STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345335	A. BUILDING _____ B. WING _____	C 01/12/2023

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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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 1/9/23 through 1/12/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # Z6Vt11	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 1/9/23 through 1/12/23. Event # Z6VT11. The following intakes were investigated NC00191999, NC00196278, NC00190089, NC00194967. 3 of the 10 complaint allegations were substantiated with deficiency.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		2/14/23

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

Electronically Signed | 02/09/2023

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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview the facility failed to maintain residents ' dignity by failing to provide incontinence care when a nurse aide (NA #2) told a resident he would have to wait (Resident # 36). This made Resident #36 feel "embarrassed" and uncared for. The facility also failed to maintain a residents' dignity by allowing a resident to sit in a soiled brief during her meal (Resident #235). Resident #325 stated she felt like "poop" and complained of being uncomfortable and burning to her skin. This occurred for 2 of 2 residents (Resident #36, Resident #235) reviewed for dignity and respect. The findings included:	F 550	F550 Resident Rights On 1/9/23, resident #36 was provided incontinent care by the nursing assistant. NA #2 was verbally educated by the Director of Nursing (DON) regarding resident rights and incontinent care. On 1/10/23, resident #235 was provided incontinent care by the nursing assistant. NA #4 was verbally educated by the Director of Nursing (DON) regarding resident rights and incontinent care. On 1/9/23, the Treatment Nurse completed a skin check on resident #36 and #235 with no new concerns identified. On 1/10/23, the Nursing Supervisor initiated an audit of all residents who are incontinent or require assistance with	

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F 550	Continued From page 2 1.Resident #36 was admitted to the facility on 10/15/22 with diagnoses that included hemiplegia (inability to move muscles) and hemiparesis (weakness of the muscles) following stroke. A review of the Minimum Data Set (MDS) dated 10/21/22 revealed Resident #36 was cognitively intact and was totally dependent on staff for toilet use and extensive assistance for personal hygiene. Resident #36 was coded as always incontinent of bowel and bladder. During an observation of Resident #36 on 1/9/23 at 1:21 PM, he was seen propelling himself down the hall in his wheelchair. Resident #36 stopped at the medication cart and told the NA #5 that he needed to see the Nursing Assistant to be cleaned up. The staff acknowledged she would let the nursing assistant know. An interview was conducted with Resident #36 on 1/9/23 at 1:27 PM. Resident #36 stated that he had to wait to be cleaned up every day. Resident #36 stated that he was tired of sitting in the hallway wet. Resident #36 stated sometimes it could take more than an hour for someone to assist him. He stated that it made him feel embarrassed and upset that staff acted like they didn ' t care that he needed to be changed. An observation and interview were conducted of Nursing Assistant (NA) #2 on 1/9/23 at 1:33 PM. NA #2 was observed telling Resident #36 that she was not able to provide him with incontinent care until she had finished taking up the meal trays off the hall. During an interview with NA #2 she stated that she could not change Resident #36 while the meal trays were on the hall. NA #2 stated that incontinence care was provided as	F 550	toileting. This audit is to ensure residents had been provided incontinent care/toileting assistance timely to include during mealtime. The Nursing Supervisor will address all concerns identified during the audit to include providing incontinent care when indicated and education of staff. Audit was completed by the Nursing Supervisor on 1/10/23. On 1/10/23, the Social Worker initiated questionnaires with all alert and oriented residents regarding toileting assistance/incontinent care. This questionnaire is to identify any resident with concerns related to toileting assistance/incontinent care to include care during mealtimes. The Nursing Supervisor will address all concerns identified during the audit to include providing toileting assistance/incontinent care when indicated and education of staff. Questionnaires were completed by 1/12/23. On 1/31/2023, the Administrative Nurses initiated an in-service with all nurses and nursing assistants regarding Dignity and Respect-Incontinent Care with emphasis on providing toileting assistance/incontinent care timely, steps to provide toileting assistance/incontinent care during mealtime and obtaining assistance when care cannot be provided timely by assigned staff. In-service will be completed by 2/14/2023. After 2/14/23, any nurse or nursing assistant who has not worked or received the in-service will complete it prior to the next scheduled work shift. All newly hired nurses and nursing assistants will be educated during	

