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

NOV 1 5 2012

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 _____	10/18/2012

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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews the facility failed to ensure resident dignity for 3 of 19 residents observed during a lunch meal by failing to provide utensils for and staff making an out loud comment about one resident (# 167) and allowing staff to stand and reach over/around 2 residents to feed them while the staff carried on a conversation between themselves and not with the residents they were assisting (# 81 and # 87). Findings include: 1. Resident # 167 was admitted to the facility on 05/04/2012. Resident # 167 diagnoses included Dementia with behavior disturbances. The resident's quarterly Minimum Data Set (MDS) dated 08/10/2012 documented the resident to be severely cognitively impaired, receiving a mechanically altered therapeutic diet and needing extensive assistance via 1 person for eating. The resident's care plan dated 08/27/2012 indicated the resident needed assistance with activities of daily living which included eating and that staff would assist the resident with meals as needed. On 10/15/2012 between 12:05 p.m. and 12:45 p.m. a continuous observation of the lunch meal	F 241	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 findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The 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. F 241 Resident #167 was given silverware by the Nursing Assistant upon identification of need on 10/15/2012. Residents #81 and #87 finished their meal on 10/15/2012 with staff assistance.	11/15/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lynn W Bullock RN LNHA	Administrator	11-9-2012

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 241	Continued From page 1 was made. There were 6 staff members (3 nurses, 2 nursing assistants, and an administrative staff member) observed assisting 19 residents at 6 separate tables in the dining room. At 12:07 p.m. resident # 167 was observed eating his pureed diet with his hands as his silverware was on the floor between his chair and the wall. The observation also revealed resident # 167 had a cast on his right wrist and hand. During the observation resident # 167 was getting the pureed food on and in the cast while he was using his hands to feed him self. During the observation at 12:10 p.m. staff member # 4 made an out loud comment about resident #167 - "How crude, he's eating with his hands and he has a cast on." Staff member #4 was then observed to walk out of dining room without assisting resident # 167 or attempting to find out why he had no silverware. On 10/15/2012 at 12:35 p.m. an interview with staff member #12 was conducted concerning resident #167 still being observed eating his pureed meal with his hands. Staff member #12 stated, "He is supposed to have and be using silverware." Staff member #12 was observed to look for and find resident # 167's silverware on floor next to the wall. Staff member #12 removed the silverware and left the dining room with out assisting resident # 167 or informing other staff in the dining room the resident needed assistance. Resident # 167 was observed for a total of 33 minutes eating without silverware. At 12:40 p.m. staff member # 12 returned to the dining room with clean silverware for the resident. Resident # 167 was then observed to finish eating the lunch meal using the silverware (spoon).	F 241	Residents have the potential to be affected. The Staff Facilitator inserviced all nursing staff and any staff member with feeding duties beginning on 11/8/2012 on dignity with meal service to include staff not standing while feeding a resident, assuring residents have utensils to meet their needs, and to not have conversations with other staff members while feeding residents. The Director of Nursing/Assistant Director of Nursing and/or Nurse Supervisor will observe meal services to include breakfast, lunch, and dinner to assure that staff are sitting while feeding, resident utensils are present/appropriate, and staff are not having personal conversations or commenting about residents during the meal service utilizing a Dignity Meal Service Observation Quality Improvement Audit Tool three times a week for four weeks then monthly for three months. The Administrator will review the completed Dignity Meal Service Quality Improvement Audit Tool weekly for four weeks then monthly for three months. The results of the Quality Improvement audit tool will be submitted to the monthly Executive Quality Improvement Committee for review, recommendations of monitoring, and continued compliance in this area.	

