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	04/18/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 Based on record review, staff and resident interviews, the facility failed to invite the resident to participate in the care planning process for 1 of 26 residents whose care plans were reviewed (Resident #84). The findings included: Resident #84 was admitted to the facility on [DATE]. The care plan general note dated 11/08/23 by Social Worker #1 revealed a care plan meeting was held with Resident #84's Responsible Party (RP). Review of the care plan general note dated 1/25/24 by Social Worker #2 revealed Resident #84's RP was invited to participate in a care plan meeting but had not responded to the invite. A message was left for Resident #84's RP to return the call to review the care plan via telephone. Review of the progress notes from 1/25/24 through 4/16/24 revealed no documentation regarding Resident #84 being invited to attend a care plan meeting or that a care plan meeting was held. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #84 was cognitively intact. During an interview on 4/15/24 at 11:25 am, Resident #84 stated she had not been invited to attend a care plan meeting and did not recall participating in the development of her care plan. Resident #84 stated she wanted to attend the care plan meeting so she could discuss her goal to return home. (continued on next page)

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 4/16/24 at 2:48 pm with Social Worker #1 who reported she did not recall participating in a care plan meeting with Resident #84 or the RP since her admission. She stated when she reviewed the care plan progress note dated 1/25/24 from Social Worker #2, she thought the care plan was reviewed with Resident #84, but she did not confirm that the care plan review occurred. Social Worker #1 stated the normal process was for Social Worker #2 to send the invitations to the RP to confirm they would be attending the scheduled care plan either in person or via telephone and when the care plan meeting was held a sign in sheet was completed with names of those in attendance. Social Worker #1 was unable to find any documentation that the care plan meeting took place from 1/25/24 to present and she was unable to state why a care plan meeting for Resident #84 was not held. Social Worker #1 stated she spoke with Resident #84 and the RP often but could not remember when the last care plan meeting took place. During an interview on 4/16/24 at 3:03 pm with Social Worker #2 she revealed she was responsible to send the invitations for care plan meetings but did not hold the care plan meeting. Social Worker #2 stated she attempted to contact Resident #84's RP on 1/25/24 because she did not receive a response to the mailed care plan meeting invitation to set up a time to review the care plan over the phone with Social Worker #1. Social Worker #2 stated she documented in a progress note that she was unable to speak with Resident #84's RP but did leave a message regarding scheduling a time to review the care plan for Resident #84. Social Worker #2 stated she did not review the care plan with Resident #84 for the 1/25/24 planned care plan meeting. An interview was conducted with the Administrator on 4/17/24 at 2:37 pm, and she revealed Social Worker #1 was responsible to ensure Resident #84 was invited to the care plan meeting and that the care plan meeting was held as required.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 Based on record review and staff interviews, the facility failed to complete a Minimum Data Set (MDS) significant change assessment within 14 days for the use of a soft belt restraint for 1 of 1 resident reviewed for restraints (Resident #1). The findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses which included dementia. The Physical Device Use Evaluation-Initial dated 12/29/23 revealed Resident #1 was evaluated for the use of a soft belt restraint for prevention of injury to self-characterized by high risk for injury and falls related to dementia and poor safety awareness. Review of Resident #1's physician orders revealed an order dated 12/29/23 for soft belt restraint while up in chair for safety. Remove for activities, meals, and activities of daily living (ADLs) care. The care plan dated 12/31/23 revealed Resident #1 had a physical restraint device (soft belt) in use for prevention of injury to self with interventions which included to remove during supervised activities and meals and re-apply upon completion. The MDS significant change assessment with a completion date of 1/19/24 revealed Resident #1 was coded for use of a trunk (torso) restraint daily when in chair or out of bed. An interview was conducted on 4/17/24 at 11:38 am with the MDS Nurse who reported the significant change assessment was to be completed within 14 days of Resident #1's order for the soft belt restraint. The MDS Nurse stated the normal process was the significant change assessment was completed within 14 days of the significant change, but she was unable to state why Resident #1's significant change assessment was completed late. During an interview on 4/17/24 at 2:34 pm the Administrator stated the MDS Nurse was responsible to ensure the MDS assessment was completed on time for Resident #1's soft belt restraint.