		IDENTIFICATION NUMBER:	, ,	CONSTRUCTION		E SURVEY IPLETED
		345335	B. WING		01	C / <b>/12/2023</b>
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
FRANKLIN	N OAKS NURSING AND I	REHABILITATION CENTER		04 NC HIGHWAY 39 N DUISBURG, NC 27549		
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
E 000	Initial Comments		E 000			
F 000	investigation survey v through 1/12/23. The compliance with the r	equirement CFR 483.73, ness. Event ID # Z6Vt11	F 000			
	survey was conducted 1/12/23. Event # Z6V	complaint investigation d from 1/9/23 through T11. The following intakes 00191999, NC00196278, 94967.				
F 550 SS=G	3 of the 10 complaint substantiated with de Resident Rights/Exer CFR(s): 483.10(a)(1)	ficiency. cise of Rights	F 550			2/14/23
	self-determination, an access to persons an	ght to a dignified existence, nd communication with and				
	with respect and dign resident in a manner promotes maintenance	and in an environment that be or enhancement of his or ognizing each resident's lity must protect and				
	access to quality care severity of condition,	cility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and				

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.

		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 02/22/2023 RM APPROVED O. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		E SURVEY IPLETED
		345335	B. WING			0.	C 1/12/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				17	704 NC HIGHWAY 39 N		
FRANKLIN	I OAKS NURSING AND I	REHABILITATION CENTER		L	OUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	provision of services residents regardless of §483.10(b) Exercise of The resident has the rights as a resident of or resident of the Unit §483.10(b)(1) The face resident can exercise interference, coercion from the facility. §483.10(b)(2) The resi free of interference, cor reprisal from the facilit rights and to be supp exercise of his or her subpart. This REQUIREMENT by: Based on observation and staff interview the residents ' dignity by incontinence care wh a resident he would h This made Resident a uncared for. The facilit	ansfer, discharge, and the under the State plan for all of payment source. of Rights. right to exercise his or her f the facility and as a citizen ted States. cility must ensure that the this or her rights without n, discrimination, or reprisal sident has the right to be coercion, discrimination, and ity in exercising his or her orted by the facility in the rights as required under this - is not met as evidenced ns, record review, resident e facility failed to maintain	F	550	F550 Resident Rights On 1/9/23, resident #36 was provided incontinent care by the nursing assis NA #2 was verbally educated by the Director of Nursing (DON) regarding resident rights and incontinent care. On 1/10/23, resident #235 was provided incontinent care by the nursing assis	tant. ded	
	Resident #325 stated complained of being to to her skin. This occu	r meal (Resident #235). she felt like "poop" and uncomfortable and burning rred for 2 of 2 residents ent #235) reviewed for			NA #4 was verbally educated by the Director of Nursing (DON) regarding resident rights and incontinent care. On 1/9/23, the Treatment Nurse completed a skin check on resident # and #235 with no new concerns iden On 1/10/23, the Nursing Supervisor initiated an audit of all residents who incontinent or require assistance with	tified. are	

Event ID: Z6VT11

Facility ID: 923025

If continuation sheet Page 2 of 22

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY
			5.4/14/0				С
		345335	B. WING			01/	12/2023
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RANKLI	N OAKS NURSING AND	REHABILITATION CENTER			704 NC HIGHWAY 39 N .OUISBURG, NC 27549		
		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETIC DATE
F 550	Continued From pag	e 2	F 5	50			
		admitted to the facility on			toileting. This audit is to ensure reside	nts	
		ses that included hemiplegia			had been provided incontinent		
	-	scles) and hemiparesis			care/toileting assistance timely to inclu	ıde	
		scles) following stroke.			during mealtime. The Nursing Supervi		
					will address all concerns identified dur	ing	
		num Data Set (MDS) dated			the audit to include providing incontine	ent	
		esident #36 was cognitively			care when indicated and education of		
		dependent on staff for toilet			staff. Audit was completed by the Nurs	sing	
		ssistance for personal			Supervisor on 1/10/23.	J	
	incontinent of bowel	36 was coded as always			On 1/10/23, the Social Worker initiated		
					questionnaires with all alert and orient residents regarding toileting	ea	
	During an observatio	n of Resident #36 on 1/9/23			assistance/incontinent care. This		
		seen propelling himself down			questionnaire is to identify any resider	nt	
		hair. Resident #36 stopped			with concerns related to toileting		
		rt and told the NA #5 that he			assistance/incontinent care to include		
	needed to see the Nu	ursing Assistant to be			care during mealtimes. The Nursing		
	cleaned up. The staf	f acknowledged she would			Supervisor will address all concerns		
	let the nursing assist	ant know.			identified during the audit to include providing toileting assistance/incontine	ent	
		nducted with Resident #36 on			care when indicated and education of		
		esident #36 stated that he			staff. Questionnaires were completed	by	
		aned up every day. Resident			1/12/23.		
		as tired of sitting in the			On 1/31/2023, the Administrative Nurs initiated an in-service with all nurses a		
		nt #36 stated sometimes it an hour for someone to			nursing assistants regarding Dignity a		
		I that it made him feel			Respect-Incontinent Care with emphasis		
		set that staff acted like they			on providing toileting	010	
	-	needed to be changed.			assistance/incontinent care timely, ste	ps	
		5			to provide toileting assistance/incontin		
	An observation and i	nterview were conducted of			care during mealtime and obtaining		
	<b>.</b>	A) #2 on 1/9/23 at 1:33 PM.			assistance when care cannot be provi		
		telling Resident #36 that she			timely by assigned staff. In-service wil		
		de him with incontinent care			completed by 2/14/2023. After 2/14/23		
		taking up the meal trays off			any nurse or nursing assistant who ha		
		terview with NA #2 she			not worked or received the in-service		
		I not change Resident #36			complete it prior to the next scheduled		
		were on the hall. NA #2			work shift. All newly hired nurses and	ring	
	i sialeu inal incontiner	nce care was provided as			nursing assistants will be educated du	nng	1