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F 241	Continued From page 2 An interview with staff member #4 was conducted on 10/15/2012 at 12:45 p.m. Staff member #4 indicated resident # 167 was supposed to be using silverware to eat his meals. Staff member #4 also indicated she did not look for resident # 167's silverware and had left the dining room but did not give a reason as to why she left the dining room without finding or providing the resident with silverware or assisting the resident or asking other staff to assist the resident. 2. Resident # 81 was admitted to the facility on 11/15/2008. Resident # 81's diagnoses included Alzheimer's disease and Dementia. The resident's quarterly Minimum Data Set (MDS) dated 08/07/2012 documented the resident to be severely cognitively impaired and needed extensive assistance via 1 person for eating. The resident's most recent care plan dated 08/07/2012 indicated the resident needed assistance with activities of daily living which included eating and staff would assist the resident with meals. On 10/15/2012 between 12:05 p.m. and 12:45 p.m. a continuous observation of the lunch meal was made. There were 6 staff members (3 nurses, 2 nursing assistants, and an administrative staff member) observed assisting 19 residents at 6 separate tables. During the observation resident # 81 was observed being fed by staff member # 10. Staff member # 10 was observed to stand next to and over resident # 81 who was seated at a table at the end of the dining room. Staff member # 10 was observed to reach over resident # 81's shoulder, obtain a scoop of food and place it at the resident's lips. During this	F 241		

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F 241	Continued From page 3 process Staff member # 10 was also observed to be carrying on a conversation with staff member #11 who was also assisting with feeding resident # 87. Staff members # 10 and # 11 were observed laughing about what they were discussing and talked to each other the entire meal. Occasionally staff member #10 would tell resident # 81 to "Take a bite." This process by the staff was observed until the residents finished eating their meals. An interview was conducted on 10/15/2012 at 12:40 p.m. with staff member # 10. Staff member # 10 was asked why she was standing up and/or over resident # 81, reaching around/over the resident's shoulder while feeding the resident. Staff member # 10 indicated the reason she was standing up and feeding the resident the way she did was because it was too tight (not enough space) to sit next to the table to feed the resident. Staff member # 10 stated, "I know I am supposed to be seated when we feed the residents but there isn't enough room." 3. Resident # 87 was admitted to the facility on 09/03/2010. Resident # 87's diagnoses included Alzheimer's disease. The resident's quarterly Minimum Data Set (MDS) dated 08/28/2012 documented the resident to be severely cognitively impaired and needing extensive assistance via 1 person for eating. The resident's care plan dated 09/03/2012 indicated the resident needed assistance with activities of daily living which included eating and that staff would assist the resident with meals. On 10/15/2012 between 12:05 p.m. and 12:45	F 241		

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F 241	Continued From page 4 p.m. a continuous observation of the lunch meal was made. There were 6 staff members (3 nurses, 2 nursing assistants, and an administrative staff member) observed assisting 19 residents at 6 separate tables. During the observation resident # 87 was observed being fed by staff member # 11. Staff member # 11 was observed to stand next to and over resident # 87 who was seated at a table at the end of the dining room. Staff member # 11 was observed to reach over and around resident # 87 to obtain food from resident # 87's plate. Staff member # 11 would then tell resident # 87 she needed to eat what was on the utensil as it was brought to the resident's mouth. During this process Staff member # 11 was also observed to be carrying on a conversation with staff member #10 who was feeding another resident. Staff members # 11 and # 10 were observed laughing about what they were discussing and talked to each other the entire meal. Staff member #11 was not observed to engage resident #87 in conversation or give any individual attention to the resident except feed the resident and occasionally wipe the residents face. This process by the staff was observed until the residents finished eating their meals. An interview was conducted on 10/15/2012 at 1:05 p.m. with staff member # 11. Staff member # 11 was asked why she was standing up/over resident # 87 and reaching around the resident while feeding the resident. Staff member # 11, "I stand up most of the time to feed the residents. I have never been told we needed to do anything else." Staff member # 11 was asked if she was ever told or instructed to sit next to the resident when providing assistance with feeding a	F 241		

