quarterly Minimum Data Set assessment dated 3/25/25 revealed the resident was cognitively intact. Review of the grievances filed since the last standard survey on 4/18/24 revealed Resident #95 had filed 3 grievances with the facility on 3/6/25, and 4/23/25.	F 585	This questionnaire is to identify any resident concerns that have not been addressed by the facility and to ensure all grievances were investigated and that a Grievance Resolution Summary was reviewed with the resident and/or resident representative or a written copy of the grievance resolution was provided to the resident and/or resident representative when requested per the Resident Concern and Grievance guidelines. The Social Worker will address all concerns identified during the audit to include completion of a grievance form, investigation of concern and reviewing grievance summary response/providing written responses to the resident and/or resident representative per resident preference. The questionnaires will be completed by 6/5/2025. On 5/29/2025, the Administrator, Assistant Administrator, Director of Nursing and the Social Worker were in-serviced by the Facility Consultant regarding Resident Grievance Policy and Guidelines to include the Administrators responsibility to ensure all grievances are investigated, grievance form completed and the resident or resident representative will be notified timely of the results of the investigation of any corrective measures taken, and notification will be documented on facility grievance form. and the resident or resident representative are notified timely of the results of the investigation to include a written grievance summary response when requested of any corrective measures taken, and	

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F 585	Continued From page 5 The 3/6/25 grievance filed by Resident #95 was related to staff not waiting 3 to 5 minutes between eye drops during administration. The document showed the grievance was received by the nurse. The area of outcome expectation of person voicing concern was not filled out. The grievance form was assigned to the Director of Nursing. The grievance form investigation revealed Resident #95 had three different eye drops due at the same time for his left eye. Staff training on the administration of eye drops was conducted. The grievance resolution section was blank. The Administrator signed off the grievance on 3/7/25. The grievance filed on 4/23/25 was regarding ants on Resident #95's room windowsill. The document showed the grievance was received by the nurse. The grievance form investigation revealed 6 to 7 ants were observed on the windowsill. The area of outcome expectation of person voicing concern was not filled out. The grievance for was assigned to Maintenance. Resident's skin was assessed by the nurse, and room checked for open food. Maintenance sprayed windowsill inside resident's room and outside of room. Other rooms were checked, and the resident's room was deep cleaned. The grievance resolution section was blank except for the Administrator's signature on 4/24/25. An interview was conducted with Resident #95 on 5/8/25 at 2:40 PM and he reported he had not received a written resolution regarding the outcome of the grievances he had reported and had not been informed verbally. c. Resident #52 was admitted to the facility on 1/17/25.	F 585	notification will be documented on facility grievance form. Written responses will be provided timely upon request. All newly hired Administrator, Assistant Administrator, Director of Nursing and Social Workers will be educated during orientation by the Staff Development Coordinator. Five resident grievances will be reviewed by the Assistant Administrator during the Interdisciplinary Team Meeting (IDT) meeting utilizing the Concerns Audit Tool weekly x 2 weeks, then monthly for one month to ensure all grievances are investigated, grievance form completed and the resident or resident representative notified timely of the results of the investigation of any corrective measures taken, and notification will be documented on facility grievance form and the resident or resident representative notified timely of the results of the investigation to include a written grievance summary response when requested of any corrective measures taken. Written responses will be provided timely upon request. Any areas of identified concern will be immediately addressed by the Administrator during the audit to include completing an investigation as indicated and providing a written Grievance Summary to the resident and/or resident representative upon request. The Assistant Administrator will forward the results of the Concerns Audit Tool to the Quality Assurance Performance	

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F 585	Continued From page 6 Review of the quarterly Minimum Data Set assessment dated 1/21/25 revealed the resident was cognitively intact. Review of the grievances filed since the last standard survey on 4/18/24 revealed Resident #52 had filed 4 grievances with the facility on 2/7/25, 3/31/25, 4/4/25, 4/10/25. Review of the 2/7/25 grievance revealed Resident #52 complained she did not receive her nighttime insulin dose. The document showed the grievance was received by the nurse. The area of outcome expectation of person voicing concern was not filled out. The grievance was assigned to the Director of Nursing. The grievance form investigation indicated staff were interviewed and had administered Resident #95's nighttime insulin. There was no documentation in the action taken/action to be taken section. The resolution section was blank except for the Administrator's signature on 2/8/25. The 3/31/25 grievance revealed Resident #52 complained her room was too hot. The section for employee receiving the grievance was not filled out. The area of outcome expectation of person voicing concern was not filled out. The grievance was assigned to the Director of Nursing. The grievance investigation revealed the room temperature was at 71 degrees Fahrenheit and within normal range. The vent was closed by maintenance. The resolution section was checked no for investigation findings were reported to the person voicing concern and no written response was requested. There was no documentation for notification issuance of the decision regarding the grievance investigation. The Administrator signed off the grievance on	F 585	Improvement (QAPI) Committee monthly x 2 months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 585	Continued From page 7	F 585		

4/1/25.