Facility ID: 923025

If continuation sheet Page 3 of 22

		ID HUMAN SERVICES				F	TED: 02/22/2023 ORM APPROVED
STATEMENT O	S FOR MEDICARE & F DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) I	NO. 0938-0391 DATE SURVEY COMPLETED
		345335	B. WING				C 01/12/2023
NAME OF PI	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE		0
				17	704 NC HIGHWAY 39 N		
FRANKLIN	I OAKS NURSING AND	REHABILITATION CENTER		L	OUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 550	hours. An observation trays were still in the #36 was provided income An interview was conn Nursing on 1/9/23 at that she expected that trays, take care of the hygiene, and continue 2.Resident #235 was 1/7/23 with multiple d tract infection. An interview was conn 1/9/23 at 10:10 AM. N #235 was alert and o During an interview wa 1/10/23 at 10:13 AM had asked to be charn 8:15 AM and knew th on her wall and staff stated they were busy when they got time. F this made her feel "like lay in urine and bowe room. Resident #235 uncomfortable and busi incontinent due to the Resident # 235 stated breakfast meal soiled present or evidence of linens. An interview was connected the state of the states of th	added on the residents every 2 on revealed that the meal hall at 1:33 PM. Resident continent care at 1:50 PM. ducted with the Director of 1:35 PM. The DON stated at staff would stop passing e resident, perform hand e to pass out trays. admitted to the facility on iagnoses to include urinary ducted with Nurse #2 on Nurse #2 stated Resident riented X 4. with Resident #235 on Resident #235 stated she nged before breakfast about e time because of the clock (unable to recall which staff) y and would change her Resident #235 stated that would change her Resident #235 stated that the poop" because she had to el while her meal was in the stated that it was urned when she was e open area on her buttocks. d that she had to eat her 1. There were no odors of incontinence on the bed	F	550	orientation regarding Dignity and Respect-Incontinent Care. The Administrative Nurses will comp 10 resident care audits for incontiner care to include resident #36 and resi #235 weekly x 4 weeks then monthly month utilizing the Resident Care Au Tool. This audit is to ensure all reside to include resident #36 and resident are offered toileting assistance/incon timely care to include incontinent car during mealtime when indicated per facility protocol. The Administrative Nurses will immediately address all concerns identified during the audit to include but not limited to providing incontinent care when indicated and/ re-training of staff. The Director of Ne will review and initial the Resident Ca Audit Tool weekly x 4 weeks then mo x 1 month for completion and to ensu areas of concern are addressed. The Administrator will forward the resi of Resident Care Audit Tool to the Qu Assurance Performance Improvement (QAPI) Committee monthly x 2 mont The QAPI Committee will meet mont 2 months and review the Resident C Audit Tools to determine trends and issues that may need further interver put into place and to determine the m for further and/or frequency of monitor	at dent y x 1 dit ents, #235, tinent e o y y y y are onthly ure all sults uality nt hs. hly x are ( or utions eed	
	Assistant #4 who was	ducted with Nursing s assigned to Resident #235 M. NA #4 stated that she					

Facility ID: 923025

If continuation sheet Page 4 of 22

CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES				RM APPROVE IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING			TE SURVEY MPLETED C
		345335	B. WING		0	1/12/2023
NAME OF P	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CO	•	
FRANKLI	N OAKS NURSING AND	REHABILITATION CENTER		INC HIGHWAY 39 N IISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 550 F 580 SS=D	had not been made a needed assistance. N wait until after she ha trays before providing stated that incontinent every 2 hours and as stated she was alway the residents. NA#4 s Resident #235 at the 7:30 AM. Incontinent resident at 10:40 AM An interview was con Nursing (DON) on 1/1 stated that she expect passing trays, take ca hand hygiene, and co Notify of Changes (In CFR(s): 483.10(g)(14) S483.10(g)(14) Notified (i) A facility must imm consult with the resid consistent with his or representative(s) whe (A) An accident involver results in injury and h physician intervention (B) A significant chan mental, or psychosoc deterioration in health status in either life-thi- clinical complications (C) A need to alter tra-	ware that Resident #235 NA #4 stated that she would ad passed out the breakfast g incontinent care. NA #4 at rounds were conducted needed. NA #4 further as on the hall checking on stated she had rounded on beginning of the shift about ce care was provided to the ducted with the Director of 10/23 at 10:45 AM. The DON cted that staff would stop are of the resident, perform ontinue to pass out trays. jury/Decline/Room, etc.) 4)(i)-(iv)(15) cation of Changes. nediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which has the potential for requiring n; ge in the resident's physical, cial status (that is, a n, mental, or psychosocial reatening conditions or ); eatment significantly (that is, e an existing form of erse consequences, or to	F 550	DEFICIENC	Y)	2/14/23

