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 _____	10/27/2016

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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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 observation, record review and staff interviews the facility failed to include in a resident ' s Care Plan to transfer the resident with 2 persons for 1 of 2 residents observed to be transferred with a mechanical lift (Resident #84). The findings included: Resident #84 was admitted to the facility on 9/4/14 and had a diagnosis of dementia and osteoporosis. The Care Area Assessment (CAA) for Activities of Daily Living dated 6/23/16 revealed the resident required assistance with transfers. The CAA for Falls dated 6/23/16 noted the resident had	F 279	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	11/14/16

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

Electronically Signed | 11/09/2016

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F 279	Continued From page 1 impaired mobility in both lower extremities and impaired balance during transfers and mobility. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 8/29/16 revealed the resident had severe cognitive impairment. The MDS noted the resident was unsteady during surface to surface transfers and only able to stabilize with staff assistance. The MDS revealed the resident had impaired range of motion in both lower extremities. The MDS noted the resident required 2 person assistance with transfers. The Care Plan dated 10/1/14 for Resident #84 noted the resident required assistance with transfers due to an unsteady gait and lack of strength. The Care Plan noted the resident was to be transferred with a mechanical lift. The resident ' s Care Guide was posted on the inside of the resident ' s closet door to be used as a reference for the resident ' s care by direct care staff. The Care Guide noted the resident was to be transferred with a (name of mechanical lift) and a large vest. The Care Plan and the Care Guide did not provide information regarding the number of staff needed to transfer the resident. On 10/26/16 at 5:20 AM, NA (Nursing Assistant) #1 was observed to transfer Resident #84 with the named mechanical lift with one person assist. On 10/26/16 at 11:40 AM, an interview was conducted with the MDS Nurse and the Administrator. The MDS Nurse stated they felt it was best practice and in the resident ' s best interest for the resident to be transferred with 2 staff members when the (name of mechanical lift) was used. The MDS Nurse stated that all staff were trained in orientation and in safety in-services to use 2 persons when transferring a resident with the mechanical lift. The MDS Nurse stated this information was not included in their transfer policy and they did not include this	F 279	Deficiencies does not note 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. F279 Develop Comprehensive Care Plan 1. Corrective action for the resident affected Resident # 84 care plan and resident care guide was updated on 10/27/16 by the MDS Nurse to reflect 2 person assist. 2. Corrective action for resident having the potential to be affected A 100% audit was completed by MDS Nurses on 11/2/16 of all residents to include resident # 84 requirement for transfers to include # of persons, to ensure transfer requirements are addressed on the care plan and care guide. Care plans and care guides were immediately revised to reflect resident□s current transfer requirements for all identified areas of concern during the audit by MDS Nurses on 11/2/16. 3. Measures put in place or systemic changes made to ensure the deficient practice does not reoccur	

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F 279	Continued From page 2 information in the resident ' s Care Plan. An interview was conducted with NA #1 on 10/27/16 at 6:46 AM. The NA stated she was trained she could transfer residents with 1 or 2 persons when using the (name of mechanical lift). The NA stated she did not get a second person because the room was so small and she felt comfortable transferring the resident by herself. On 12/27/16 at 9:41 AM an interview was conducted with the Staff Development Coordinator (SDC). The SDC stated the NAs were trained during orientation and in safety in-services to check the resident ' s Care Guide to for information regarding the lift to be used to transfer the resident and the correct size of the lift pad to be used. The SDC stated the NAs were trained to use 2 people when using the (name of mechanical lift) to transfer a resident. The SDC stated this was for safety because one person was needed to guide the resident and you never knew what might happen during the transfer. The SDC stated this information was not put in writing in their policy, training materials or care plans. On 10/27/16 at 10:59 AM the Administrator stated in an interview that she felt it was best nursing practice to use 2 persons when using the (name of mechanical lift) for transfers but did not put this information in writing unless there was an issue with a specific resident.	F 279	The MDS Coordinator, Social Worker, Dietary Manager, and Activity Director were in serviced on 11/1/16 by the Administrator ensuring the ADL coding from the MDS assessment is reflected on the resident□s Comprehensive care plan/resident care guide to include transfers. A 100% in-service of all license nurses and certified nursing assistants to include nursing assistant #1 was initiated on 11/9/16 by the Staff Facilitator to ensure all license nurses and certified nursing assistants review changes made to the Comprehensive care plan/resident care guide prior to providing care. Staff will not be allowed to work until in servicing is completed. 4. How the facility plans to monitor the measures to make sure solutions are sustainable The DON, QI Nurse and Nursing Supervisors will monitor ADL coding for 10% of MDS for all residents to include resident #84 for transfers using a Transfer QI audit tool to ensure requirements for transfer to include number of persons are addressed on the resident care plan and care guide. The Nursing Supervisor will immediately update the care plan and care guide and provide retaining with the MDS nurse for any identified areas of concern. The Transfer QI Audits Tools will be reviewed and initialed weekly x 8 weeks then monthly x 1 month by the Administrator to ensure compliance and to	