The grievance filed by Resident #52 on 4/4/25 was related to a staff member not changing gloves between providing care of another resident and Resident #52. The nurse was the person who received the grievance. The area of outcome expectation of person voicing concern was not filled out. The grievance was assigned to the Director of Nursing. The investigation revealed the staff member completed a return demonstration of hand hygiene and glove donning and doffing. The resolution section was blank except for the Administrator's signature on 4/5/25.

Review of the grievance initiated by Resident #52 on 4/10/25 revealed staff did not get resident up the previous day as requested and Resident #52 did not receive her nighttime insulin. The Director of Nursing received the grievance. The area of outcome expectation of person voicing concern was not filled out. The grievance was assigned to the Director of Nursing. The grievance investigation revealed Resident #52 refused to allow staff to use the lift pad because she stated it was not in good repair. The investigation further revealed Resident #52 received her nighttime insulin. The resolution section was blank except for the Administrator's signature on 4/11/25.

An interview was conducted with Resident #52 on 5/8/25 at 2:50 PM and she reported she had not received a written resolution regarding the outcome of the grievances she had reported and had not been informed verbally of the grievance outcomes.

An interview was conducted with the Social

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Worker on 5/8/25 at 8:55 AM. The Social Worker stated concerns voiced by residents were written up on the Facility Concern/Grievance Form. The Social Worker revealed grievances were reviewed daily in the morning interdisciplinary team (IDT) explain meeting. The Social Worker stated the grievance was entered into the grievance log and sent to the responsible department for follow up. The Social Worker reported grievance follow-ups were communicated verbally. She indicated that the person filing a grievance could receive a written copy of the grievance resolution upon request.

An interview was conducted with the Director of Nursing (DON) on 5/8/25 at 9:05 AM revealed the grievances were reviewed daily in the morning interdisciplinary meeting and each evening in the evening interdisciplinary meeting. The DON stated once she received the concern, she or one nursing staff would conduct an investigation. The DON stated she sometimes discussed the outcome of the grievances verbally with the complainants. The DON stated once the investigation was completed and the grievance form filled out, the grievance forms were returned to the Administrator for review.

During an interview with the Administrator on 5/8/25 at 9:15 AM she stated she was responsible for coordinating the grievance process. She stated once she received the concern from the Social Worker, the concern was distributed to the department responsible for addressing the issue. The Administrator stated the grievances were returned to her to be reviewed as the grievance officer. The Administrator stated grievance resolutions were communicated verbally or in writing if requested.

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F 585	Continued From page 9 The Administrator stated she was not aware that there had to be written documentation of the grievance outcomes.	F 585		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to refer a resident with a newly identified serious mental illness for a Level II Preadmission Screening and Resident Review (PASRR) for 1 of 2 residents reviewed for PASSR (Resident #9). The findings included: Resident #9 was admitted to the facility on 2/19/2016 with diagnoses that included major	F 644	F644 Coordination of PASSR and Assessments On 5/27/2025, Resident #9 was referred to in the North Carolina (NC) Must System for the evaluation of a new Pre-Admission Screening and Resident Review (PASRR). Facility still awaiting new PASRR level from NC Must. On 5/23/2025, the Minimum Data Set	6/5/25

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F 644	Continued From page 10 depressive disorder and recurrent anxiety disorder. A Level I PASRR determination notification letter dated 2/19/2016 indicated "No further PASRR screening is required unless a significant change occurs with the individual's status which suggests a diagnosis of mental illness or mental retardation or, if present, suggests a change in treatment needs for those conditions." Resident #9's medical record revealed on 8/18/2023 she had a new diagnosis of bipolar disorder with depression. Review of Resident #9's medical record revealed no documentation indicating a Level II PASRR referral had been completed after the diagnosis of a serious mental illness had been made. Resident #9's annual Minimum Data Set (MDS) assessment dated 2/7/2025 revealed she had moderate cognitive impairment and did not have a PASRR level II. During an interview with the Social Worker on 5/7/2025 at 2:17 PM she revealed she was only able to locate the PASRR level I that was conducted on 2/19/2016. The Social Worker stated she was unaware that a PASRR level II referral had not been completed for Resident #9 after she was newly identified with the diagnosis of bipolar disorder with depression. The Social Worker stated she was responsible for submitting the PASRR level II referral. The Social Worker stated new mental health diagnoses were reviewed daily in the morning interdisciplinary team meetings and Resident #9 had been overlooked.	F 644	(MDS) nurse initiated an audit of all residents with serious Mental Disorders, Intellectual Disability, or a related diagnosis condition for a Level II resident review. This audit is to identify any resident with a Level II PASRR qualifying diagnosis to ensure the resident was assessed for the need to re-submit PASRR for evaluation. The MDS nurse and/or Director of Nursing will address all concerns identified during the audit to include submission of Level II PASSR evaluation/re-evaluation when indicated and education of staff. The audit will be completed on 6/5/2025. On 5/29/2025, an in-service on Level II PASRRs was completed by the Administrator with the Social Worker, MDS nurses, Admissions Director, Director of Nursing, Unit Managers and medical providers with emphasis on referral for evaluation/re-evaluation of PASRR following changes in mental health status or newly Level II qualifying diagnosis. All newly hired Social Workers, MDS nurses, Admissions Directors, Directors of Nursing, Unit Managers, and medical providers will be in-serviced during orientation on PASRRs regarding referral for re-evaluation following changes in mental health status. In-service will be completed by 6/5/25. All newly hired Social Workers, MDS nurses, Admissions Directors, Directors of Nursing, Unit Managers, and medical providers will be educated by the Staff Development Coordinator during orientation.	