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F 241	Continued From page 5 resident. Staff member #11 indicated she was unaware there was a difference between standing and sitting while providing assistive feeding care to a resident.	F 241		
F 253 SS=E	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 observations, interviews, and record reviews the facility failed identify and repair - common use area items in 3 of 4 facility halls (100, 200, and 300) and in 2 of 4 resident common use shower/bathrooms (100 and 200). Findings include: On 10/15/2012 at 10:40 a.m. a tour of the facility was conducted. During the tour the 100 hall was observed to have rubber base board coming off wall where baseboard joints meet by room 107. The resident common use shower/bathroom on the 100 hall was observed to several have broken tiles on wall at elbow level when seated in shower chair in shower stall #1. Shower stall # 2 was observed to have a metal bracket for a soap bottle lying on floor drain. Shower stall #2 was observed to have no drain cover and had a dark substance on and in drain and surrounding tile floor area. The resident common shower/bathroom on 200 hall was observed to have the Whirlpool tub faucet dripping into the tub. The tub was stained a rust color where the	F 253	F 253 The rubber baseboard by room 107 was repaired on 11/8/2012 by the Maintenance Director. The 100 hall shower/bathroom tiles, drain cover, and metal bracket for soap dispenser were repaired and cleaned on 10/24/2012 by the Maintenance Director. The 200 hall whirlpool faucet water handle was adjusted to stop dripping by the Maintenance Director and cleaned by Housekeeper on 11/8/2012. The 200 Hall ceiling crack was repaired by outside support services on 11/6/2012. The cove base near rooms 315 – 317 was repaired by the Maintenance Director on 10-18-12. An audit was completed of the facility environment on 11/6/2012 by the Maintenance Director and Administrator to identify needed repairs. Identified areas will be documented on a facility work order form for follow up and repaired as appropriate.	11/15/2012

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F 253	Continued From page 6 water had been dripping onto the tub side. In the center of the 200 hall the ceiling was observed to be cracked and appeared to be water stained with the popcorn ceiling paint coming off around the cracked areas. The 300 hall was observed to have several pieces of rubber baseboard coming off the wall at their joints by rooms 315 -317.. A second observation was made on 10/16/2012 at 3:30 p.m. The items observed in need of repair were still observed to be unrepaired. A third observation was made on 10/17/2012 at 2:30 p.m. The items observed in need of repair were still observed to be unrepaired. An interview was conducted with the facility's maintenance director on 10/18/2012 at 12:12 p.m. The director was asked to explain the maintenance process when an item is found in need of repair. The maintenance director stated, "We have blank work orders that are kept at the main central nursing station and the staff are supposed to fill out a work order when an item is noted in need of repair. Once the maintenance work order is filled out by the staff they put it in the box at the central nurse's station and I pick it up. We (assistant and I) check the box once and hour. If it is after hours the slip is put in the box and we pick it up the next morning (M-F) unless it is an emergency and we will come in to fix or repair the item(s) for the emergency on the weekends or at night. Each work order slip is prioritized as to when the work is needed to be done. Once the work is completed the yellow copy is discarded and the original is kept in the file to show that the repair was completed or what action was done and I have a historical document	F 253	The Maintenance staff were inserviced on 11/8/2012 by the Administrator on the importance of preventative maintenance rounds to identify facility repair needs and that all needs identified should be placed on a work order form. All yellow copies of work orders generated by Maintenance staff or other facility staff members will be turned in to the Administrator for monitoring purposes and white copies of the completed work orders will be turned in to the Administrator upon completion of repair by Maintenance staff to verify the repair was made. The Staff Facilitator/Director of Nursing began inservicing all facility staff on 11/8/2012 on the work order system to include when staff see an area or item that needs repair to complete a work order to verify the identification of the need. The Maintenance Director and/or Maintenance Assistant will audit the facility for repair needs utilizing a Maintenance Round Quality Improvement Audit Tool weekly for four weeks then monthly for three months. The Administrator will review the completed Quality Improvement audit tool weekly for four weeks then monthly for three months. The results of the Quality Improvement audit tool will be submitted to the monthly Executive Quality Improvement Committee for review, recommendations of monitoring, and continued compliance in this area.	