Facility ID: 923025

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		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 02/22/202 RM APPROVE IO. 0938-039
TATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		TE SURVEY IPLETED
		345335	B. WING		0,	C 1/12/2023
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1704 NC HIGHWAY 39 N LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	(14)(i) of this section, all pertinent informati is available and provi physician. (iii) The facility must a resident and the reside when there is- (A) A change in room as specified in §483. (B) A change in resid State law or regulatio (e)(10) of this section (iv) The facility must fundate the address (findate the address	lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ons as specified in paragraph t. record and periodically mailing and email) and resident osite distinct part. A facility istinct part (as defined in e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations T is not met as evidenced iews, staff, and Responsible a, the facility failed to notify on change for 1 of 1 resident 6) reviewed for notification of	F 58	0 F580 Notification of changes On 2/8/23, the Assistant Direc Nursing reviewed current med treatment orders for resident ≠ resident representative. A cop resident⊡s current medication provided to the resident repre mail. The identified nurse was	lication/ #6 with the by of the n orders was sentative by	

Event ID: Z6VT11

Facility ID: 923025

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938	<u>8-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		345335	B. WING		C 01/12/202	23
IAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP C	•	
RANKLI	N OAKS NURSING AND	REHABILITATION CENTER		1704 NC HIGHWAY 39 N LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMP THE APPROPRIATE D	(X5) PLETIC DATE
F 580	Continued From page	e 6	F 58	30		
	Resident #6 was adm 7/16/21 with diagnose disease, dementia wi and depression. Resident #6's electro revealed a medication Depakote 125 milligra mouth 2 times daily w by the Physician Assi entered in Resident # 125mg 3 capsules by A psychiatric consult Resident #6 was see Practitioner due to Re staff during care. The was prescribed Depa mood lability (rapid e) mood). The psychiatr in Resident's #6's De her continued comba The quarterly Minimu dated for 12/6/22 indi severely cognitively in Review of Resident # there was no docume was not notified of the A telephone interview Resident #6's RP on	hitted to the facility on es that included Alzheimer's th behavioral disturbance, nic medical record (emr) n order dated 6/9/22 for ams (mg) 2 capsules by vas discontinued on 6/29/22 stant. A new order was 6's emr for Depakote r mouth 3 times daily. note dated 9/29/22 revealed n by the Psychiatric Nurse esident hitting and grabbing e note stated Resident #6 kote for behaviors and xaggerated changes in ic note indicated an increase pakote dosage was due to tive behaviors. m Data Set assessment cated the Resident was mpaired. 6's progress notes revealed entation the Resident's RP e medication change.		re-educated on notification Resident changes by the D Nursing on 2/1/23. On 2/6/23, the Administrative initiated an audit of all newl physician orders and/or char for all residents to include r the past 30 days. This audit the resident and/or resident representative were notified written orders/changes in o changes in plan of care with documentation in the electr The Administrative Nurses concerns identified during t include notification of the re- representative and/or educ Audit will be completed by 2 On 2/6/23, the Administrative initiated an audit of progress past 14 days. This audit is the resident with an acute char but not limited to behaviors the resident was assessed, notified of acute changes for representative notified of acute and/or changes in plan of c documentation in the electr The Administrative Nurses concerns identified during t include but not limited to not resident representative and staff. The audit will be com	irector of ve Nurses y written anges in orders esident #6 for t is to ensure t d of newly rders or h ronic record. will address all he audit to esident/resident ation of staff. 2/14/23. ve Nurses as notes for the to identify any nge to include and to ensure physician or further dent cute change are with ronic record. will address all he audit to brification of d education of	
	change until she visit later. She indicated th	ed the facility several days ne Director of Nursing (DON) e medication change during		2/14/23. On 2/6/23, the Director of N a bright colored sign at eac station regarding Events Re Notification of Resident Re	lursing posted h nursing equiring	

Facility ID: 923025

If continuation sheet Page 7 of 22

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/22/2023 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345335	B. WING				C / <b>12/2023</b>
NAME OF P	ROVIDER OR SUPPLIER	·		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
EDANKI		REHABILITATION CENTER		17	704 NC HIGHWAY 39 N		
				L	OUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	A telephone interview with Nurse #4. She in Resident #6's care th change was made. T unable to recall if she the medication chang when the medical pro- medication regimen, responsibility to notify An interview was com 1:22pm with the Direc revealed it was the m contact the resident's medication change. A follow up interview 2:53pm with the DON expectation when a m	was completed on 1/11/23 adicated she was assigned to e evening the medication he Nurse stated she was e notified Resident #6's RP of ge. The Nurse indicated ovider changed a resident's it was the nurses' y the RP of the change.	F	580	include but not limited to adding, changing, or stopping medications. On 2/6/23, the Administrative Nurses initiated an in-service with all nurses regarding Notification of Changes wit emphasis on notification of the reside representative for a significant chang the resident's physical, mental, or psychosocial status and/or a need to to alter treatment to include adding, changing or stopping medications wit documentation in the electronic recor In-service will be completed by 2/14/2 After 2/14/23, any nurse who has not worked or received the in-service will complete prior to the next scheduled shift. All newly hired nurses will be educated during orientation regarding. Notification of Changes The IDT (Interdisciplinary Team) will a all newly written physician orders and changes in orders for all residents to include resident #6, five (5) times a w x 4 weeks then monthly x 1 month util the Notification Audit Tool. This audit ensure the resident and/or resident representative were notified of newly written orders/changes in orders or changes in plan of care with documentation in the electronic recor The Administrative Nurses will address concerns identified during the audit to include notification of the resident/ress representative and/or education of sta The Director of Nursing will review the Notification Audit Tool 5 times weekly weeks then monthly x 1 month to ensu- all concerns are addressed. The IDT team will review progress no	nt e in need h d. 23. work y audit /or eek lizing is to d. ss all ident aff. e x 4 ure	