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F 550	Continued From page 3 needed and she rounded on the residents every 2 hours. An observation revealed that the meal trays were still in the hall at 1:33 PM. Resident #36 was provided incontinent care at 1:50 PM. An interview was conducted with the Director of Nursing on 1/9/23 at 1:35 PM. The DON stated that she expected that staff would stop passing trays, take care of the resident, perform hand hygiene, and continue to pass out trays. 2.Resident #235 was admitted to the facility on 1/7/23 with multiple diagnoses to include urinary tract infection. An interview was conducted with Nurse #2 on 1/9/23 at 10:10 AM. Nurse #2 stated Resident #235 was alert and oriented X 4. During an interview with Resident #235 on 1/10/23 at 10:13 AM Resident #235 stated she had asked to be changed before breakfast about 8:15 AM and knew the time because of the clock on her wall and staff (unable to recall which staff) stated they were busy and would change her when they got time. Resident #235 stated that this made her feel "like poop" because she had to lay in urine and bowel while her meal was in the room. Resident #235 stated that it was uncomfortable and burned when she was incontinent due to the open area on her buttocks. Resident # 235 stated that she had to eat her breakfast meal soiled. There were no odors present or evidence of incontinence on the bed linens. An interview was conducted with Nursing Assistant #4 who was assigned to Resident #235 on 1/10/23 at 10:18 AM. NA #4 stated that she	F 550	orientation regarding Dignity and Respect-Incontinent Care. The Administrative Nurses will complete 10 resident care audits for incontinent care to include resident #36 and resident #235 weekly x 4 weeks then monthly x 1 month utilizing the Resident Care Audit Tool. This audit is to ensure all residents, to include resident #36 and resident #235, are offered toileting assistance/incontinent timely care to include incontinent care during mealtime when indicated per facility protocol. The Administrative Nurses will immediately address all concerns identified during the audit to include but not limited to providing incontinent care when indicated and/or re-training of staff. The Director of Nursing will review and initial the Resident Care Audit Tool weekly x 4 weeks then monthly x 1 month for completion and to ensure all areas of concern are addressed. The Administrator will forward the results of Resident Care Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the Resident Care Audit Tools to determine trends and / or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F 550	Continued From page 4 had not been made aware that Resident #235 needed assistance. NA #4 stated that she would wait until after she had passed out the breakfast trays before providing incontinent care. NA #4 stated that incontinent rounds were conducted every 2 hours and as needed. NA #4 further stated she was always on the hall checking on the residents. NA#4 stated she had rounded on Resident #235 at the beginning of the shift about 7:30 AM. Incontinence care was provided to the resident at 10:40 AM. An interview was conducted with the Director of Nursing (DON) on 1/10/23 at 10:45 AM. The DON stated that she expected that staff would stop passing trays, take care of the resident, perform hand hygiene, and continue to pass out trays.	F 550		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 580		2/14/23

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F 580	Continued From page 5 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, and Responsible Party (RP) interviews, the facility failed to notify the RP of a medication change for 1 of 1 resident sampled (Resident #6) reviewed for notification of change. The Findings included:	F 580	F580 Notification of changes On 2/8/23, the Assistant Director of Nursing reviewed current medication/ treatment orders for resident #6 with the resident representative. A copy of the resident□s current medication orders was provided to the resident representative by mail. The identified nurse was	