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F 253	Continued From page 7 if needed." A review of the facility's completed maintenance work orders was made with the maintenance director. The maintenance director had only 1 open (un-completed) work order for the entire facility - to put wheelchair anti-tipping feet on a resident's wheel chair. The maintenance director was asked if he had any verbal work order requests that were pending for any of the halls or resident common use bath/shower rooms. The maintenance director indicated he had no knowledge of any areas needing to be repaired in any of the halls or resident common use shower/bathrooms. An observation was made of the items observed to be in need of repair with the facility's maintenance director on 10/18/2012 at 12:30 p.m. The maintenance director attempted to turn off the dripping water in the 200 hall resident common use shower/bathroom. He could not turn off the dripping water by the faucet. The maintenance director indicated each of the items was in need of repair and he had no work orders or other information indicating the items were reported to the facility or his office for repair.	F 253		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F 323 The grab bars in the common use/shower bathrooms on 100, 200, and 400 halls were repaired on 10/24/2012 by the Maintenance Director.	11/15/2012

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F 323	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure resident safety grab bars in 3 of 4 common use bathrooms (100 hall, 200 hall, and 400 hall) were securely attached to the walls. Findings include: On 10/15/2012 at 10:40 a.m. a tour of the facility was conducted. During the tour the resident common use shower/bath rooms were observed. The following common use shower/bath rooms were observed to have loose grab bars at the areas indicated: Common use shower/bathroom - 100 hall: Commode wall grab bar loose on tile wall Shower stall #1 grab bar loose on tile wall Shower stall #2 grab bar loose on tile wall Common use shower/bathroom - 200 hall: Commode wall grab bar loose on tile wall Common use shower/bathroom - 400 hall: Commode wall grab bar loose on tile wall A second observation was made on 10/16/2012 at 3:30 p.m. The grab bars noted to be loose on the walls of the common use bathrooms were still observed to be unrepaired. A third observation was made on 10/17/2012 at 2:30 p.m. The grab bars noted to be loose on the walls of the common use bathrooms were still	F 323	A 100 percent audit of all facility grab bars in common use/shower bathrooms and resident room bathrooms was completed on 10/24/2012 by the Maintenance Director. Any areas identified were repaired as appropriate. The Maintenance staff were inserviced on 11/8/2012 by the Administrator on the importance of preventative maintenance rounds to identify facility repair needs and that all needs identified should be placed on a work order form. All yellow copies of work orders generated by Maintenance staff or other facility staff members will be turned in to the Administrator for monitoring purposes and white copies of the completed work orders will be turned in to the Administrator upon completion of repair by Maintenance staff to verify the repair was made. The Staff Facilitator inserviced all facility staff beginning on 11/8/2012 on the work order system to include when staff see an area or item that needs repair to complete a work order to verify the identification of the need. The Maintenance Director and/or Maintenance Assistant will audit the facility for repair needs utilizing a Maintenance Round Quality Improvement Audit Tool weekly for four weeks then monthly for three months. The Administrator will review the completed Quality Improvement audit tool weekly for four weeks then monthly for three months.	

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F 323	Continued From page 9 observed to be unrepaired. An interview was conducted with the facility's maintenance director on 10/18/2012 at 12:12 p.m. The director was asked to explain the maintenance process when an item is found in need of repair. The maintenance director stated, "We have blank work orders that are kept at the main central nursing station and the staff are supposed to fill out a work order when an item is noted in need of repair. Once the maintenance work order is filled out by the staff they put it in the box at the central nurse's station and I pick it up. We (assistant and I) check the box once and hour. If it is after hours the slip is put in the box and we pick it up the next morning (M-F) unless it is an emergency and we will come in to fix or repair the item(s) for the emergency on the weekends or at night. Each work order slip is prioritized as to when the work is needed to be done. Once the work is completed the yellow copy is discarded and the original is kept in the file to show that the repair was completed or what action was done and I have a historical document if needed." A review of the facility's completed maintenance work orders was made with the maintenance director. The maintenance director had only 1 open (un-completed) work order for the entire facility - to put wheelchair anti-tipping feet on a resident's wheel chair. The maintenance director was asked if he had any verbal work order requests that were pending for any of the resident common use bath/shower rooms. The maintenance director indicated he had no knowledge about any areas needing to be	F 323	The results of the Quality Improvement audit tool will be submitted to the monthly Executive Quality Improvement Committee for review, recommendations of monitoring, and continued compliance in this area.	

