DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____ OCT 03 2011	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN OAKS NURSING AND REHABILITATION CENTER	1704 NC HIGHWAY 39 N LOUISBURG, NC 27549

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on family and staff interviews the facility failed to ensure privacy when discussing resident concerns with family for 1 of 3 family interviews (Resident # 82).	F 164	Franklin Oaks Nursing and Rehabilitation Center acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of finding is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. This plan of correction is submitted as a written allegation of compliance. Franklin Oaks Nursing and Rehabilitation Center's response to this statement of deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Franklin Oaks Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this statement of deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda O. Harrington — TITLE: Administrator — (X6) DATE: 9/16/11

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 164	Continued From page 1 The findings include: Resident #82 was admitted to the facility on 4/2/2011, then re-admitted on 7/25/11 with the following cumulative diagnoses: cerebral vascular accident with left side hemi paresis, Bell's palsy, diabetes mellitus type II, vascular dementia, degenerative joint disease and agitation. On her current quarterly MDS (Minimum Data Assessment), dated 6/8/11, she was assessed with cognitive impairments, needing total assistance with her ADL's (Activities of Daily Living skills), had functional limitations on one side of her extremities and rejected care 4 to 6 days a week, but less than daily. During a tour of the facilty, the family member of Resident #82 was approached for an interview. On 8/23/11 at 11:47am, the family member stated that last week, she spoke to the Administrative Nurse #1 regarding a request she had made earlier for an investigation to determine the source of the injury her relative received. She stated that Administrative Nurse #1 spoke to her twice in the hall, outside of her office, which is infront of the main nurse's station and the conversation could be overheard by others. She commented, that she didn't appreciate it. She shared that the Administrative Nurse #1's office was not occupied and she felt that the conversation should have been contained there. On 8/25/11 at 2:20pm, the Administrative Nurse #1 was interviewed. She stated that last month,	F 164	F164 1. The Administrative Nurse was inserviced by the Social Worker on ensuring privacy when discussing resident information for Resident #82 and all other residents on 09/06/11. 2. Beginning on 08/31/2011 all interviewable residents were surveyed by the Social Worker utilizing a QI tool for Privacy/Grievances. A mailing of a QI survey tool to include ensuring Privacy was completed by Social Worker on 09/13/11 to 100% of Responsible Parties. All identified areas of concern received through the resident and family privacy surveys were addressed immediately by the SocialWorker/Administrator/ Director of Nursing through the grievance process. 3. Beginning on 9/03/2011 the Social Worker will inservice all staff to include new hires on ensuring privacy of resident information. The Social Worker will compare the Privacy inservice to the employee roster by 09/22/11 to ensure all staff have been inserviced.	9/22/11

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F 164	Continued From page 2 Resident #82 was combative with staff during personal care. The resident had received a superficial scratch to her forehead on a Friday, that was noticed by a family member, during a visit on Saturday. The Administrative Nurse #1 could not determine the source of the injury but wanted to assure the relative that she had fully investigated her concern. The Administrative Nurse #1 acknowledged that she commonly speaks to the relative in passing and when she saw her near the nurse's station she wanted to take the opportunity to update her with the investigation. She stated that she stood at the doorway to her office and spoke with the relative, even though her office was empty.	F 164	4. The Social Worker will complete QI surveys on ensuring privacy of resident information with 100% of interviewable residents weekly x 4 weeks, then monthly x 3 months to ensure privacy is maintained when discussing resident information. A mailing of a QI survey tool to include ensuring Privacy was completed by Social Worker on 09/13/11 to 100% of Responsible Parties. Family/Responsible Party Satisfaction Surveys to include ensuring resident privacy will be completed quarterly X 1 year by Social Services Director to 100% of Responsible Parties. Any identified areas of concern received through the resident/family privacy surveys will be addressed immediately by the Social Worker/Administrator/DON through the grievance process 5. The Administrator will forward the results of the resident/family survey audit tools to the executive QI committee monthly x 3 months for review.	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and facility policy review the facility failed to resolve grievance for 1 of 8 sampled residents (Resident # 146) Review of the " Resident Services Handbook " revealed, in part: " make sure clothing is properly marked with first and last name " ; " the facility is not responsible for missing personal items such as clothing " ; " loss of personal item notify	F 166		