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F 580	Continued From page 6 Resident #6 was admitted to the facility on 7/16/21 with diagnoses that included Alzheimer's disease, dementia with behavioral disturbance, and depression. Resident #6's electronic medical record (emr) revealed a medication order dated 6/9/22 for Depakote 125 milligrams (mg) 2 capsules by mouth 2 times daily was discontinued on 6/29/22 by the Physician Assistant. A new order was entered in Resident #6's emr for Depakote 125mg 3 capsules by mouth 3 times daily. A psychiatric consult note dated 9/29/22 revealed Resident #6 was seen by the Psychiatric Nurse Practitioner due to Resident hitting and grabbing staff during care. The note stated Resident #6 was prescribed Depakote for behaviors and mood lability (rapid exaggerated changes in mood). The psychiatric note indicated an increase in Resident's #6's Depakote dosage was due to her continued combative behaviors. The quarterly Minimum Data Set assessment dated for 12/6/22 indicated the Resident was severely cognitively impaired. Review of Resident #6's progress notes revealed there was no documentation the Resident's RP was not notified of the medication change. A telephone interview was conducted with Resident #6's RP on 1/10/23 at 10:48am. The RP stated she was not notified of the medication change until she visited the facility several days later. She indicated the Director of Nursing (DON) made her aware of the medication change during the visit.	F 580	re-educated on notification of RR on Resident changes by the Director of Nursing on 2/1/23. On 2/6/23, the Administrative Nurses initiated an audit of all newly written physician orders and/or changes in orders for all residents to include resident #6 for the past 30 days. This audit is to ensure the resident and/or resident representative were notified of newly written orders/changes in orders or changes in plan of care with documentation in the electronic record. The Administrative Nurses will address all concerns identified during the audit to include notification of the resident/resident representative and/or education of staff. Audit will be completed by 2/14/23. On 2/6/23, the Administrative Nurses initiated an audit of progress notes for the past 14 days. This audit is to identify any resident with an acute change to include but not limited to behaviors and to ensure the resident was assessed, physician notified of acute changes for further recommendations and resident representative notified of acute change and/or changes in plan of care with documentation in the electronic record. The Administrative Nurses will address all concerns identified during the audit to include but not limited to notification of resident representative and education of staff. The audit will be completed by 2/14/23. On 2/6/23, the Director of Nursing posted a bright colored sign at each nursing station regarding Events Requiring Notification of Resident Representative to	

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F 580	Continued From page 7 A telephone interview was completed on 1/11/23 with Nurse #4. She indicated she was assigned to Resident #6's care the evening the medication change was made. The Nurse stated she was unable to recall if she notified Resident #6's RP of the medication change. The Nurse indicated when the medical provider changed a resident's medication regimen, it was the nurses' responsibility to notify the RP of the change. An interview was completed on 1/12/23 at 1:22pm with the Director of Nursing (DON). She revealed it was the nurses' responsibility to contact the resident's RP to notify them of a medication change. A follow up interview was completed on 1/12/23 at 2:53pm with the DON. She revealed it was her expectation when a medication change was confirmed, the nurse contact the RP to notify them of the change.	F 580	include but not limited to adding, changing, or stopping medications. On 2/6/23, the Administrative Nurses initiated an in-service with all nurses regarding Notification of Changes with emphasis on notification of the resident representative for a significant change in the resident's physical, mental, or psychosocial status and/or a need to need to alter treatment to include adding, changing or stopping medications with documentation in the electronic record. In-service will be completed by 2/14/23. After 2/14/23, any nurse who has not worked or received the in-service will complete prior to the next scheduled work shift. All newly hired nurses will be educated during orientation regarding Notification of Changes The IDT (Interdisciplinary Team) will audit all newly written physician orders and/or changes in orders for all residents to include resident #6, five (5) times a week x 4 weeks then monthly x 1 month utilizing the Notification Audit Tool. This audit is to ensure the resident and/or resident representative were notified of newly written orders/changes in orders or changes in plan of care with documentation in the electronic record. The Administrative Nurses will address all concerns identified during the audit to include notification of the resident/resident representative and/or education of staff. The Director of Nursing will review the Notification Audit Tool 5 times weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The IDT team will review progress notes 5	

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F 580	Continued From page 8	F 580	times a week x 4 weeks then monthly x 1 month utilizing the Notification Audit Tool. This audit is to identify any resident with an acute change to include but not limited to behaviors and to ensure the resident was assessed, physician notified of acute changes for further recommendations and resident representative notified of acute change and/or changes in plan of care with documentation in the electronic record. The Administrative Nurses will address all concerns identified during the audit to include but not limited to notification of resident representative and education of staff. The Director of Nursing will review the Notification Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Administrator will forward the results of Notification Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the Notification Audit Tool to determine trends and/or issues that may need further interventions that need to be put into place and to determine the need for further frequency of monitoring.	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677		2/14/23