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of restraints for 1 of 1 resident reviewed for restraints (Resident #1). The findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses which included dementia. Review of Resident #1's active physician orders revealed an order dated 12/29/23 for soft belt restraint while up in chair. The care plan dated 12/31/23 revealed Resident #1 had a physical restraint device (soft belt) in use for prevention of injury to self. The nursing progress note dated 3/25/24 at 3:56 pm revealed Resident #1 was in the wheelchair with the soft belt restraint applied. The nursing progress note dated 3/26/24 at 12:13 pm revealed Resident #1 was up in the chair with the soft belt restraint in place. The MDS quarterly assessment dated [DATE] revealed Resident #1 was not coded for the use of the soft belt restraint. An interview was conducted on 4/16/24 at 1:09 pm with the MDS Nurse who stated the MDS Nurse Consultant had completed Resident #1's quarterly assessment. The MDS Nurse stated the normal process to code use of the restraint was to observe the resident and review nursing notes to confirm the restraint was used. The MDS Nurse stated Resident #1 should have been coded for use of the soft belt restraint on the quarterly assessment. A telephone interview was conducted on 4/16/24 with the MDS Nurse Consultant who reported normally she reviewed nursing assessments or progress notes for the use of restraints to code the restraint on the assessment. The MDS Nurse Consultant stated she apparently missed the nursing notes for Resident #1's restraint use when she completed the quarterly assessment so the restraint was not coded. An interview was conducted on 4/17/24 at 2:36 pm with the Administrator who stated the MDS Nurse Consultant was responsible to ensure Resident #1's MDS quarterly assessment was coded accurately.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 Based on record review, staff interviews, and Medical Director interview, the facility failed to maintain ongoing communication with the dialysis treatment center for 1 of 1 residents reviewed for dialysis (Resident #23). The findings included: Resident #23 was admitted to the facility on [DATE] with diagnoses which included end stage renal disease (ESRD), and dependence on dialysis. Resident #23 had an active physician order dated 3/12/24 for dialysis on Monday, Wednesday, and Friday. The care plan, last reviewed 3/29/24, revealed Resident #23 had ESRD and was at risk for complications related to dialysis with an intervention to communicate with dialysis treatment center. Review of Resident #23's dialysis communication notebook on 4/16/24 revealed 18 out of the 50 dialysis communication forms in the notebook were not completed by the facility staff prior to dialysis treatment for Resident #23. The 18 dialysis communication forms did not have the following information noted from the facility: name of resident, name of primary care physician, date, vital signs, medications administered prior to dialysis, diet, fluid restrictions, access site assessment, significant alerts, and name of facility nurse. An interview was conducted on 4/16/24 at 11:48 am with Nurse #1 who was assigned to Resident #23. Nurse #1 revealed he was assigned to Resident #23 on multiple dates when the dialysis treatment was scheduled. He stated Resident #23 had a dialysis communication form that the vital signs were written on prior to Resident #23 being transferred to the dialysis treatment center. Nurse #1 reviewed the blank dialysis communication forms and was unable to state if he was assigned to Resident #23 when the forms were not completed because there were no dates on the forms to confirm. Nurse #1 stated he knew about the dialysis communication forms and he normally put the vital signs on the form before Resident #23 went to dialysis, but he was unable to state why the forms were blank on the facility portion of the form. An interview was conducted on 4/16/24 at 11:54 am with the Unit Manager who revealed Resident #23's dialysis communication forms should be completed prior to dialysis and sent with the Resident. The Unit Manager stated he tried to check the dialysis communication notebook but did not do it consistently and he was unable to state why Resident #23's dialysis communication forms were not completed. A telephone interview was conducted on 4/16/24 at 12:10 pm with Nurse #2 who revealed she was assigned to Resident #23 every Friday. Nurse #2 stated the dialysis communication notebook was sent with the resident when they went to dialysis and the communication forms were supposed to be completed by the nurse before going to dialysis. Nurse #2 stated she did her best to complete the dialysis communication forms for Resident #23 before dialysis, but she was unable to state why the forms were not completed. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 4/16/24 at 12:35 pm with Nurse #3 who revealed she was assigned to Resident #23 on dialysis days but was unable to recall the exact dates. Nurse #3 stated the dialysis communication forms were supposed to be completed by the nurse and sent to the dialysis treatment center with Resident #23. Nurse #3 reviewed Resident #23's blank dialysis communication forms and was unable to state why the forms were not completed by the facility. During an interview on 4/16/24 at 1:03 pm Nurse #4 revealed she was assigned to Resident #23 on dialysis days. Nurse #4 stated she was aware of the dialysis communication forms that were supposed to be completed prior to dialysis and sent with Resident #23 but she stated at times she was busy and did not fill the forms out. An interview was conducted on 4/16/24 at 1:39 pm with the Director of Nursing (DON) who revealed the dialysis communication forms were to be completed prior to Resident #23's dialysis treatment by the nurse that was assigned to their care. The DON reviewed Resident #23's dialysis communication forms and confirmed the forms were not completed by the facility. The DON stated the facility did not have a process in place to ensure the dialysis communication forms were being completed. An interview was conducted on 4/17/24 at 9:48 am with the Medical Director who stated the dialysis communication forms were important to communicate with the dialysis treatment center about the care of the resident and they should be filled out by the facility prior to the resident going to dialysis. During an interview on 4/17/24 at 2:31 pm the Administrator revealed the nurses assigned to Resident #23 on the dialysis treatment days were responsible for the completion of the dialysis communication forms.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43222 Based on a lunch meal tray line observation, staff interviews and record review the facility failed to provide pureed food items with a smooth consistency. This failure had the potential to affect 21 of 21 residents who had diet orders for a pureed diet texture. The findings included: A review of the Order Listing Report dated 4/17/24 revealed 18 residents with diet orders for a pureed diet texture and 3 residents with an order for pureed meats. Review of the menus revealed the facility followed the National Dysphagia Diet (NDD) for residents with diet orders for a pureed diet texture. The NDD recorded a dysphagia pureed diet required all foods pureed and thickened, if necessary, to a pudding-like consistency, lump free, requiring little to no chewing. A continuous observation of the lunch meal tray line with the Nutrition Consultant on 3/12/24 from 11:57 AM - 12:01 PM revealed the pureed chicken pastry was placed on the steam table with a lumpy consistency. The Cook stated she was intending to serve these items at lunch meal today, and that she had prepared them. She stated the consistency should be smooth, like pudding. The Nutrition Consultant agreed that the pureed chicken and pureed carrots had visible lumps. He asked the Cook to further blend both pureed items. An interview was conducted with the Dietary Manager (DM) on 4/16/24 at 1:13 PM. He revealed that pureed foods should be a pudding-like consistency. The DM stated he had not observed lumpy consistency of pureed foods previously and did not receive any complaints on this issue. He indicated that the Cook had been cooking at the facility for the last [AGE] years, so perhaps she was nervous, or it was an oversight. The DM stated the Cook will receive re-education on puree consistency, but it was good that she corrected it in the moment. During an interview with the Registered Dietitian (RD) on 4/17/24 at 12:26 PM, she revealed that the consistency of pureed foods should be like pudding. If residents on a puree diet were served foods with a lumpy consistency, they could possibly choke. She stated she had not noticed lumpy pureed foods at the facility and ordered pre-pureed rice, pasta, corn, and bacon due to high risk of inappropriate consistency with these foods. The Speech Language Pathologist (SLP)/Rehab Manager was interviewed on 4/17/24 at 1:52 PM. She revealed that the puree diet consistency should be like pudding, which is smooth without particles without the need for chewing. If a lumpy consistency was served, it would not be considered pureed but more like mechanical soft. The risks would be pocketing (hold pieces that they cannot swallow in their cheek), and residents may get tired or have decreased strength due to more chewing. The SLP/Rehab Manager stated she had not witnessed pureed foods to have lumpy consistency at the facility. The Administrator stated in an interview on 4/17/24 at 10:48 AM that if the pureed foods had lumps in them, then those dishes would need to be further blended to a proper puree consistency.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43222 Based on observation and staff interviews, the facility failed to allow cook pans and dome lids to completely dry prior to assemblage and stacking for three of three observations. The facility also failed to clean the convection ovens. These practices had the potential to affect food served to residents. The findings included: 1. An observation of the kitchen and interview with the Dietary Manager (DM) was conducted on 4/15/24 at 9:58 AM. Twelve steam table pans were observed to be stacked wet and ready for reuse on a cart next to the 3-part sink. The DM stated the pans should be air dried and stacked at an angle to prevent wet nesting. During a follow-up tour of the kitchen on 4/16/24 at 8:46 AM with the DM, three pans on the cart next to the 3-part sink were observed with wet nesting. The DM stated the wet pans were due to them falling on top of each other and not stacked at an angle to air dry. An observation of the kitchen during lunch meal service on 4/16/24 at 12:27 