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F 166	Continued From page 3 Social Worker " ; " Administrator has the right to assign investigation to designee " ; " at conclusion Administrator or designee will review findings with resident and family " . Review of the " Resident/Family Grievance Policy " revealed, in part: concerns reported to staff were to be forwarded to their Department Head, Supervisor, or Administrator and the Administrator would oversee resolution of the grievance process to include investigation, follow-up and notification of appropriate persons. Interview with Resident #146 on 8/23/11 at 9:52 AM revealed that he had a baseball cap that went missing 2 - 3 months ago. He stated that he reported the missing item to the Laundry Aide and asked for it to be replaced but had not heard back from anyone yet. Resident #146 further stated that he had mentioned the hat several times and he did not feel the issue had been resolved. On 8/25/11 at 12:19 PM, interview with the Housekeeping/Laundry Manager revealed he was not aware Resident #146 was missing a baseball hat. On 8/25/11 at 12:22 PM, interview with Laundry Aide #1 reveled that Resident #146 reported a missing baseball hat to her about 2 months ago. She stated that she looked for the hat but could not find it " but we wait a few days to see if it turns up " . Laundry Aide #1 indicated that when residents reported missing items to her she was to tell her Manager so he could write it up and the item might be replaced. She further stated	F 166	F166 1. Resident #146 was interviewed by the Social Worker on 08/25/11 and a Resident Concern was completed for the missing item. Resident #146 was reimbursed by the facility for the missing item on 08/31/11. 2. Beginning on 08/31/2011 all interviewable residents were surveyed by the Social Worker utilizing a QI tool for Resolution of Grievances. A mailing was completed by Social Worker on 09/13/11of a QI survey tool to include prompt resolution of grievances to 100% of Responsible Parties. All identified areas of concern received through the resident and family resolution of grievances surveys were addressed immediately by the SocialWorker/Administrator/ Director of Nursing through the grievance process. 3. Beginning on 9/03/2011 the Social Worker will in-service all staff to include new hires on following the correct process of the facility grievance policy. The Social Worker will compare the Grievance Inservice to the employee roster by 09/22/11 to ensure all staff have been inserviced.	9/22/11

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F 166	Continued From page 4 that she did not tell her Manager about Resident #146 ' s missing baseball hat. On 8/25/11 at 12:25 PM interview with the Housekeeping/Laundry Manager revealed that it was his expectation that staff pass on information about missing personal items to him so he could write it up, investigate and get back to the resident.	F 166	4. The Social Worker will complete QI surveys on prompt resolution of grievances with 100% of interview able residents weekly x 4 weeks, then monthly x 3 months to ensure prompt resolution of grievances. A mailing of a QI survey tool to include ensuring prompt resolution of greivances was completed by Social Worker on 09/13/11 to 100% of Responsible Parties. Family/Responsible Party Satisfaction Surveys to include prompt resolution of grievances will be mailed quarterly X 1 year by Social Services Director to 100% of Responsible Parties. Any identified areas of concern received through the resident/family prompt resolution of grievances surveys will be addressed immediately by the Social Worker/Administrator/DON through the grievance process 5. The Administrator will forward the results of the resident/family survey audit tools to the executive QI committee monthly x 3 months for review.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain a clean mattress for 1 (Resident #24) of 2 sampled residents with a double winged mattress. On 8/23/11 at 10 AM Resident #24 was observed resting in bed. A fitted sheet was not covering the double winged mattress under the resident. On 8/24/11 at 5:45 PM Resident #24 was observed in his room, sitting in his wheelchair. The resident ' s bed was made up with a bedspread covering approximately ¾ ' s of the bed. The mattress underneath was a double winged mattress and appeared to be bare; there was no fitted sheet visible.	F 253		