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F 677	Continued From page 9 Based on observations, record review, resident and staff interview the facility failed to provide Activities of Daily Living (ADL) care to residents who were dependent on staff assistance for 3 of 3 residents (Resident #36, Resident #235, Resident #8) reviewed for ADL care. The findings included: 1.Resident #36 was admitted to the facility on 10/15/22 with diagnoses that included hemiplegia (inability to move muscles) and hemiparesis(weakness of the muscles) following stroke. Resident #36 ' s care plan dated 10/16/22 revealed a goal that Activities of Daily Living/Personal Care would be completed with staff support to maintain or achieve highest practical level of functioning. The interventions for the goal read in part bathing-total dependence, personal hygiene/grooming extensive assistance. A review of the Minimum Data Set (MDS) dated 10/21/22 revealed Resident #36 was cognitively intact and was totally dependent on staff for toilet use and extensive assistance for personal hygiene. Resident #36 was coded as always incontinent of bowel and bladder. During an observation of Resident #36 on 1/9/23 at 1:21 PM, he was seen propelling himself down the hall in his wheelchair. Resident #36 stopped at the medication cart and told the NA #5 that he needed to see the Nursing Assistant to be cleaned up. The staff acknowledged she would let the nursing assistant know. Further observation of Resident #36 revealed that	F 677	F677 ADL Care Provided for Dependent Residents On 1/9/23, resident #36 was provided incontinent care by the nursing assistant. NA #2 was verbally educated by the Director of Nursing (DON) regarding resident rights and incontinent care. On 1/10/23, resident #235 was provided incontinent care by the nursing assistant. NA #4 was verbally educated by the Director of Nursing (DON) regarding resident rights and incontinent care. On 1/10/23, resident #8 nails were cleaned and trimmed, and facial hair removed per resident preference. Nursing Assistant #1 was verbally educated by the Director of Nursing regarding resident rights and incontinent care. On 1/10/23, the Administrative Nurses initiated an audit of all residents who are incontinent or require assistance with toileting. This audit is to ensure residents had been provided incontinent care/toileting assistance timely to include during mealtime. The Administrative Nurses will address all concerns identified during the audit to include providing incontinent care when indicated and education of staff. Audit will be completed by 2/14/23. On 1/12/23, the Administrative Nurses initiated an audit of nail care and facial hair for all residents to include resident #8. This audit is to ensure all residents were provided nail care and facial hair removed per resident preference. The Administrative Nurses will address all concerns identified during the audit to	

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F 677	Continued From page 10 on 1/9/23 at 1:26 PM, he propelled himself into his room and rang his call light. Resident #36 then propelled himself back out into the hall. An interview was conducted with Resident #36 on 1/9/23 at 1:27 PM. Resident #36 stated that he had to wait to be cleaned up every day. Resident #36 stated that he was tired of sitting in the hallway wet. Resident #36 stated sometimes it could take more than an hour for someone to assist him. An observation and interview were conducted of Nursing Assistant (NA) #2 on 1/9/23 at 1:33 PM. NA #2 stated to Resident #36 that she was not able to provide him with incontinent care until she had finished taking up the meal trays off the hall. During an interview with NA #2 she stated that she could not change Resident #36 while the meal trays were on the hall. An interview was conducted with NA #3 on 1/9/23 at 1:35 PM. NA #3 stated it was unsanitary to change residents while distributing meal trays to residents. She stated that staff were supposed to ask the resident if they could wait a few minutes until all of the trays were passed. An interview was conducted with the Director of Nursing on 1/9/23 at 1:35 PM. The DON stated that she expected that staff would stop passing trays, take care of the resident, perform hand hygiene, and continue to pass out trays. Resident #36 received incontinent care at 1:50 PM. 2.Resident #235 was admitted to the facility on 1/7/23 with multiple diagnoses to include urinary	F 677	include providing nail care and removing facial hair per resident preference. The audit will be completed by 2/14/23. On 1/12/23, the Social Worker initiated questionnaires with all alert and oriented residents regarding (1) toileting assistance/incontinent care. This questionnaire is to identify any resident with concerns related to toileting assistance/incontinent care to include care during mealtimes and (2) Resident Preference to identify resident preference regarding nail care and facial hair. The Administrative Nurses will address all concerns identified during the audit to include providing toileting assistance/incontinent care when indicated, updating care plan for resident preference when indicated and education of staff. Questionnaires will be completed by 2/14/23. On 2/6/23, the Administrative Nurses initiated an in-service with all nurses and nursing assistants regarding (1) Dignity and Respect-Incontinent Care with emphasis on providing toileting assistance/incontinent care timely, steps to provide toileting assistance/incontinent care during meal time and obtaining assistance when care cannot be provided timely by assigned staff and (2) Resident Preference/ADLs with emphasis on assisting residents with ADLs per preference to include but not limited to nail care and removal of facial hair. In-services will be completed by 2/14/23. After 2/14/23, any nurse or nursing assistant who has not worked or received the in-service will complete prior to the	