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F 279	Continued From page 3	F 279	ensure all areas of concern were addressed. The Administrator will compile the results of the Transfer QI audit tool and present to the Executive QI Committee monthly X 3 months to determine the need for and/or frequency of continued monitoring, recommendations for monitoring and continued compliance.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to wash a resident ' s perineal area during incontinence care for 1 of 2 residents observed to receive incontinence care (Resident #61). The findings included: The facility was not able to provide a written procedure for incontinence care. Resident # 61 was admitted to the facility on 2/1/13 and had a diagnosis of advanced Alzheimer ' s Disease. The Care Area Assessment dated 11/24/15	F 315	F315 No catheter, prevent UTI, restore bladder 1. Corrective action for the resident affected On 10/26/16 at 6:00 am, resident #61□s perineal area was immediately washed with soap and water, rinsed and dried by NA #2 and the Nursing Supervisor. NA #2 was re-educated by the Staff Facilitator on	11/14/16

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F 315	Continued From page 4 revealed the resident required assistance with activities of daily living and was occasionally incontinent of bowel and bladder due to cognitive impairment. The resident ' s Care Plan dated 6/26/16 noted the resident had urinary incontinence and to provide incontinence care as needed. The Resident Care Guide, a reference document for the NAs (Nursing Assistants) that provided direct care directed the NAs to do frequent incontinent checks and to provide incontinent care when needed. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 7/22/16 revealed the resident had short and long term memory loss and had moderate cognitive impairment. The MDS showed the resident required extensive assistance for toileting and was incontinent of bowel and bladder. On 10/26/16 at 5:45 AM, NA #2 was observed to provide incontinence care for Resident #61. The NA was observed to turn the resident onto the left side and removed the incontinent brief. The brief was observed to be wet with a small amount of soft stool. The NA used pre-moistened wipes to wash the resident ' s peri-rectal area and buttocks. The NA turned the resident over onto her back and proceeded to apply an incontinent brief. The NA was asked if she had washed the resident ' s perineal area to which the NA replied: " I washed her from behind. " The NA proceeded to remove the brief and washed the resident ' s perineal area with soap and water, rinsed and dried the area and applied an incontinent brief. On 9/27/16 at 12:03 PM, the Staff Development Coordinator stated in an interview the NA should have washed the resident ' s perineal area to get the area clean and to remove the urine from the resident ' s skin.	F 315	10/26/16 with return demonstration by NA #2 on proper peri care/incontinence care. 2. Corrective action for residents having the potential to be affected A 100% audit on all license nurses and nursing assistants to include NA #1 to ensure providing proper pericare/incontinence care to all residents to include resident # 61 was completed on 11/2/16 by the DON, QI Nurse, Staff Facilitator and Nursing Supervisor. Retraining was immediately conducted by the DON, QI Nurse, Staff Facilitator and Nursing Supervisor for all identified areas of concern during the audit. 3. Measures put in place or systemic changes made to ensure the deficient practice does not reoccur 100% of license nurses and nursing assistants to include NA #1 will be in serviced by the DON and Staff Facilitator on how to provide proper peri care/incontinence care. In servicing will be completed by 11/11/16. All newly hired license nurses and nursing assistants will be educated by the Staff Facilitator, Director of Nurses and Nursing Supervisor on proper perineal/incontinence care during the orientation process. No staff will be allowed to work until in servicing is completed. 4. How the facility plans to monitor the measures to make sure solutions are	