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F 253	Continued From page 5 On 8/25/11 at 11:25 AM the Resident was not in his room. The resident ' s bed was made up with a bedspread covering ¾ ' s of the bed. The mattress underneath was a double winged mattress and appeared to be bare; there was no fitted sheet visible. On 8/25/11 at 11:27 AM the Director of Nursing (DON) was present to pull back the bedspread and sheets of Resident #24 ' s bed. Under the bedspread were 3 draw sheets folded up into the middle of the mattress. Under these was a bed alarm pad. There was no fitted sheet on the mattress. When the bed alarm pad was lifted up there was a crumbly substance present, similar to bread and other food crumbs, moderately to sparsely spread throughout the approximately 2 foot by 2 foot area. The mattress had several random smudge marks and a scant amount of a white powdery substance on it. On 8/25/11 at 11:29 AM interview with the DON revealed that it was the responsibility of housekeeping to sanitize the mattresses but that it was her expectation that the Nursing Assistants would keep the mattress in a clean state and free of crumbs. She also stated that the double winged mattresses have a special fitted sheet that is supposed to be used on the mattress. On 8/25/11 at12:40 PM interview with Nursing Assistant # __ revealed that she was aware she should have placed a special fitted sheet on the mattress but that she did not do it because she was trying to hurry up and get her work done.	F 253	F253 1. The mattress of Resident #24 was cleaned of food debris/smudges/powdery substance on 08/25/11. 2. The Administrator and Housekeeping Supervisor completed a 100% audit of mattresses for cleanliness on 08/25/11. 3. The Director of Nursing and Housekeeping Supervisor began inservice training with 100% of nursing and housekeeping staff on 08/25/11 on observing mattresses and under bed alarms for cleanliness & cleaning soiled mattress upon observation. 4. The Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Social Worker, Admissions Coordinator, Ward Clerks, Activity Director, Supply Clerk, Lab Nurse, Housekeeping Supervisor & MDS Data Entry will completed a mattress audit tool on all mattresses 5 X week x 1month, then weekly x 2 months during daily rounds to ensure mattresses are free of food debris/stains/smudges. The Administrator will review and initial the mattress audit tools weekly to ensure the compliance. 5. The Administrator will forward the results of the audit tools to the Executive QI committee monthly x 3 months for review.	9/22/11
F 279 SS=B	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		

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F 279	Continued From page 6 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that care plan goals are measurable for 3 (Residents # 139, #76, #94) of 17 sampled residents and failed to develop a Comprehensive Care Plan for 1 (Resident #93) of 17 sampled residents. The findings include: 1a. Resident #139 was admitted to the facility on 07/12/11. The admission Minimum Data Set (MDS) assessment dated 07/19/11 indicated that the resident had a stage III pressure ulcer.	F 279	F279 1. The care plans of Residents #139, #76 and #94 were updated by the MDS nurse on 09/09/11 to include measurable goals. Resident #93 is no longer in the facility 2. On 09/13/11, the MDS Nurse began a 100% audit of care plans to ensure that each resident had a comprehensive care plan to include measurable goals. 3. The interdisciplinary care plan team was in serviced on 08/26/11 by the Director of Nursing on development of a comprehensive care plans for all residents to include measurable objectives (goals) and timetables to meet the residents needs. 4. The MDS nurse will audit all scheuduled care plans per the care plan calander for completion and inclusion of measurable goals utilizing a care plan audit tool weekly X 4 weeks, then monthly X 2 months. The DON will review the care plan audit tool weekly X 4 weeks, then monthly X 2 months to validate application of measurable goals and timetables. 5. The Administrator will forward the results of the audit tools to the Executive QI committee monthly x 3 months for review.	9/22/11

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F 279	Continued From page 7 The care plan for pressure ulcer was reviewed. The care plan goal was " current ulcer will not worsen thru next review " . On 08/25/11 at 5:30 PM, the MDS Nurse was interviewed. The MDS Nurse agreed that the care plan goal was not measurable and will work on it. 1b. Resident #139 was admitted to the facility on 07/12/11. The MDS assessment dated 07/19/11 indicated that the resident had no memory and decision making problems. Review of the resident's weights revealed that on admission (07/12/11), the resident weighed 375 lbs (pound) and on 08/17/11, the resident weighed 322 lbs., a 53 lbs. weight loss in one month. The care plan for nutrition was reviewed. The goal was " resident will maintain adequate nutrition thru next review " . On 08/25/11 at 5:30 PM, the MDS Nurse was interviewed. The MDS Nurse agreed that the care plan goal was not measurable and will work on it. 2. Resident #76 was admitted to the facility on 12/10/08 and was re-admitted on 04/11/11. The quarterly MDS assessment dated 08/08/11 indicated that the resident had no memory and decision making problems and was on dialysis.	F 279		