Event ID: Z6VT11

Facility ID: 923025

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/22/2023 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345335	B. WING				C 12/2023
NAME OF PI	ROVIDER OR SUPPLIER		I	ST	IREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
FRANKLIN	N OAKS NURSING AND F	REHABILITATION CENTER		1704 NC HIGHWAY 39 N LOUISBURG, NC 27549			
(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 580	Continued From page	28	F	580	times a week x 4 weeks then monthly x month utilizing the Notification Audit To This audit is to identify any resident wit an acute change to include but not limit to behaviors and to ensure the residen was assessed, physician notified of acu- changes for further recommendations a resident representative notified of acu- change and/or changes in plan of care with documentation in the electronic record. The Administrative Nurses will address all concerns identified during t audit to include but not limited to notification of resident representative a education of staff. The Director of Nurse will review the Notification Audit Tool weekly x 4 weeks then monthly x 1 mo to ensure all concerns are addressed. The Administrator will forward the resu of Notification Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months The QAPI Committee will meet monthly 2 months and review the Notification A Tool to determine trends and/or issues that may need further interventions tha need to be put into place and to determ the need for further frequency of	ol. h ted t ute and e he ind sing nth lts y x udit t	
F 677 SS=E		or Dependent Residents	F	677	monitoring.		2/14/23
	out activities of daily I services to maintain g personal and oral hyg	ent who is unable to carry iving receives the necessary good nutrition, grooming, and giene; i is not met as evidenced					

Facility ID: 923025

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		MEDICAID SERVICES				OMB NO.		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE S COMPLE		
		0.45005				С		
		345335	B. WING			01/12	2/2023	
NAME OF P	ROVIDER OR SUPPLIER				CITY, STATE, ZIP CODE			
FRANKLII	N OAKS NURSING AND	REHABILITATION CENTER		1704 NC HIGHWAY LOUISBURG, NC				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	DVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE	
F 677	Continued From page	<b>a</b> Q	F 67	7				
		ns, record review, resident	1.07		Care Provided for Depende	ant		
		e facility failed to provide		Residents	care i romaca foi Deperiat			
		ng (ADL) care to residents			esident #36 was provided			
		on staff assistance for 3 of 3			care by the nursing assista	int.		
		36, Resident #235, Resident			verbally educated by the			
	#8) reviewed for ADL	care.			lursing (DON) regarding			
	The first in the local sector				nts and incontinent care.			
	The findings included	1:			resident #235 was provide care by the nursing assista			
	1 Resident #36 was a	admitted to the facility on			verbally educated by the	III.		
		ses that included hemiplegia			Jursing (DON) regarding			
	(inability to move mus				its and incontinent care.			
		ss of the muscles) following		-	resident #8 nails were			
	stroke.				l trimmed, and facial hair			
					r resident preference.			
	Resident #36 's care				istant #1 was verbally			
	revealed a goal that A	would be completed with		-	the Director of Nursing sident rights and incontine	nt		
		ain or achieve highest		care.		111		
		tioning. The interventions for			the Administrative Nurses			
	-	bathing-total dependence,			audit of all residents who a			
	personal hygiene/gro	oming extensive assistance.		incontinent of	or require assistance with			
					s audit is to ensure reside	nts		
		num Data Set (MDS) dated			ovided incontinent			
		esident #36 was cognitively dependent on staff for toilet			g assistance timely to inclu time. The Administrative	de		
		sistance for personal			address all concerns identi	fied		
		6 was coded as always			udit to include providing	lica		
	incontinent of bowel a	-			care when indicated and			
				education of	f staff. Audit will be comple	ted		
	-	n of Resident #36 on 1/9/23		by 2/14/23.				
		een propelling himself down			the Administrative Nurses			
		hair. Resident #36 stopped t and told the NA #5 that he			audit of nail care and facial			
	needed to see the Nu				esidents to include residen lit is to ensure all residents			
		acknowledged she would			ed nail care and facial hair			
	let the nursing assista				r resident preference. The			
					ve Nurses will address all			
	Further observation c	of Resident #36 revealed that		concerns ide	entified during the audit to			