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F 677	Continued From page 11 tract infection. Resident #235 ' s care plan dated 1/9/23 revealed a goal that Activities of Daily Living/Personal Care would be completed with staff support to maintain or achieve highest practical level of functioning. The interventions for the goal read in part; bathing, personal hygiene/grooming with extensive assistance plus one staff physical assistance. During an interview with Resident #235 on 1/10/23 at 10:13 AM Resident #235 stated she had asked to be changed before breakfast and staff (unable to recall which staff) stated they were busy and would change her when they got time. An interview was conducted with Nursing Assistant #4 who was assigned to Resident #235 on 1/10/23 at 10:18 AM. NA #4 stated that she had not been made aware that Resident #235 needed assistance. NA #4 stated that she would wait until after she had passed out the breakfast trays before providing incontinent care. An observation was conducted of NA #4 providing incontinent care for Resident #235 on 1/10/23 at 10:25 AM. Resident #235 was incontinent of urine only. There were no issues with the incontinent care provided and barrier cream was applied Resident #235 ' s buttocks. An interview was conducted with the Director of Nursing (DON) on 1/10/23 at 10:45 AM. The DON stated that she expected that staff would stop passing trays, take care of the resident, perform hand hygiene, and continue to pass out trays.	F 677	next scheduled work shift. All newly hired nurses and nursing assistants will be educated during orientation regarding Dignity and Respect-Incontinent Care and Resident Preference/ADLs. The Administrative Nurses will complete 10 resident care audits to include resident #36, resident #235 and resident #8 weekly x 4 weeks then monthly x 1 month utilizing the Resident Care Audit Tool. This audit is to ensure staff assist residents with ADLs per resident preference to include but not limited to nail care, removal of facial hair and offering toileting assistance/incontinent timely to include incontinent care during mealtime when indicated per facility protocol. The Administrative Nurses will immediately address all concerns identified during the audit to include but not limited to providing nail care, removing facial hair, providing incontinent care when indicated and/or re-training of staff. The Director of Nursing will review and initial the Resident Care Audit Tool weekly x 4 weeks then monthly x 1 month for completion and to ensure all areas of concern are addressed. The Administrator will forward the results of Resident Care Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the Resident Care Audit Tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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3.Resident #8 was admitted to the facility on 2/19/06 with diagnoses that included dementia. A review of the Minimum Data Set (MDS) dated 12/6/22 revealed Resident #8 was cognitively intact and was totally dependent on staff for toilet use and personal hygiene. There were no refusals of care coded for Resident #8.

Resident #8 ' s care plan dated 7/3/19 revealed a goal that Activities of Daily Living/Personal Care would be provided by staff due to resident ' s impaired mobility.

An observation of Resident #8 on 1/10/23 at 9:57 AM revealed she had facial chin hair and long fingernails that had a brown substance beneath them. The facial chin hair was about 1 inch in length and her nails were about 2 inches in length with jagged edges.

An interview was conducted with Resident #8 on 1/10/23 at 10:00 AM. Resident #8 stated that staff had not offered to shave the hair on her chin. Resident #8 further stated that her nails were long and thick. She stated that her nails were longer than she liked them. She was unable to recall when she last received nail care.

An observation and interview were conducted with Resident #8 on 1/12/23 at 2:34 PM. Resident #8 had hair on her chin and her nails were long. Resident #8 stated that she really wished someone would cut her nails. The nails on Resident #8 ' s contracted right hand appeared to be indenting the palm of the hand. Resident #8 stated that this did not hurt but it was uncomfortable.

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F 677	Continued From page 13 An interview was conducted with Nursing Assistant #1 on 1/12/23 at 2:31 PM. NA #1 stated that Resident #8 ' s nails were long, and she did need to have the hair on her chin shaved. NA #1 stated that resident ' s nails were to be trimmed as needed. An observation and interview conducted with Nurse #3 on 1/12/23 at 2:34 PM revealed that Resident #8 ' s nails were long. Nurse #3 stated that she was able to smell an odor coming from Resident #8 ' s hand. Nurse #3 acknowledged that Resident #8 ' s chin hair needed to be shaved. An interview was conducted with the Director of Nursing on 1/12/23 at 3:01 PM. The DON stated that she expected that shaving and nail care would be provided with ADL care and as needed.	F 677		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and	F 867		2/14/23