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F 323	Continued From page 10 repaired in any of the resident common use shower/bathrooms. An observation was made with the facility's maintenance director on 10/18/2012 at 12:30 p.m. of the items observed to be in need of repair. The maintenance director indicated each of the grab bars observed and noted above was loose and in need of repair and he had no work orders or other information indicating the items were reported to the facility or his office for repair.	F 323		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure the contracted Dentist's recommendations for dental services (tooth/root extractions of broken teeth) were acted on for 1 of 3 sampled residents (# 125). Findings include: Resident #125 was admitted to the facility on 04/10/2012. Resident #125's diagnoses included	F 412	F 412 Resident # 125 was seen by the dentist on 10/18/2012. A 100 percent audit was completed by the Nursing Supervisor on 11/1/2012 to assure dental recommendations made were acted upon by the facility. Any areas identified were addressed as appropriate for resident individual needs. The Staff Facilitator/Director of Nursing inserviced all nurses, and ward clerk beginning on 11/8/2012 about assuring that dental consult recommendations are followed through to include notification of attending physician and Responsible Party and scheduling appointments as appropriate with outside dental providers to meet individual resident needs.	11/15/2012

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 _____	10/18/2012

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 412	Continued From page 11 Parkinson's disease, Dementia, Aphasia, and generalized pain. The resident's medications included Tylenol 325mg 2 tablets 2 times daily. Additional physician's orders included a regular diet with no added salt or concentrated sweets and a dental consult request dated 08/21/2012. The resident's quarterly Minimum Data Set (MDS) dated 07/19/2012 indicated the resident as being cognitively intact and requiring supervision assistance while eating. The MDS also indicated the resident had no swallowing disorders or difficulty chewing. Resident # 125's care plan dated 04/10/2012 indicated the resident required assistance to maintain maximum function of self sufficiency with oral hygiene. On 10/16/2012 at 9:41 a.m. an interview was conducted with resident # 125. Resident # 125 stated, "I have a broken tooth, they called a dentist and he didn't have an opening then and has never called back. I have a hard time chewing my food because of the broken tooth." A review of resident # 125's medical record revealed the resident received a dental exam/consult dated 08/14/2012 by the Long Term Care Associates, Inc. dental services. The exam and consult indicated the resident was to have his teeth cleaned daily and recommended extractions of 2 broken teeth/roots - #4 & #15 which the resident would need hospitalization to complete. On 08/21/2012, the resident's physician documented on the dental consult page - Agree if Pt and family can. A complete review of the resident's paper and electronic chart was conducted. No documentation could be found or that the facility could provide to show the resident, family, or responsible person was contacted	F 412	The Director of Nursing will review all dental consults completed weekly for four weeks then monthly for three months to assure dental recommendations have follow through utilizing a Dental Services Recommendation Quality Improvement Audit Tool. The Administrator will review the completed Dental Services Recommendation Quality Improvement Audit Tools weekly for four weeks then monthly for three months. The results of the Quality Improvement audit tool will be submitted to the monthly Executive Quality Improvement Committee for review, recommendations of monitoring, and continued compliance in this area.	

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F 412	Continued From page 12 concerning the dental consult recommendation or an appointment was set up to have the 2 broken teeth/roots extracted. A review of the physician's progress notes dated 6/12/12; 9/19/12; 9/28/12; 10/04/12; and 10/09/12 revealed there was no documentation to indicate the recommendation by the dental services provider was acted on or followed up with. The nurse's notes for August, September, and October 2012 were reviewed. There was no entry to indicate the family or responsible person was ever contacted notifying them of the need to have extractions of the 2 broken teeth/roots. On10/18/2012 at 9:10 a.m. an interview with Staff member # 6 was conducted concerning the resident's thinned medical record. Staff member #6 indicated she looked in resident # 125's thinned (older - stored) medical records and could not find any further physician's progress notes or other information to show the family and/or responsible person was notified of the dental consult recommendation. On 10/18/2012 at 8:50 a.m. an interview was conducted with staff member # 7, a facility clerk who made family contacts and appointments for facility residents. Staff member # 7 was asked if a family contact or an appointment was attempted and/or made for resident # 125 to have the 2 broken teeth/roots removed per the recommendation of the consulting dentist. Staff member # 7 stated, "I tried to call the family but they never called back. I didn't make any further attempts to contact them after the second time." Staff member # 7 was asked, If there was a change in the resident's condition could the facility ever get in touch with the family? Staff member # 7 indicated the facility had no trouble making contact with the family and responsible	F 412		