Facility ID: 923025

If continuation sheet Page 10 of 22

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/22/2023 M APPROVEI D. 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345335	B. WING				C / <b>12/2023</b>
NAME OF PI	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				17	704 NC HIGHWAY 39 N		
FRANKLIN	N OAKS NURSING AND	REHABILITATION CENTER		L	OUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	Continued From page	<b>-</b> 10		677			
1 0/1				0//			
		, he propelled himself into			include providing nail care and remov		
		s call light. Resident #36 If back out into the hall.			facial hair per resident preference. Th audit will be completed by 2/14/23.	C	
		il back out into the fiait.			On 1/12/23, the Social Worker initiate	d	
	An interview was con	ducted with Resident #36 on			questionnaires with all alert and orien		
	1/9/23 at 1:27 PM. Re	esident #36 stated that he			residents regarding (1) toileting		
	had to wait to be clea	ned up every day. Resident			assistance/incontinent care. This		
		as tired of sitting in the			questionnaire is to identify any reside	nt	
	-	nt #36 stated sometimes it			with concerns related to toileting		
		an hour for someone to			assistance/incontinent care to include		
	assist him.				care during mealtimes and (2) Reside		
	An observation and it	nterview were conducted of			Preference to identify resident prefere regarding nail care and facial hair. Th		
		A) #2 on 1/9/23 at 1:33 PM.			Administrative Nurses will address all		
		dent #36 that she was not			concerns identified during the audit to		
	able to provide him w	vith incontinent care until she			include providing toileting		
		p the meal trays off the hall.			assistance/incontinent care when		
		vith NA #2 she stated that			indicated, updating care plan for resid		
	-	e Resident #36 while the			preference when indicated and educa		
	meal trays were on th	ne hall.			of staff. Questionnaires will be comple	eted	
		duated with NA #2 are 1/0/22			by $2/14/23$ .		
		ducted with NA #3 on 1/9/23 ated it was unsanitary to			On 2/6/23, the Administrative Nurses initiated an in-service with all nurses a	and	
		ile distributing meal trays to			nursing assistants regarding (1) Digni		
		I that staff were supposed to			and Respect-Incontinent Care with	- ,	
		ey could wait a few minutes			emphasis on providing toileting		
	until all of the trays w				assistance/incontinent care timely, ste		
					to provide toileting assistance/incontin	nent	
		ducted with the Director of			care during meal time and obtaining		
		1:35 PM. The DON stated			assistance when care cannot be prov		
		at staff would stop passing			timely by assigned staff and (2) Resid	lent	
	trays, take care of the hygiene, and continu	e resident, perform hand			Preference/ADLs with emphasis on assisting residents with ADLs per		
	nygiene, and continu	e io pass out itays.			preference to include but not limited to	h	
	Resident #36 receive	d incontinent care at 1:50			nail care and removal of facial hair.	-	
	PM.				In-services will be completed by 2/14/	23.	
					After 2/14/23, any nurse or nursing		
	2.Resident #235 was	admitted to the facility on			assistant who has not worked or rece	ived	
	1/7/23 with multiple d	liagnoses to include urinary			the in-service will complete prior to th	e	

Facility ID: 923025

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						38-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVI COMPLETED	
			A. DOILDING		с	
		345335	B. WING		01/12/20	23
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CO		
				1704 NC HIGHWAY 39 N		
FRANKLI	N OAKS NURSING AND I	REHABILITATION CENTER		LOUISBURG, NC 27549		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	IPLETIO DATE
F 677	Continued From page	e 11	F 67	7		
	tract infection.			next scheduled work shift. A	All newly hired	
				nurses and nursing assistar	nts will be	
		e plan dated 1/9/23 revealed		educated during orientation		
		of Daily Living/Personal Care		Dignity and Respect-Inconti	nent Care and	
	-	with staff support to maintain actical level of functioning.		Resident Preference/ADLs. The Administrative Nurses	will complete	
	The interventions for			10 resident care audits to in		
	bathing, personal hyg	•		#36, resident #235 and resi		
		plus one staff physical		x 4 weeks then monthly x 1		
	assistance.			the Resident Care Audit Too	ol. This audit is	
				to ensure staff assist reside		
	During an interview w			per resident preference to in		
		Resident #235 stated she nged before breakfast and		limited to nail care, removal and offering toileting	of facial hair	
		which staff) stated they		assistance/incontinent time	v to include	
		change her when they got		incontinent care during mea		
	time.	5 5		indicated per facility protoco		
				Administrative Nurses will in	nmediately	
	An interview was con			address all concerns identif		
		assigned to Resident #235		audit to include but not limit		
		M. NA #4 stated that she		nail care, removing facial ha		
		ware that Resident #235 IA #4 stated that she would		incontinent care when indic re-training of staff. The Dire		
		d passed out the breakfast		will review and initial the Re		
	trays before providing	•		Audit Tool weekly x 4 weeks		
				x 1 month for completion ar		
		conducted of NA #4 providing		areas of concern are addres		
		esident #235 on 1/10/23 at		The Administrator will forwa		
		#235 was incontinent of urine ssues with the incontinent		of Resident Care Audit Tool Assurance Performance Im		
		rrier cream was applied		(QAPI) Committee monthly	-	
	Resident #235 's but			The QAPI Committee will m		
				2 months and review the Re		
		ducted with the Director of		Audit Tools to determine tre		
		10/23 at 10:45 AM. The DON		issues that may need furthe		
		ted that staff would stop		put into place and to determ		
		are of the resident, perform ontinue to pass out trays.		for further and / or frequenc	y of	
	i nanu nyyiene, and co	munue io pass out liays.		monitoring.		