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opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that

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will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

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F 867	Continued From page 16 §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, and Responsible Party interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put in place following the complaint survey conducted on 3/4/21. This was for a recited deficiency on the current recertification and complaint survey in the area of notification of changes. The continued failure during two federal surveys shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross referenced to: F580: Based on record reviews, staff, and Responsible Party (RP) interviews, the facility failed to notify the RP of a medication change for 1 of 1 resident sampled (Resident #6) reviewed for notification of change.	F 867	F867 QAPI/QAA Improvement Activities On 2/6/23, The Administrator, Director of Nursing and QA Nurse initiated an audit of previous citations and action plans related to F580 Notification of Change within the past 2 years to ensure the Quality Assurance Performance Improvement (QAPI) committee has maintained and monitored interventions that were put into place. Action plans were revised and updated and presented to the QAPI Committee by QA Nurse for any concerns identified. The Facility Consultant and/or Regional Vice President will address all concerns identified during the audit to include but not limited to the education of staff. Audit will be completed by 2/14/23. On 1/31/23, the Facility Consultant initiated an in-service with the Administrator, Director of Nursing (DON) and Quality Assurance (QA) Nurse	

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F 867	Continued From page 17 During the complaint survey on 3/4/21 the facility was cited for failing to notify a resident's RP when the resident experienced urinary retention and required an indwelling urinary catheter. An interview was completed on 1/12/23 with the Director of Nursing (DON) and Corporate Consultant. The DON indicated the QAA committee met monthly to discuss the facility's ongoing performance improvement plans. The DON indicated there were no current monitoring plans in place for notification of changes. The Corporate Consultant indicated it was his expectation the facility identify all affected residents, reevaluate the Performance Improvement Plan, and correct the deficient practice.	F 867	regarding the Quality Assurance (QA) process to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QA process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include professional standards. In-service also included identifying issues that warrant development and establishing a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA process. In-service will be completed by 2/14/23. All newly hired Administrator, DON and QA nurse will be educated during orientation regarding the QA Process. All data collected for identified areas of concerns, to include notification of change will be taken to the Quality Assurance committee for review monthly x 6 months by the QA Nurse. The Quality Assurance committee will review the data and determine if plans of corrections are being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the QA Nurse. The Facility Nurse Consultant and/or Regional Vice President will ensure the facility is maintaining an effect QA program by reviewing and initialing the Executive committee Quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include	

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F 867	Continued From page 18	F 867	notification of change and all current citations and QA plans are followed and maintained Quarterly x2. The Facility Consultant and/or Regional Vice President will immediately retrain the Administrator, DON and QA nurse for any identified areas of concern. The results of the Monthly Quality Assurance meeting minutes will be presented by the Quality Assurance Nurse to the Executive Committee Quarterly x 2 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	
F 914 SS=E	Bedrooms Assure Full Visual Privacy CFR(s): 483.90(e)(1)(iv)(v) §483.90(e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident; §483.90(e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide privacy curtains wide enough for visual privacy around the beds of 3 of 3 rooms on the 400 Hall (Room 421, 415, 404) and 6 of 6 rooms on the 300 Hall (Room 302, 330, 335, 332, 338, 341) The findings included:	F 914	F914 Bedrooms Assure Full Visual Privacy On 1/11/23, the Housekeeping Supervisor replaced privacy curtains for rooms 421, 415, 404, 302, 330, 335, 332, 338, and 341 to provide full visual privacy. On 1/11/23, the Housekeeping Supervisor initiated an audit of all resident rooms to include rooms 421, 415, 404, 302, 330,	2/14/23