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F 412	Continued From page 13 person when the resident's condition changed. Staff member #7 was asked if she had documented that she attempted to contact the family and received no response or return calls. Staff member #7 stated, "No I didn't write anything down anywhere." Staff member #7 was asked if she notified facility administration or if any other staff member may have contacted the family. Staff member #7 indicated she was not sure if she had notified any other staff and stated, "I didn't make any further calls and I don't know if anyone else made any attempts." An interview with the facility's social worker was conducted on 10/18/2012 at 9:40 a.m. The social worker indicated she had spoken with the resident on several occasions but was never told by the resident or other staff the resident had any dental problems. An interview with the facility's dietary manager was conducted on 10/18/2012 at 9:45 a.m. The dietary manager indicated he had spoken with the resident on several occasions but was unaware the resident had any chewing/eating/dental problems. An interview was conducted with the Administrator on 10/18/2012 at 9:55 a.m. The administrator could not explain why the dental recommendation was never followed up on except there had been position changes to the clerical staff since she had taken over the Administrator's position.	F 412		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431	F 431 The Domeboro medication for resident # 125 was discarded on 10/17/2012 by the Administrator.	11/15/2012

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F 431	Continued From page 14 a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review the facility failed to ensure expired medications were removed from 1 of 9	F 431	All medication rooms and medication carts were inspected by Director of Nursing/Assistant Director of Nursing on 10/17/2012 to assure no expired medications were present. Any items identified were discarded and replaced as appropriate. The Director of Nursing/Staff Facilitator inserviced the nurses beginning on 11/8/2012 to assure all nurses understand that medications that are expired must be discarded and not stored in the medication rooms or on medication carts and what to do when an expired medication is found. The Director of Nursing/Assistant Director of Nursing and/or Nursing Supervisor will inspect medication rooms and medication carts to assure no expired medications are present utilizing a Medication Room/Medication Cart Inspection Quality Improvement Audit Tool weekly for four weeks then monthly for three months. The Administrator will review the Medication Room/Medication Cart Inspection Quality Improvement Audit Tools weekly for four weeks then monthly for three months to assure the check system is in place and is working to meet compliance with follow up action taken immediately for any potential identified issue.	

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F 431	Continued From page 15 medication storage areas. Findings include: On 10/17/2012 at 9:30 a.m. an observation was made of the 100 hall (Gold) medication administration cart located in the central nurse's station medication room with staff members #3 and #4 (nurses). In the 3rd drawer from the top an open box of Domeboro solution. The medication was prescribed for resident # 125. The manufacturer's information imprinted on medication box indicated the batch/lot number was 291449F and the manufacturer's expiration date was 06/2012. The individual packages of the medication remaining in the box also indicated in bold black letters the manufacturer's expiration date - 06/2012. A review of the prescription label on the medication box indicated the medication was prescribed for resident #125. A review of resident #125's medical record indicated the physician gave orders dated 10/09/2012 for - Domeboro soak, dissolve 1 packet in 12 oz. of warm water, soak 3rd digit of right hand twice daily x5 days. The prescription label indicated the date the medication prescription was filled by the pharmacy was 10/09/2012. On 10/17/2012 at 9:40 a.m. an interview with staff members #3 and #4 was conducted. Both staff members #3 and #4 indicated the medication had expired on 06/2012 per the manufacturer's stamped date on the box and the individual packets remaining inside the box. Both nurses also indicated the medication was dispensed by their back up pharmacy (Rite Aid) on 10/09/2012 -	F 431	The results of the Quality Improvement audit tool will be submitted to the monthly Executive Quality Improvement Committee for review, recommendations of monitoring, and continued compliance in this area.	