Facility ID: 923025

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345335	B. WING				
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
FRANKLII	FRANKLIN OAKS NURSING AND REHABILITATION CENTER				1704 NC HIGHWAY 39 N _OUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 677	Continued From page	9 12	F	677			
	<ul> <li>2/19/06 with diagnose A review of the Minim 12/6/22 revealed Ress intact and was totally use and personal hyg refusals of care coded</li> <li>Resident #8 's care p goal that Activities of would be provided by impaired mobility.</li> <li>An observation of Res AM revealed she had fingernails that had a them. The facial chin length and her nails w with jagged edges.</li> <li>An interview was con 1/10/23 at 10:00 AM. staff had not offered t Resident #8 further st long and thick. She st longer than she liked recall when she last r</li> <li>An observation and ir with Resident #8 on 1 #8 had hair on her ch Resident #8 stated th someone would cut h Resident #8 's contract</li> </ul>	d for Resident #8. blan dated 7/3/19 revealed a Daily Living/Personal Care staff due to resident 's sident #8 on 1/10/23 at 9:57 facial chin hair and long brown substance beneath hair was about 1 inch in vere about 2 inches in length ducted with Resident #8 on Resident #8 stated that o shave the hair on her chin. tated that her nails were them. She was unable to eceived nail care. hterview were conducted 1/12/23 at 2:34 PM. Resident in and her nails were long. at she really wished er nails. The nails on acted right hand appeared to o of the hand. Resident #8					

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TATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	O. 0938-039 E SURVEY IPLETED
		345335	B. WING		01	C / <b>12/2023</b>
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1704 NC HIGHWAY 39 N LOUISBURG, NC 27549		
(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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 677	Continued From page	e 13	F 6	77		
F 867 SS=D	that Resident #8 's n need to have the hair stated that resident 's as needed. An observation and ir Nurse #3 on 1/12/23 Resident #8 's nails of that she was able to s Resident #8 's nails of that she was able to s Resident #8 's nails of that she was able to s Resident #8 's nails of that she was able to s Resident #8 's nails of that she was able to s Resident #8 's nails of that she was able to s shaved. An interview was con Nursing on 1/12/23 at that she expected that would be provided wi QAPI/QAA Improvem CFR(s): 483.75(c)(d)( §483.75(c) Program f monitoring. A facility must establis policies and procedur collections systems, a adverse event monito procedures must inclu following: §483.75(c)(1) Facility systems to obtain and from direct care staff, resident representativ information will be us	23 at 2:31 PM. NA #1 stated ails were long, and she did on her chin shaved. NA #1 s nails were to be trimmed herview conducted with at 2:34 PM revealed that were long. Nurse #3 stated smell an odor coming from Nurse #3 acknowledged hin hair needed to be ducted with the Director of t 3:01 PM. The DON stated at shaving and nail care th ADL care and as needed. ent Activities (e)(g)(2)(i)(ii) feedback, data systems and sh and implement written	F8	67		2/14/23

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		E CONSTRUCTION	(X3) DATE COMF	
		345335	B. WING				/12/2023
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRANKLIN	I OAKS NURSING AND I	REHABILITATION CENTER			1704 NC HIGHWAY 39 N LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 867	systems to identify, cc information from all de not limited to the facil §483.70(e) and include will be used to develop indicators. §483.75(c)(3) Facility and evaluation of per- including the methods development, monitor §483.75(c)(4) Facility including the methods systematically identify analyze and use data adverse events in the facility will use the da prevent adverse ever §483.75(d) Program s systemic action. §483.75(d)(1) The fac aimed at performance implementing those a and track performance implement policies ac	ovement. maintenance of effective ollect, and use data and epartments, including but ity assessment required at ding how such information op and monitor performance development, monitoring, formance indicators, ology and frequency for such ring, and evaluation. adverse event monitoring, s by which the facility will 7, report, track, investigate, and information relating to e facility, including how the ta to develop activities to nts. systematic analysis and cility must take actions e improvement and, after alized and sustained. cility will develop and ddressing: a systematic approach to causes of problems	F	867			
	(ii) How they will deve	elop corrective actions that					

Facility ID: 923025

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 02/22/2023 MAPPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345335	B. WING		_		C 12/2023
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
FRANKLII	N OAKS NURSING AND F	REHABILITATION CENTER		704 NC HIGHWAY 39 N OUISBURG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	level to prevent quality safety problems; and (iii) How the facility with of its performance implemsure that improvem §483.75(e) Program a §483.75(e)(1) The face performance improve high-risk, high-volume consider the incidence of problems in those a outcomes, resident sa resident choice, and o §483.75(e)(2) Perform activities must track m resident events, analy implement preventive that include feedback facility. §483.75(e)(3) As part improvement activities distinct performance in number and frequenc conducted by the faci and complexity of the available resources, a assessment required Improvement projects annually a project tha problem-prone areas	rect change at the systems y of care, quality of life, or II monitor the effectiveness provement activities to pents are sustained. Activities. Solution the effectiveness provement activities to pents are sustained. Activities. Solution the effectiveness provement activities for its ment activities that focus on e, or problem-prone areas; e, prevalence, and severity areas; and affect health afety, resident autonomy, quality of care. Annote improvement nedical errors and adverse vze their causes, and actions and mechanisms and learning throughout the of their performance s, the facility must conduct mprovement projects. The y of improvement projects lity must reflect the scope facility's services and as reflected in the facility at §483.70(e). In must include at least t focuses on high risk or identified through the data s described in paragraphs	F 867				