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F 279	Continued From page 8 The resident's weights were reviewed. On 05/03/11, the resident weighed 167 lbs and on 08/17/11, the resident weighed 183 lbs, 16 lbs weight gain in 3 months. The care plan for nutrition was reviewed. The goal was " will maintain adequate nutrition thru next review and will maintain adequate level of functioning thru next review " . On 08/25/11 at 5:30 PM, the MDS Nurse was interviewed. The MDS Nurse agreed that the care plan goal was not measurable and will work on it. 3. Resident #94 was admitted to the facility on 12/4/08. Cumulative diagnoses included dementia and psychosis. The most recent Minimum Data Set, a quarterly dated 06/06/11, revealed that Resident #94 required limited assistance of 1 person for transfers and extensive assistance of 1 person for walking in her room. The Care Plan, updated 7/21/11, included the problem, " Requires assistance/potential to restore or maintain max. (maximum) function of self-sufficiency for mobility characterized by the following functions: positioning, locomotion/ambulation r/t (related to) unstable health condition. " The goal read, " Resident will maintain or increase mobility function/strength/flexibility (range of motion) thru next review (estimated date 10/21/11). "	F 279		

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F 279	Continued From page 9 During an interview on 08/25/11 at 5:59 PM, Administrative Nurse #2 acknowledged that the goal was very vague and not measurable. 4. Resident #93 was admitted to the facility on 6/7/11 for comfort care with diagnosis including multi system organ failure, acute kidney failure, Diabetes Mellitus, chronic obstructive pulmonary disease, cardio vascular disease, acute pancreatitis and cholecystitis. The Resident expired on 6/29/11. The resident ' s Medical Record was reviewed and revealed a " Do Not Resuscitate " Order with an effective date of 6/7/11. The Physician ' s Orders included " Dilaudid 0.5 mg (milligrams) IV (Intravenous) Q2h (every 2 hours) PRN (as needed) mild pain, Dilaudid 1 mg IV Q2h PRN moderate pain, Dilaudid 2 mg PRN severe pain or shortness of breath " . Review of the " Risk Assessment - Wandering " dated 6/7/11 for Resident #93 revealed the resident was " chairfast total assist with transport " with a summary score on the assessment of 1. The form read, in part " A resident who scores greater than 5 is at risk. " Review of the " Fall Risk Evaluation " dated 6/7/11 for Resident #93 revealed " Chairfast - total assist with transport " , there were no other risk factors checked and the total score was 1. The form read, in part " A resident who scores 10 or higher is at risk for falls. " In addition " No	F 279		

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F 279	Continued From page 10 follow-up required " was checked. The Admission Minimum Date Set (MDS) dated 6/14/11 revealed the resident was cognitively impaired, had no wandering behaviors or falls, was on a pain management regimen, oxygen therapy and IV medications. Review of the Care Plan revealed an Interim Care Plan with no date. The Interim Care Plan listed two problems 1) " Trauma, Potential for R/T (related to) Wandering " and 2) " trauma, Potential for R/T Fall Risk. The associated goals were: 1) " whereabouts will be known to staff as demonstrated by no events of leaving facility " and 2) " resident will remain fee of injury as evidenced by no falls or accidents. " There were no other problem areas or goals within the interim care plan. Review of the " Interdisciplinary Care Plan Progress Notes " dated 6/30/11 revealed " ARD (Assessment Reference Date - the end point of the MDS assessment observation period) 6/14/11 CAA (Care Area Assessment) will not be completed due to resident expired " . Interview with the MDS Coordinator on 8/25/11 at 7 PM revealed that given the Assessment Reference Date (ARD) for Resident #93 was 6/14/11 the MDS and Care Assessment Area summaries were due to be completed on 6/20/11 and the Comprehensive Care Plan was due to be completed on 6/27/11. The MDS coordinator further revealed the CAA summaries had not been completed for Resident #93 by 6/20/11 or thereafter and a Comprehensive Care Plan was	F 279		

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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 11 not developed for Resident #93 by 6/27/11 or thereafter. Interview with the Assistant Director of Nursing on 8/25/11 at 7:15 PM revealed all Interim Care plans are the same for all residents and include only wandering risk and fall risk. She further indicated that care plans are not individualized to include Pain Management or Comfort Care until the time of the Comprehensive Care Plan.	F 279		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F329 1. The Zinc for Resident #76 was discontinued on 08/25/11. 2. An audit of 100% of residents receiving medications with ordered stop dates to include Zinc was completed on 09/01/11 by the Director of Nursing and the Facility Nurse Consultant to ensure that all residents receiving medications with ordered stop dates to include Zinc had an appropriate stop date and medications were stopped per physician's order. 3. A 100% inservice for all licensed nurses was completed on 09/20/11 by the Director of Nursing on obtaining stop dates for Zinc Sulfate and marking the stop date on the Medication Administration Record for any medication with an ordered stop date.	9/29/11