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F 644	Continued From page 11 An interview was conducted with the Administrator on 5/8/2025 at 3:55 PM who revealed the Social Worker was responsible for Resident #9's PASRR review.	F 644	The Unit Managers will review all new admissions/re-admissions and all residents with a newly diagnosed serious mental disorder, intellectual disability, or a related diagnosis condition for a level II resident review weekly x 4 weeks, then monthly x 1 month utilizing the PASRR Audit Tool. This audit is to ensure that any resident with a newly written PASRR qualifying diagnosis is reviewed to determine the need for re-submission of PASRR through NC Must. The Unit Manager and MDS nurse will address all concerns identified during the audit to include completing a new PASRR review. The Administrator/Assistant Administrator will review the PASRR Audit Tool weekly for 4 weeks, then monthly for 1 month for completion to ensure all areas of concern were addressed. The Quality Assurance Performance Improvement (QAPI) nurse will forward the results of the PASRR Audit Tool to the QAPI Committee monthly x 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the	F 814	F814- Dispose of Garbage and Refuse	6/5/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345335	A. BUILDING _____ B. WING _____	C 05/08/2025

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F 814	Continued From page 12 facility failed to ensure the dumpster was maintained free of leakage and pooled spillage for 1 of 1 dumpster. This practice had the potential to attract pests and rodents. The findings included: On 5/07/25 at 1:58 PM the dumpster area was observed. The middle bottom rim of the 22-foot-long compact dumpster was observed with a 6 inch by 4-inch buildup of gray sludge on the exterior side. From the sludge a large pool of milky grey liquid puddled, 6 feet long beside and underneath the dumpster. A second observation of the dumpster on 5/08/25 at 9:25 AM revealed the middle bottom rim of the 22-foot-long compact dumpster was observed with a 6 inch by 4-inch buildup of gray sludge on the exterior side. From the sludge a large pool of milky grey liquid puddled, 6 feet long beside and underneath the dumpster and continued to spread 18 feet away from the dumpster. In an interview on 5/08/25 at 9:30 AM the Dietary Manager stated the dumpster had been emptied that week and trash company replaced that dumpster with the leaking dumpster. He indicated he would call the dumpster company and have the dumpster replaced. In an interview on 5/08/25 at 10:57 AM the Administrator stated all staff use the dumpster and should report on any concerns with the area to management.	F 814	Properly On 5/8/2025 at 4:00 PM, a GFL technician arrived at the facility and removed the compactor to take offsite for repairs due to ruptured seal. A temporary dumpster was brought to the facility. On 5/12/2025 at 9:00 AM, GFL delivered repaired compactor. On 5/12/2025, the Dietary Manager initiated an audit of the dumpster for 14 days to ensure the dumpster was free of leakage and pooled spillage. The Administrator will address all concerns found in the audit. This audit was completed on 05/26/2025. On 5/12/2025, an in-service for all staff was initiated by the Administrator and/or Assistant Administrator regarding reporting of any concerns with the dumpster area to management. This in-service will be completed by 6/5/25. After 6/5/25, all newly hired staff will be educated during orientation by the Staff Development Coordinator. The Maintenance Director will conduct dumpster observations 5 times a week x 4 weeks, then monthly x 1 month utilizing the Dumpster Audit Tool and will notify the Administrator of any concerns discovered. This audit is to ensure the dumpster is free of leakage and pooled spillage. The Administrator will address all identified concerns.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 814	Continued From page 13	F 814	The Quality Assurance Performance Improvement (QAPI) nurse will forward the results of the Dumpster Audit Tool the QAPI Committee monthly x 1 month for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	