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F 914	Continued From page 19 a. An observation on 1/11/23 at 12:45 PM noted that the privacy curtain for room 421 did not go completely around bed B. There was approximately 20 feet of insufficient privacy curtain. This would not allow full visual privacy when the resident was receiving care or when the resident desired privacy. The room was occupied and the curtain for bed A was wide enough. b. An observation on 1/11/23 at 12:55 PM noted there was no privacy curtain for room 415 around bed B. There was approximately 50 feet of insufficient privacy curtain. The room was occupied and the curtain for bed A was wide enough. c. An observation on 1/11/23 at 12:58 PM noted there was no privacy curtain for room 404 around bed B. There was approximately 50 feet of insufficient privacy curtain. The room was occupied and the curtain for bed A was wide enough. d. An observation on 1/11/23 at 1:02 PM noted that the privacy curtain for room 302 did not go completely around bed A. There was approximately 20 feet of insufficient privacy curtain. This would not allow full visual privacy when the resident was receiving care or when the resident desired privacy. The room was occupied and the curtain for bed B was wide enough. e. An observation on 1/11/23 at 1:05 PM noted that the privacy curtain for room 330 did not go completely around bed B. There was approximately 20 feet of insufficient privacy curtain. This would not allow full visual privacy when the resident was receiving care or when the resident desired privacy. The room was occupied	F 914	335, 332, 338, and 341 utilizing a resident census to ensure privacy curtain were in place and provided full visual privacy. The Housekeeping Supervisor will address all concerns identified during the audit to include replacing any curtain that does not provide full visual privacy. The audit will be completed by 2/14/23. On 1/31/23, the Administrator initiated an in-service with Housekeeping Manager and Housekeeping staff regarding Privacy Curtains with emphasis on checking privacy curtains daily during the room cleaning and to replace any privacy curtain that does not provide full visual privacy. In-service will be completed by 2/14/23. After 2/14/23, any housekeeping staff who have not worked or received the in-service will complete upon the next scheduled work shift. All newly hired housekeeping staff will be in serviced during orientation regarding Privacy Curtains. On 1/31/23, the Administrative Nurses initiated an in-service with all nurses and nursing assistants regarding Privacy Curtains with emphasis on when providing care, the privacy curtain must provide full visual privacy. The nurse and\or nursing assistant are to notify the Housekeeping Supervisor if any privacy curtains does not provide full visual privacy when providing care to the residents and complete a work order slip. In-service will be completed by 2/14/23. After 2/14/23, any nurse or nursing assistant who have not worked or received the in-service will complete upon the next scheduled work shift. All newly hired nurses or nursing assistants will be	

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F 914	Continued From page 20 and the curtain for bed A was wide enough. f. An observation on 1/11/23 at 1:07 PM noted that the privacy curtain for room 335 did not go completely around bed B. There was approximately 20 feet of insufficient privacy curtain. This would not allow full visual privacy when the resident was receiving care or when the resident desired privacy. The room was occupied and the curtain for bed A was wide enough. g. An observation on 1/11/23 at 1:08 PM noted that the privacy curtain for room 332 did not go completely around bed B. There was approximately 20 feet of insufficient privacy curtain. This would not allow full visual privacy when the resident was receiving care or when the resident desired privacy. The room was occupied and the curtain for bed A was wide enough. h. An observation on 1/11/23 at 1:09 PM noted that the privacy curtain for room 338 did not go completely around bed B. There was approximately 20 feet of insufficient privacy curtain. This would not allow full visual privacy when the resident was receiving care or when the resident desired privacy. The room was occupied and the curtain for bed A was wide enough. i. An observation on 1/11/23 at 1:10 PM noted that the privacy curtain for room 341 did not go completely around bed B. There was approximately 20 feet of insufficient privacy curtain. This would not allow full visual privacy when the resident was receiving care or when the resident desired privacy. The room was occupied and the curtain for bed A was wide enough. An interview was conducted with the Maintenance	F 914	in serviced during orientation regarding Privacy Curtains. The Housekeeping Supervisor will audit 10% of all resident rooms with privacy curtains, to include rooms 421, 415, 404, 302, 330, 335, 332, 338, and 341, utilizing a Privacy Curtain Audit Tool weekly x 4 weeks then monthly x 1 month. This audit is to ensure that the privacy curtains provide full visual privacy when providing resident care. The Housekeeping Supervisor will immediately address any identified areas of concern during the audit to include replacement of privacy curtains when indicated. The Administrator will review the Privacy Curtain Audit tool weekly x 4 weeks then monthly x 1 month for completion and to ensure all areas of concern are addressed. The Administrator will forward the results of the Privacy Curtain Audit Tool to the QAPI Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the Privacy Curtain Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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

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F 914	Continued From page 21 Director on 1/11/23 at 1:10 PM. The Maintenance Director stated that sometimes housekeeping put up the wrong size curtains. The Maintenance Director stated that he would look at the privacy curtains and have them changed. An interview was conducted with the Administrator on 1/11/23 at 3:25 PM revealed that she expected that every resident would have their privacy when care is provided.	F 914		