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	345335	A. BUILDING _____ B. WING _____	08/25/2011

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

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F 329	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to discontinue the medication as ordered for 1(Resident #76) of 10 sampled residents. The findings include: Resident #76 was admitted to the facility on 12/10/08 and was re-admitted on 04/11/11 with multiple diagnoses including status post left above the knee amputation. The quarterly MDS assessment dated 08/08/11 indicated that the resident had no memory and decision making problems. Review of the resident's records revealed that on 05/21/11, the physician had ordered for Zinc Sulfate 220 mgs (milligram) by mouth daily for 60 days to promote wound healing, stop date 07/20/11. Review of the July, 2011 MAR (Medication Administration Record) revealed that Zinc Sulfate was not discontinued on July 20, 2011 as ordered and was administered to the resident the whole month. Review of the August, 2011 MAR revealed that the Zinc Sulfate was still administered to the resident daily as of 8/25/11. On 08/25/11 at 2:15 PM, the unit nurse supervisor was interviewed. She stated that the Zinc Sulfate should have been discontinued on	F 329	4. The Director of Nursing will audit all new orders received for all medications with ordered stop dates to include Zinc Sulfate to ensure medication is stopped per physician order. All identified medications with ordered stop dates to include Zinc Sulfate will be reviewed weekly X 4 weeks, then monthly X 2 months utlilizing a QI audit tool to ensure medication has been discontinued per physician order by the Director of Nursing. 5. The Administrator will forward the results of the audit tools to the Executive QI committee monthly x 3 months for review.	

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F 329	Continued From page 13 07/20/11 but was not. She stated that she would discontinue the medication on the MAR.	F 329		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to maintain their medication error rate 5% or below by not following doctor's orders and manufacturers' specification. There were 9 errors of 56 opportunities resulting to 16 % error rate. The findings include: 1 a. Resident #128 was admitted to the 05/19/10. On 05/19/10, there was a doctor's order for Glucophage 500 mgs by mouth twice a day, take with food for Diabetes Mellitus. On 08/24/11 at 4:35 PM, Nurse #1 was observed during medication pass. Nurse #1 was observed to prepare and to administer the resident's medications including the Glucophage. The nurse did not administer the medication with food as ordered. Dinner was scheduled to be delivered at 5:15 PM. On 08/24/11 at 5:00 PM, Nurse #1 was interviewed. She stated that dinner was about to be served and she would give crackers to the resident. She acknowledged that she did not	F 332	F332 1. Nurse #1 was retrained on administering meds as ordered by the physician to include giving meds with food when ordered & administering correct dosage as ordered by the QI Nurse on 08/25/11. Nurse #2 was restrained on administering meds as ordered by the physician to include following the Do Not Crush List & administering meds in the correct form as ordered by the QI nurse on 09/05/11. Nurse #3 was retrained on flushing gastric tubes prior to medication administration/administering meds with food when ordered/administration of meds per ordered times by the QI nurse on 09/07/11. 2. Med pass audits were completed on Nurse #1on 09/07/11, Nurse #2 on 09/13/11& Nurse #3 on 09/07/11 by the Director of Nursing/Assistant Director of Nursing.	9/29/11