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 02/22/202 RM APPROVE O. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C - 01/12/2023		
		345335	B. WING				
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
FRANKLIN	I OAKS NURSING AND	REHABILITATION CENTER		1704 NC HIGHWAY 39 N LOUISBURG, NC 27549			
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 867	Continued From page	e 16 ssessment and assurance.	F 86	57			
	assurance committee governing body, or de functioning as a gove activities, including im program required und (e) of this section. Th (ii) Develop and imple action to correct idem (iii) Regularly review data collected under resulting from drug re available data to mak This REQUIREMENT by: Based on record rev Party interviews, the and Assurance (QAA maintain implemented interventions the com the complaint survey was for a recited define recertification and con notification of change during two federal su	erning body regarding its hplementation of the QAPI der paragraphs (a) through e committee must: ement appropriate plans of tified quality deficiencies; and analyze data, including the QAPI program and data egimen reviews, and act on the improvements. is not met as evidenced iews, staff, and Responsible facility's Quality Assessment ) Committee failed to d procedures and monitor imittee put in place following conducted on 3/4/21. This		F867 QAPI/QAA Improvemen On 2/6/23, The Administrator, Nursing and QA Nurse initiate previous citations and action p to F580 Notification of Change past 2 years to ensure the Qu Assurance Performance Impro (QAPI) committee has maintai monitored interventions that w place. Action plans were revis updated and presented to the Committee by QA Nurse for an identified. The Facility Consult	Director of d an audit of olans related e within the ality ovement ined and rere put into ed and QAPI ny concerns		
	failed to notify the RP	renced to: rd reviews, staff, and P) interviews, the facility of a medication change for ed (Resident #6) reviewed		Regional Vice President will a concerns identified during the include but not limited to the e staff. Audit will be completed b On 1/31/23, the Facility Consu- initiated an in-service with the Administrator, Director of Nurs and Quality Assurance (QA) N	audit to ducation of by 2/14/23. iltant sing (DON)		

Facility ID: 923025

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	02/22/2023 APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345335	B. WING _			01/12/2023		
					REET ADDRESS, CITY, STATE, ZIP CODE <b>704 NC HIGHWAY 39 N</b>	•		
FRANKLIN OAKS NURSING AND REHABILITATION CENTER			LC	DUISBURG, NC 27549				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 867	was cited for failing to the resident experien required an indwelling An interview was con Director of Nursing (I Consultant. The DOI committee met month ongoing performance DON indicated there plans in place for not Corporate Consultant expectation the facilit residents, reevaluate	survey on 3/4/21 the facility o notify a resident's RP when ced urinary retention and g urinary catheter. hpleted on 1/12/23 with the OON) and Corporate N indicated the QAA hly to discuss the facility's e improvement plans. The were no current monitoring ification of changes. The t indicated it was his y identify all affected	F	367	regarding the Quality Assurance (QA) process to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QA process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include professional standa In-service also included identifying iss that warrant development and establis a system to monitor the corrections ar implement changes when the expecte outcome is not achieved and sustainin an effective QA process. In-service will completed by 2/14/23. All newly hired Administrator, DON and QA nurse will educated during orientation regarding QA Process. All data collected for identified areas of concerns, to include notification of cha- will be taken to the Quality Assurance committee for review monthly x 6 mon by the QA Nurse. The Quality Assurance committee will review the data and determine if plans of corrections are b followed, if changes in plans of action required to improve outcomes, if furthes staff education is needed, and if increa- monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting the QA Nurse. The Facility Nurse Consultant and/or Regional Vice President will ensure th facility is maintaining an effect QA program by reviewing and initialing the Executive committee Quarterly meeting minutes and ensuring implemented procedures and monitoring practices t address interventions, to include	ards. ues hing d d g l be the f nge ths ce eing are er ased by e g		

Facility ID: 923025

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			()(0)		OMB NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		345335	B. WING		01/12/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FRANKLII	N OAKS NURSING AND	REHABILITATION CENTER		1704 NC HIGHWAY 39 N LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETIO	
F 867	Continued From pag	ie 18	F 867	<ul> <li>notification of change and all current citations and QA plans are followed an maintained Quarterly x2. The Facility Consultant and/or Regional Vice President will immediately retrain the Administrator, DON and QA nurse for identified areas of concern.</li> <li>The results of the Monthly Quality Assurance meeting minutes will be presented by the Quality Assurance N to the Executive Committee Quarterly for review and the identification of tren development of action plans as indicated to determine the need and/or frequence continued monitoring.</li> </ul>	any urse x 2 ds, ied	
F 914 SS=E	§483.90(e)(1)(iv) Be assure full visual priv §483.90(e)(1)(v) In 1 March 31, 1992, exc bed must have ceilin extend around the b privacy in combinatio curtains. This REQUIREMEN	-	F 914	1	2/14/23	
	facility failed to provi enough for visual pri 3 rooms on the 400			F914 Bedrooms Assure Full Visual Privacy On 1/11/23, the Housekeeping Superv replaced privacy curtains for rooms 42 415, 404, 302, 330, 335, 332, 338, and 341 to provide full visual privacy. On 1/11/23, the Housekeeping Superv initiated an audit of all resident rooms include rooms 421, 415, 404, 302, 330	isor to	