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F 315	Continued From page 5 The Director of Nursing stated in an interview on 9/27/16 at 1:46 PM the NA should have washed the resident ' s perineal area in the front.	F 315	sustainable Resident Care peri care/incontinence QI audit tools will be completed by the DON, QI Nurse, Staff Facilitator and Nursing Supervisors to observe 10% of license nurses and nursing assistants to include NA #1 providing peri care/incontinence care on incontinent residents, to include resident #61, weekly x 8 weeks then monthly x 1 month to include nights and weekends. Retraining will be immediately conducted by the DON, QI Nurse, Staff Facilitator and Nursing Supervisor for all identified areas of concern during the audit. The Resident Care Audits Tool will be reviewed and initialed weekly x 8 weeks then monthly x 1 month by the Administrator or DON to ensure compliance and all areas of concern were addressed. The Administrator will compile the results of the Resident Care peri care/incontinence audit tools and present to the Executive QI Committee monthly X 3 months for further action and/or change in frequency of required monitoring.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441		11/14/16

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F 441	Continued From page 6 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to follow infection control procedures for handwashing during direct resident care for 2 of 4 sampled residents observed to receive care (Resident #36 and #84). The findings included: The facility ' s Handwashing Policy dated 9/2014	F 441	F441 Infection Control 1. Corrective action for the resident affected Immediate re-education of NA #1 was provided by the Staff Facilitator on	

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F 441	Continued From page 7 read: " Personnel are required to wash their hands after each direct resident contact for which handwashing is indicated by acceptable standards of practice. Personnel should wash their hands: Between resident contacts. " Resident ' s #36 and #84 resided in the same room. On 10/26/16 at 5:12 AM, upon entering the room, NA (Nursing Assistant) #1 was observed to secure an incontinent brief on Resident #36 and cover the resident with the bed spread. The NA removed her gloves and discarded the gloves in a trash can. The NA then went to Resident #84 and pulled up the resident ' s socks and adjusted the resident ' s clothing. The NA then proceeded to transfer the resident with a mechanical lift to a wheelchair. The NA did not wash her hands in between care of the two residents. On 10/26/16 at 5:25 AM, NA #1 stated in an interview that she was supposed to wash her hands after removing gloves and after providing direct care to a resident. The NA stated she forgot to wash her hands after removing her gloves and caring for Resident #84. On 10/27/16 at 9:41 AM the Staff Development Coordinator stated in an interview that NA #1 should have washed her hands prior to caring for Resident #84. On 10/27/16 at 1:48 PM, the Director of Nursing stated in an interview the NA should have washed her hands between residents.	F 441	10/26/16 regarding the infection control hand washing policy. Residents #36 and #84 were assessed for signs and symptoms of infection on 10/26/16 by the DON with no negative outcomes. 2. Corrective action for residents having the potential to be affected A 100% observation by the DON, QI Nurse, Staff Facilitator and Nursing Supervisors was completed on 11/5/16 to ensure proper hand washing during direct resident care to include care on resident #36 and #84, by license nurses and nursing assistants to include NA #1 with no negative findings. Retraining was immediately conducted by the DON, QI Nurse, Staff Facilitator and Nursing Supervisor for all identified areas of concern during the audit. All other residents were assessed on 10/27/16 by the DON, QI Nurse, Staff Facilitator and Nursing Supervisors for signs and symptoms of infection with no negative findings. 3. Measures put in place or systemic changes made to ensure the deficient practice does not reoccur 100% of all license nurses and nursing assistants will be in serviced on When do you need to wash your hands and the hand washing policy by the Staff Facilitator, DON and Nursing Supervisor by 11/11/16. All newly hired license nurses and nursing assistants will be educated on the hand washing policy and	

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F 441	Continued From page 8	F 441	When do you need to wash your hands in-service during the orientation process by the staff Facilitator, DON and Nursing Supervisor. No staff will be allowed to work until in servicing is completed. 4. How the facility plans to monitor the measures to make sure solutions are sustainable Resident Care Hand washing audit tools will be completed on 10% of nursing staff by the DON, Qi Nurse, Staff Facilitator and Nursing Supervisors to observe staff washing their hands during direct resident care, to include residents #36 and #84, weekly X 8 weeks then monthly x 1 month to include nights and weekends. Retraining will be conducted with the license nurse or nursing assistant by the DON, QI Nurse, Staff Facilitator and Nursing Supervisors during the audit for any identified areas of concern. The Resident Care Hand washing Audits will be reviewed and initialed weekly x 8 weeks then monthly x 1 month by the Administrator or DON to ensure compliance and to ensure all areas of concern were addressed. The Administrator will compile the results of the Resident Care Hand washing Audit tools and present to the Executive QI Committee monthly X 3 months for further action and/or change in frequency of required monitoring.	