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F 332	Continued From page 14 administer the medication with food. 1 b. Resident #128 was admitted to the facility on 05/19/10. On 02/25/11, there was a doctor's order for QVar 2 puffs inhaled orally twice daily for COPD (Chronic Obstructive Pulmonary Disease). On 08/24/11 at 4:35 PM, Nurse #1 was observed during the medication pass. Nurse #1 handed the inhaler to the resident and the resident inhaled 2 puffs without waiting at least a minute between puffs. The nurse was not observed to give instruction to the resident to wait at least a minute between puffs. On 08/24/11 at 5:00 PM, Nurse #1 was interviewed. She agreed that she did not instruct the resident to wait at least a minute between puffs. She also stated that she was not aware that the resident had already inhaled 2 puffs and she administered another puff giving the resident 3 puffs of Q Var. 2 a. Resident # 100 was admitted to the facility on 06/27/11. On 07/21/11, there was doctor's order for Potassium 7.5 ml (milliliter)/10 meq (milliequivalent) by mouth daily. On 08/24/11 at 8:23 AM, Nurse #2 was observed during the medication pass. Nurse #2 was observed to prepare the resident's medications including Klor-Con 10 meq tablet by crushing them and to administer the medications with pudding.	F 332	3. The Director of Nursing completed inservice training with 100% of medication nurses & medication aides on 09/20/11 on Medication Administration to include administering meds as ordered by the physician, administering meds with food when ordered, administering correct dosage as ordered, following the Do Not Crush List, administering meds in the correct form as ordered, flushing gastric tubes prior to administration of medication and administering meds as per ordered times. 4. The Director of Nursing/Assistant Director of Nursing & the facility Pharmacy Consultant completed Med Pass audits on 09/20/11 of 100% of medication nurses and medication aides. Nurses or Medication Aides observed with areas of concern were immediately retrained during the med pass audit by the DON/ADON or Pharmacy Consultant. Three medication nurses or medication aides will be observed during medication pass per week X 2 months to include all shifts and weekends by the ADON/SDC/Lab Nurse. The Director of Nursing will review the med pass audits weekly for further recommendations. 5. The Administrator will forward the results of the audit tools to the Executive QI committee monthly x 3 months for review.	

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F 332	Continued From page 15 A list of medications that should not be crushed was provided by the DON (Director of Nursing. Klor-Con tablet was one on the list that should not be crushed. On 08/24/11 at 8:35 AM, Nurse #2 was interviewed. She stated that she did not realize that the order for Klor-Con was on liquid form and she administered the tablet form. She also acknowledged that Klor-Con tablet should not be crushed but she had crushed it. 2 b. Resident #100 was admitted to the facility on 06/27/11. On 08/02/11, there was a doctor's order to increase the Dilantin from 100 mgs twice a day to 200 mgs (8 ml) by mouth twice a day for Seizure Disorder. On 08/24/11 at 8:23 AM, Nurse #2 was observed during the medication pass. She was observed to prepare the resident's medications including Dilantin 100 mgs 2 capsules. On 08/24/11 at 8:35 AM, Nurse #2 was interviewed. She stated that she did not realize the order was to give in liquid form and she administered the capsule form. 3. Resident #28 was admitted to the facility on 07/14/08. On 07/14/08, there was an order for Aspirin 325 mgs by mouth daily. On 08/24/11 at 8:32 AM, Nurse #2 was observed during the medication pass. She was observed to	F 332		

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F 332	Continued From page 16 prepare and to administer the resident's medications including Enteric Coated Aspirin 325 mgs. tablet. On 08/24/11 at 8:35 AM, Nurse #2 was interviewed. She stated that she was not aware that Aspirin 325 mgs comes in 2 forms, plain Aspirin and Enteric Coated Aspirin. An undated facility policy entitled " Administration of Oral Medications through a Nasogastric Tube or Gastrostomy Tube " read in part, " For unstabilized gastrostomy tubes: test for placement by aspiration of stomach contents. Verify tube patency by instilling small amount of water, 1-2 ounces (30-60 milliliters) in the syringe. " 4 a. Resident #72 was admitted to the facility on 11/19/10. Diagnoses included status post gastrostomy tube (G tube), chronic obstructive pulmonary disease and chronic diarrhea. On 08/24/11 at 9 AM, Nurse #3 was observed administering medications via gastric tube (G tube) to Resident #72. The nurse checked placement by aspirating stomach contents, then immediately began to instill the medications. During an interview on 08/25/11 at 11:40 AM, Nurse #3 stated she did not realize she needed to flush the tube with water prior to administering medications. 4 b. Resident #72 was admitted to the facility on 11/19/10. Diagnoses included status post gastrostomy tube (G tube), chronic obstructive	F 332		