PM revealed water dripped from a dome lid as a Dietary Aide took it from the rack and placed it on top of a plated meal. Fifty-two dome lids were observed with wet nesting on the inside edge. The DM stated they should be dry, but the water collected on the inside edge due to placement on the dry rack. He instructed the Dietary Aide to shake off the excess water before placed on top of the plate. During a follow-up interview with the DM on 4/16/24 at 1:08 PM, he revealed the pans had slipped and fallen from their stacking position. The DM stated his staff had been trained on how to properly place clean pans to prevent wet nesting. The Administrator was interviewed on 4/17/24 at 12:31 PM. She revealed that she went to the kitchen on 4/17/24 and noticed the water on the inside edge of the dome lids. She stated it was a manufacturer issue. However, when she purposely put water on the inside edge of one of the domes and placed it on top of a plate, she noticed the water did not touch the plate. The Administrator indicated there was a short period of time in between breakfast and lunch for dishes/pans to air dry. The Administrator revealed that there should not be any water on any clean dishes/pans for service. Staff needed to be re-educated on how the pans needed to be placed to ensure they were completely air dried. 2. An observation of the kitchen and interview with the DM were conducted on 4/15/24 at 9:58 AM. The convection oven had a thick, black layer on the bottom and brown grease covered both glass doors on the top oven. The bottom oven did not have the black substance, but grease covered both glass doors on the inside. The DM stated the ovens were due to be cleaned, and they were usually cleaned every few weeks. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation of the kitchen and interview with the DM were conducted on 4/16/24 at 11:43 AM. The inside of all glass doors was covered by brown grease. The top oven doors were cleaned slightly, and the black substance on the bottom of the top oven remained. The DM stated that staff started to clean the convention ovens. During a follow-up interview with the DM on 4/16/24 at 1:09 PM, he revealed that the convention ovens should be cleaned fully by the end of the day. Kitchen staff began cleaning the ovens the night before. The Administrator was interviewed on 4/17/24 at 12:33 PM. She stated that the black substance on the bottom of the top oven was part of the equipment itself and could not be scraped off. The Administrator indicated that the black substance might be due to overuse and was not present when ovens were new. She revealed that the convention ovens were supposed to be cleaned every two weeks, but that was changed to weekly. On 4/17/24 at 1:59 PM, the Administrator presented a piece of the black substance on the bottom of the top oven. She stated it seemed like plastic material caused by the degreaser that could be removed. The Administrator indicated that the convention ovens were not delivered with the black substance present.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43222 Based on staff interviews and record review, the facility failed to maintain a complete and accurate medical record for 1 of 26 residents' medical records reviewed (Residents #79). The findings included: Resident #79 was readmitted to the facility on [DATE] with a diagnosis of dysphagia (difficulty swallowing). The medical record included no evidence of a signed waiver related to Resident #1's dietary status. An interview was conducted with Resident #79 on 4/15/24 at 11:13 AM. He revealed that he wanted to eat regular food and drink thin liquids and signed a waiver in the past to do so freely. On 4/16/24 at 1:20 PM, the Dietary Manager (DM) was interviewed. He stated that Resident #79 had mentioned to him recently that he signed a waiver to eat regular foods. The Speech Language Pathologist (SLP)/Rehab Director was interviewed on 4/16/24 at 3:29 PM. She revealed that Resident #79 previously signed a waiver (date unknown) to eat regular foods despite his NPO status. During a follow-up interview with the SLP/Rehab Director on 4/17/24 at 9:11 AM, she revealed that once the waiver was signed, it would be discussed in the interdisciplinary team (IDT) morning meeting and given to either the assigned Unit Manager or Medical Records to upload into the chart. An interview was conducted with the Registered Dietitian on 4/17/24 at 9:42 AM. She revealed that Resident #79 was presented with a waiver to discuss the benefits/risks of by mouth intake or going against medical advice. The Director of Nursing (DON) was interviewed on 4/17/24 at 9:14 AM. She revealed that she was aware Resident #79 had a signed waiver in place provided by the SLP/Rehab Manager and the MD was aware of Resident #79's signed waiver for regular foods/liquids. Once the waiver was signed, Medical Records should have uploaded it to Resident #79's chart. During an interview with the Medical Director (MD) on 4/17/24 at 10:00 AM, he revealed that the waiver form was to make sure the resident understood and was aware of the risks of their decision to go AMA. He was aware that Resident #79 signed a waiver to eat regular foods. The Administrator was interviewed on 4/17/24 at 10:42 AM, and she revealed that the purpose of the signed waiver was for education only to notify Resident #79 of the risks/benefits of his actions when he ate and aspirated. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the signed waiver by Resident #79 dated 4/17/24 revealed that he understood the risks and wished to go AMA for his dietary order.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 45044 Based on observations, record review, and staff interviews the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the 2/4/22 recertification and complaint investigation survey. This was for one deficiency previously cited in the area of infection prevention and control (F880). This deficiency was recited during the facility's current recertification survey of 4/18/24. The continued failure of the facility during 2 federal surveys shows a pattern of the facility's inability to sustain an effective QAA Program. The findings included: The tag is cross referenced to: F880: Based on observations, record review, and staff interviews, the facility failed to handle visibly soiled and wet linen to avoid contamination of staff clothing for 1 of 1 laundry aides observed (Laundry Aide #1). During the facility's recertification and complaint investigation survey of 2/4/22 the facility failed to follow the Centers for Disease Control and Prevention (CDC) guidelines for personal protective equipment (PPE) when a staff member was observed entering a quarantine room without wearing gloves and a gown An interview was completed on 4/18/24 at 9:30am with the Administrator and Director of Nursing. The Administrator indicated the QAA committee met monthly to discuss the facility's ongoing performance improvement plans. The Administrator indicated there were no current monitoring plans in place for infection prevention and control. The Administrator indicated it was her expectation the facility continued to follow the QAA process and monitor those issues within the facility so they would not receive a recited deficiency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45045 Based on observations, record review, and staff interviews, the facility failed to handle visibly soiled and wet linen to avoid contamination of staff clothing for 1 of 1 laundry aides observed (Laundry Aide #1). The findings included: Review of the facility policy titled The Infection Prevention and Control Program (IPCP) dated April 2023 revealed the facility was to establish and maintain an effective program that provides a safe, sanitary, and comfortable environment and attempts to prevent the development and the transmission of diseases and infections. Review of the facility policy titled Laundry Infection Control Responsibilities dated April 2023 revealed soiled linen may contain germs that are capable of causing possible infections. The policy further read to always wear personal protective equipment (PPE) when handling soiled linen which included an apron or gown to protect your clothing and gloves. A continuous observation on 4/17/24 from 8:18 am through 8:28 am revealed Laundry Aide #1 pushed a laundry bin from the soiled linen area to the washing machine with gloved hands and removed visibly soiled and wet linen from the laundry bin and placed the items in the washing machine. The Laundry Aide #1 was then observed to lean her upper body to the waist into the laundry bin to remove the remainder of the visibly soiled and wet linen from the laundry bin with the front and sleeves of her uniform touching the top and interior of the laundry bin. The empty laundry bin was then pushed to the soiled linen area, and it was observed to have multiple areas of brown substance on the interior upper portion of the laundry bin. Laundry Aide #1 returned from the soiled linen area with a second laundry bin and placed the visibly soiled and wet linen into the washing machine with gloved hands. Laundry Aide #1 did not wear an apron or gown while handling the soiled and wet linens and no aprons or gowns were observed in the laundry area. An immediate interview was conducted on 4/17/24 at 8:28 am with Laundry Aide #1 who revealed she only used gloves when handling soiled linens and she removed the gloves after sorting the laundry and then used hand sanitizer. She stated she did not use any other PPE when handling or sorting laundry. A follow-up interview was conducted on 4/17/24 at 10:00 am with Laundry Aide #1who stated the facility had given her a gown to wear one day when she was doing the laundry, but gowns had not been provided for use again. Laundry Aide #1 stated she was not educated that a gown or apron was supposed to be worn when handling the soiled linens and she stated she did not know where to locate a gown or an apron to use. (continued on next page)

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	04/18/2024