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F 431	Continued From page 16 4 months after the manufacturer indicated the medication was expired. The nurses indicated the expired medication had been used for 5 days as indicated by the physician's orders between 10/10-15/2012. Neither nurse could explain why an expired medication was accepted from the pharmacy and used on a resident. An interview was conducted with the facility's Director of Nursing (DON) and Administrator on 10/18/2012 at 9:55 a.m. The DON was asked her expectation for ensuring expired medications were removed/discarded prior to use. The DON and Administrator both indicated all the nursing staff were expected to check the expiration dates of all medications prior to administration and during the course of receiving and stocking medications in the facility's medication rooms and carts. The DON indicated the nursing staff should have identified the Domeboro solution as being expired when it was received from the pharmacy and not used the medication on resident #125.	F 431		

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	345335	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 11/06/2012 the ceilings and walls in the Mech. Room in the dining room needed repair in order to maintain the one (1) rating of the room. B. The mech room across from room 214 had unprotected openings in the ceiling. C. The corridor door to the clean linen side of the laundry failed to close and latch. 42 CFR 483.70 (a)	K 029	A. Ceilings and walls in the Dining Room Mechanical room were repaired in order to maintain the one (1) rating of the room by Hillco Support Services on November 7th and 8th, 2012. B. The Ceiling in the Mechanical room across from room 214 were sealed by Hillco Support Services on November 7, 2012. C. The Maintenance Director adjusted the Corridor Door to the clean linen side of the laundry to ensure that it closes and latches appropriately on November 7, 2012. A/B A 100% audit of all ceilings and walls in the facility was conducted by the Administrator and Maintenance Director on 11/6/2012 including all Mechanical Rooms to ensure the one (1) rating is maintained and there are no unprotected openings. All identified areas of concerns were repaired by Hillco Support Services by 11/26/2012. C. A 100% audit by the Maintenance Director was conducted of all doors to ensure doors close and latch appropriately on 11/7/2012. All identified areas of concern were corrected by the Maintenance Director by 11/21/2012. Maintenance staff were inserviced on Preventative Maintenance to include all needed repairs on 11/8/2012 by the Administrator. A Maintenance Round Quality Improvement Audit Tool to include ceilings, walls and doors will be completed by the Maintenance staff weekly by 4 weeks, then monthly x 3 months. The Administrator will review the completed Maintenance Round Quality Improvement Tool for completion weekly X 4 weeks, then monthly X 3 months.	12/3/2012
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Administrator — (X6) DATE 11/26/2012

Lynn W Bullock

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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K 051	Continued From page 1 path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: A. Based on observation on 11/06/2012 if the Fire Alarm was silienced the magnetic locks on the exit doors would relock and the smoke and fire doors would remain open. 42 CFR 483.70 (a)	K 051	The results of the Quality Improvement Tool will be submitted to the monthly Executive Quality Improvement Committee for review, recommendations of monitoring and continued compliance in this area. K 051 Fire Alarm Panel was repaired by an outside contractor on 11/6/2012 to ensure that all exit doors remain open until the fire alarm system is reset. The Maintenance staff were inserviced by the Administrator on 11/21/2012 on ensuring all exit doors must remain unlocked during a fire alarm until the fire alarm system is reset. Fire Alarm tests will be performed by the Maintenance staff to ensure all exit doors remain open during a fire alarm until the fire alarm system is reset weekly X 4 weeks, then monthly X 3 months utilizing the Quality Improvement Fire Alarm Test Audit Tool. The Administrator will review the Quality Improvement audit tool for completion weekly X 4 weeks, then monthly X 3 months. The results of the Quality Improvement audit tool will be submitted to the monthly Executive Quality Improvement Committee for review, recommendations of monitoring, and continued compliance in this area.	12/3/2012

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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 findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The 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.