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F 332	Continued From page 17 pulmonary disease and chronic diarrhea. Physician orders for August 2011 for Resident #72 included an order to administer Prednisone 10 milligrams via G tube and to give with food. On 08/24/11 at 9 AM, Nurse #3 was observed to administer the prednisone with other medications. Resident #72 was not offered any food. The resident's breakfast tray was not in her room. During an interview on 08/24/11 at 9:43 AM, Nurse #3 acknowledged that she had not given food with the prednisone. She stated that breakfast trays came early on the hall and that Resident #72 had already eaten. During an interview on 08/24/11 at 10:03 AM, Administrative Nurse #1 said that for medication ordered to be given with food, she expected the nurse to give the medication at meal time or with crackers. Administrative Nurse #1 added that Resident #72 liked graham crackers. 4 c. Resident #72 was admitted to the facility on 11/19/10. Diagnoses included status post gastrostomy tube (G tube), chronic obstructive pulmonary disease and chronic diarrhea. Physician orders for August 2011 for Resident #72 included an order to administer Senokot 1 tablet via G tube at bedtime every other day. On 08/24/11 at 9 AM, Nurse #3 was observed to administer the Senokot.	F 332		

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F 332	Continued From page 18 Review of the Medication Administration Record for August 2011 revealed that Resident #72 was to receive Senokot 1 tablet via G tube at bedtime every other day. The administration time was written as 0800 (8 AM). During an interview on 08/24/11 at 9:43 AM, Nurse #3 said she did not notice that the order was written for bedtime and would need to get clarification from the physician. 5. Resident #1 was admitted to the facility on 11/23/10. Diagnoses included status post gastrostomy (G) tube placement. On 08/24/11 at 9 AM, Nurse #3 was observed administering medications via gastrostomy tube (G tube) to Resident #1. The nurse checked placement by aspirating stomach contents, then immediately began to instill the medications. During an interview on 08/25/11 at 11:40 AM, Nurse #3 stated she did not realize she needed to flush the tube with water prior to administering medications.	F 332	F334 1. The Social Worker provided the responsible party of Resident #83 with educational materials regarding the benefits and potential side effects of the influenza vaccine on 08/26/11. 2. On 09/14/11the Admission Coordinator provided educational materials regarding the benefits and potential side effects of the influenza vaccine to 100% of interviewable residents. A mailing was completed by the Administrator on 09/09/11to 100% of responsible parties with educational materials regarding the benefits and potential side effects of the influenza vaccine. 3. The Director of Nursing completed inservicing of 100% of licensed nurses on providing annual education regarding the flu vaccine and receiving annual consent from the resident or responsible party on 09/20/11. On 08/26/11, the Admissions Coordinator and Social Worker were inserviced by the Administrator on providing educational materials regarding the benefits and potential side effects of the influenza immunization to the resident or legal representative on admission and required signature on the receipt of information acknowledgement form that materials had been provided.	9/20/11
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza	F 334		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 334	Continued From page 19 immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal	F 334	4. The Admissions Coordinator will complete a QI tool to monitor for receipt of educational materials regarding the benefits and potential side effects of the influenza vaccine for all new admissions. The Administrator will review and initial the new admit reciept of information acknowledgement audit tool weekly X 4 weeks, then monthly x 2 months to ensure the monitoring is taking place. A annual mailing will be completed by the Administrator to 100% of responsible parties with educational materials regarding the benefits and potential side effects of the influenza vaccine. The DON/ADON/SDC/Lab Nurse will validate receipt of educational material with documentation of receipt on the the resident immunization record prior to offering the flu immunization. The Admissions Coordinator will audit all residents immunization records monthly during flu immunization season to ensure validation of educational material has been completed. 5. The Administrator will forward the results of the influenza audit tools to the Executive QI committee monthly x 3 months for review.	

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F 334	Continued From page 20 representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide education regarding the benefits and potential side effects of influenza vaccine prior to offering the vaccine to 1 (Residents #83) of 5 sampled residents. The findings include: The facility's policy on Immunizations dated February, 2009 was reviewed. The policy read in part "Before offering the influenza or pneumococcal immunization, residents or residents' legal represenatives will be provided education regarding the benefits and potential side effects of these immunizations with documentation in the medical record."	F 334		

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F 334	Continued From page 21 Resident #83 was admitted to the facility on 11/3/09. Review of the resident's immunization record revealed that on 10/8/10, an influenza vaccine was administered to the resident. There was no documentation in the record that eduation regarding the benefits and potential side effects of influenze vaccine was provided to the resident and/or resident's representative prior to the administration of the influenza vaccine. On 8/25/11 at 1:00pm, the infection control nurse was interviewed. She stated that the Admissions Coordinator maintained copies of letters mailed to resident's represenatives which explained the benefits and potential side effects. On 8/25/11 at 2:05pm, the Admissions Coordinator was interviewed. She was unable to produce a copy of educational material for immunizations that was sent to Resident #83 and/or his representative. The Administrative Nurse #1 was interviewed on 8/25/11 at 2:10pm. She explained that resident and families are given information on immunizations at the time of their admission. If the facility received permission to give a vaccine, through a written consent, then the facility administered the vaccine annually, without any further contact. However, if the resident or resident's representative declined the vaccine, the facility then would contact them again, providing the benefits and potential side effects of the influenza vaccine.	F 334		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356		