Event ID: Z6VT11

Facility ID: 923025

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		MEDICAID SERVICES				NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · · ·	(X3) DATE SURVEY COMPLETED	
		345335	B. WING			C )1/12/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT			
				1704 NC HIGHWAY 39 N			
FRANKLI	N OAKS NURSING AND	REHABILITATION CENTER		LOUISBURG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE SED TO THE APPROPRIATE SFICIENCY)	(X5) COMPLETIC DATE	
F 914	Continued From pag	e 10	E 01				
1 314			F 91		14 utilizina e vezident		
		1/11/23 at 12:45 PM noted			341 utilizing a resident		
	completely around be	in for room 421 did not go		place and provided f	vacy curtain were in		
		t of insufficient privacy		The Housekeeping S			
		ot allow full visual privacy			identified during the		
		as receiving care or when the			acing any curtain that		
		acy. The room was occupied		does not provide full			
		ed A was wide enough.		audit will be complet			
		artindo mao onough.			ninistrator initiated an		
	b. An observation on	1/11/23 at 12:55 PM noted		in-service with House			
		curtain for room 415 around			staff regarding Privacy		
		proximately 50 feet of		Curtains with empha			
	insufficient privacy cu			privacy curtains daily	÷		
		tain for bed A was wide		cleaning and to repla			
	enough.			curtain that does not	• • •		
				privacy. In-service v	vill be completed by		
	c. An observation on	1/11/23 at 12:58 PM noted		2/14/23. After 2/14/2	3, any housekeeping		
	there was no privacy	curtain for room 404 around		staff who have not w	orked or received the		
	bed B. There was ap	proximately 50 feet of		in-service will comple	ete upon the next		
	insufficient privacy cu	urtain. The room was		scheduled work shift	t. All newly hired		
	occupied and the cur	tain for bed A was wide		housekeeping staff v	vill be in serviced		
	enough.			during orientation reg	garding Privacy		
				Curtains.			
		1/11/23 at 1:02 PM noted		On 1/31/23, the Adm			
		in for room 302 did not go			e with all nurses and		
	completely around be			nursing assistants re			
		t of insufficient privacy			isis on when providing		
		ot allow full visual privacy			tain must provide full		
		as receiving care or when the		visual privacy. The n	÷		
		acy. The room was occupied		assistant are to notif			
	and the curtain for be	ed B was wide enough.			vacy curtains does not		
	o An observation on	1/11/23 at 1:05 PM noted			ivacy when providing and complete a work		
		in for room 330 did not go			will be completed by		
	completely around be			2/14/23. After 2/14/2			
		t of insufficient privacy			o have not worked or		
		ot allow full visual privacy			ce will complete upon		
		as receiving care or when the		the next scheduled v			
		acy. The room was occupied			ing assistants will be		

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/22/2023 MAPPROVEI D. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMF	SURVEY
		345335	B. WING				C 112/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1	704 NC HIGHWAY 39 N		
FRANKLIN	I OAKS NURSING AND	REHABILITATION CENTER		L	OUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 914	Continued From page	e 20	F	914			
	and the curtain for be	ed A was wide enough. 1/11/23 at 1:07 PM noted		011	in serviced during orientation regardi Privacy Curtains. The Housekeeping Supervisor will au	-	
	completely around be	in for room 335 did not go ed B. There was t of insufficient privacy			10% of all resident rooms with privac curtains, to include rooms 421, 415, 302, 330, 335, 332, 338, and 341, ut	y 404,	
	when the resident wa	ot allow full visual privacy as receiving care or when the			a Privacy Curtain Audit Tool weekly x weeks then monthly x 1 month. This		
		acy. The room was occupied ed A was wide enough.			is to ensure that the privacy curtains provide full visual privacy when provi resident care. The Housekeeping	ding	
	-	1/11/23 at 1:08 PM noted in for room 332 did not go			Supervisor will immediately address identified areas of concern during the	-	
	completely around be				audit to include replacement of privation	су	
		t of insufficient privacy			curtains when indicated. The		
		ot allow full visual privacy			Administrator will review the Privacy	h a 14	
		as receiving care or when the acy. The room was occupied			Curtain Audit tool weekly x 4 weeks t monthly x 1 month for completion and		
	•	ed A was wide enough.			ensure all areas of concern are addressed.		
	h. An observation on	1/11/23 at 1:09 PM noted			The Administrator will forward the res	ults	
	that the privacy curta	in for room 338 did not go			of the Privacy Curtain Audit Tool to th	е	
	completely around be				QAPI Committee monthly x 2 months		
		t of insufficient privacy			The QAPI Committee will meet mont		
		ot allow full visual privacy			2 months and review the Privacy Cur		
		as receiving care or when the			Audit Tool to determine trends and /		
	-	acy. The room was occupied			issues that may need further interver put into place and to determine the n		
		ed A was wide enough.			for further and / or frequency of	eeu	
	i. An observation on	1/11/23 at 1:10 PM noted			monitoring.		
		in for room 341 did not go					
	completely around be						
		t of insufficient privacy					
	curtain. This would ne	ot allow full visual privacy					
		as receiving care or when the					
		acy. The room was occupied ed A was wide enough.					
	An interview was con	nducted with the Maintenance					

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 02/22/2023 APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345335	B. WING					C 12/2023
NAME OF P	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STAT	E, ZIP CODE	•	
FRANKLI	N OAKS NURSING AND	REHABILITATION CENTER			704 NC HIGHWAY 39 N OUISBURG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION VE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 914	Director on 1/11/23 a Director stated that so up the wrong size cur Director stated that h curtains and have the An interview was con Administrator on 1/11	t 1:10 PM. The Maintenance ometimes housekeeping put rtains. The Maintenance e would look at the privacy em changed. ducted with the /23 at 3:25 PM revealed that ery resident would have their	F	914				

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