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/24 at 10:04 am with the Housekeeping Manager, she revealed that only gloves were required to be worn when handling soiled linens. She stated if the linen was very soiled the staff had the option to wear a gown if they wanted to, but she was not aware of a requirement to wear a gown on when handling soiled linens. The Housekeeping Manager stated the Infection Preventionist (staff member responsible for the facility's IPCP) had provided education to the staff in laundry, but she did not recall being told gowns were required when sorting soiled linens. An interview with the Infection Preventionist (IP) was conducted on 4/17/24 at 10:11 am who revealed the laundry staff should wear gloves when handling the dirty linen. She stated that the education she provided to the laundry staff was that gloves were to be worn when working with soiled linen, no other PPE was needed for soiled or regular linen. The IP was unable to recall when the education for the laundry staff was conducted. A follow-up interview was conducted on 4/17/24 at 10:55 am with the IP who clarified the education that was provided to the laundry staff included the use of gowns when handling soiled linen. The IP stated she must have misunderstood when asked about what PPE laundry staff were required to use when handling soiled linen. An interview was conducted on 4/17/24 at 2:19 pm with the Director of Nursing (DON) who revealed she would have to review the policy and speak with the IP regarding the requirements for laundry staff handling soiled linen. During an interview on 4/17/24 at 2:25 am the Administrator stated Laundry Aide #1 should have worn a gown when handling soiled linen if the policy stated it was required. A follow-up interview on 4/18/24 at 8:20 am with the Administrator and DON revealed the policy had been reviewed and the laundry staff had been educated in the proper use of PPE when handling soiled linen.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 43222 Based on observations, staff interviews, and record review, the facility failed to maintain an effective pest control program as evidenced by observations of fly activity in the kitchen on 3 different occasions. The facility failed to utilize insect light traps and implement pest service recommendations to prevent reoccurring pest activity. This practice had the potential to affect residents in the facility. The findings included: Review of the Pest Control Service Agreement without a date revealed the following pests were covered by the contract: roaches, rodents, ticks, ants (except carpenter), crickets, fleas, spiders, ground beetles, earwigs, silverfish, and stored product pests. Observations of live pest activity occurred on the following: - 4/15/24 at 10:00 AM: 3 flies observed at the entrance to the drain in the middle of the kitchen in between the steamer and convention ovens. The Dietary Manager (DM) was present and stated the cover to the drain cracked, and a new one has been ordered. - 4/16/24 at 11:51 AM: 1 fly observed on overhead light above steam tray line. - 4/16/24 at 12:22 PM: 1 fly observed flying around steam table during lunch meal service On 4/16/24 at 3:45 PM, two wall mounted insect light traps were observed unplugged at the front entrance across from the dining room and on the administrative hall adjacent to the front entrance. The Maintenance Director was seen servicing both light traps at the time. The DM was interviewed on 4/16/24 at 1:10 PM. He revealed that the kitchen was sprayed for pests monthly. The DM stated that he had not observed flies in the kitchen before, but now that the temperature was increasing, there would be more fly activity. He indicated that he would call the pest control company for the observance of the flies within the last 2 days. The DM presented an invoice for drain covers ordered on 4/15/24. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Maintenance Director on 4/17/24 at 11:09 AM, he revealed that the pest control company visited monthly to spray areas of the facility and lay down traps. He indicated that a fly spray was used during the monthly visits. He heard about the flies in the kitchen on 4/15/24 and had not received any complaints about flies previously.The Maintenance Director stated that the fuses blew at least once monthly in both insect light traps outside of the dining room and on administrative hall. He stated the traps were working last week, and they were serviced on 4/15/24 and were now operable. The Maintenance Director indicated that an indoor fly spray was purchased on 4/15/24. The back service hall outside door was used frequently and flies entered through that door. He stated that the insect light trap in the back service hall was knocked down by a meal cart about 2 weeks ago, and it was replaced on 4/15/24. He had observed flies in the back service hall next to the kitchen since the trap was knocked down. The Maintenance Director indicated the pest control company was asked to service the facility on 4/15/24 outside of the monthly visits, and he sprayed outside the service door where the trash was located as well as the service loading dock. On 4/17/24 at 12:36 PM, the Administrator was interviewed. She revealed that when she went into the kitchen on 4/16/24, she saw a few flies flying around. The Administrator stated that the meal carts were hard to control in the service hallway, and the fly light trap kept getting knocked down. She had 3 new fly light traps installed on 4/16/24, including the traps outside of the dining room, on the administrative hallways, and the back service hall. The Administrator indicated that the pest control company came out yesterday to spray extra around doors, windows, and traffic areas. She stated that a kitchen/building with multiple doors was difficult to be fly-free. They controlled it the best they could with tactics including pest control, fly lights, manual fly swatters, and education to staff to not leave the doors open.