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F 356	Continued From page 22 The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to post the nurse staff information as required.	F 356	F356 1. The nursing data staffing sheet was corrected by the scheduler on 08/25/11. 2. The Scheduler, Ward Clerk and Director of Nursing were inserviced by the Administrator on 08/26/11 on posting of nursing staffing information on a daily basis to include the total numbers of hours worked for nurses and nurse aides. 3. Beginning on 08/26/11, the scheduler will provide a copy of the nurse staffing data to the Administrator daily. The Administrator will review and initial the nurse staffing data weekly to ensure the accuracy of posting x 4 weeks. 4. The Administrator will forward the results of the posting of staffing information requirement audit tools to the Executive QI committee monthly ~~x 3 months~~ for review.	9/22/11

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F 356	Continued From page 23 The findings include: During the initial tour of the facility on 8/22/11 at 3:45pm, a posting of the nurse staffing did not contain the total number of hours worked for nurse aides and nurses. On 8/25/11 at 11:30am, a record review was conducted of staff postings from 8/5/11 through 8/25/11. None of the postings contained total number of hours worked for nurse aides and nurses. Further, staff receiving orientation were listed in the hours worked on 8/22/11 and 8/24/11. On 8/20/11, the staffing reported that 10 Registered Nurses worked the 11-7 shift. On 8/25/11 at 2:00pm, another observation was made of the nurse staffing, which did not contain the total number of hours worked for nurse aides and nurses. The Administrative Nurse #1 was interviewed on 8/25/11 at 2:20pm. She stated that she reviews the nurse staffing daily to assure that it's posted but does not review the information for accuracy. She shared that she was unaware that it was a requirement to list the total hours worked for staff and that staff, in orientation should not be included on the staffing. She then commented that she had overlooked that 10 Registered Nurses were listed as being on staff, night shift 11-7, on 8/20/11. She stated that was an error. Two of her staff are assigned to compile the information. On 8/25/11 at 2:50pm the scheduler who handles the nurse aide staff posting was	F 356		

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 _____	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 356	Continued From page 24 interviewed. She stated that she has never totaled up the actual hours worked for the nurse aides. The scheduler stated that she was unaware that it was required to be posted on the staffing. She was also unaware that staff in orientation should not be listed on the form. She commented, " That no one had ever told me to do the form differently."	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345335	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN OAKS NURSING AND REHABILITATION CENTER	1704 NC HIGHWAY 39 N LOUISBURG, NC 27549

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: A. Based on observation on 09/23/2011 there were 02 cylinders in use with out a "NO Smoking " sign on wheel chairs in the corridor and in rooms 303 and 307. 42 CFR 483.70 (a)	K 076	Franklin Oaks Nursing and Rehabilitation Center acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of the finding is factually correct and provisions of quality of care of residents. The plan of correction is submitted as written allegation of compliance. Franklin Oaks Nursing and Rehabilitaion Center's response to the statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further to refute any of the statement of deficiencies through informal dispute resolution, formal appeal procedure and/or other administrative or legal proceed. No Smoking Signs were place on wheelchairs in rooms 303 & 307 on 09/23/11. The Maintenance Supervisor and Supply Clerk have identified all residents requiring portable oxygen cylinders to ensure No Smoking Signs were present on chairs. The Supply Clerk will complete a weekly audit of all residents with portable oxygen cylinders to ensure No Smoking Signs are on the wheelchairs. Audit results will be forwarded to the Administrator for review and appropriate action.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: A. Based on observation on 09/23/2011 there was a surge protecter used as permenate wiring in a residents room. The surge ptotecter was removed at the time of the survey.	K 147	The identified surge protector was removed from the resident room on 09/23/11. The Maintenance Supervisor identified and removed any surge protectors from resident rooms on 10/6/11. The Maintenance Supervisor and Department Heads will monitor for compliance during daily rounds The results will be forwarded to the Administrator for review and further recommendations.	

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

Administrator | 10/7/11

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.

CD