STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345263	A. BUILDING _____ B. WING _____	C 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACON VALLEY NURSING AND REHABILITATION CENTER	245 OLD MURPHY ROAD FRANKLIN, NC 28734

(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 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigation survey. Event ID G9Y711.	F 000		
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to label resident personal care items in 2 resident rooms on 1 of 4 hallways (Rooms #316 and #318) and failed to label and properly store resident care equipment in 2 resident bathrooms on 2 of 4 resident hallways (Rooms #210, #318 and #320). Findings included: 1. a. Observations in room #316 on 1/24/17 at 12:42 PM revealed an unlabeled bath basin resting upside down on the sink. Observations in room #316 on 1/25/17 at 2:28 PM revealed an unlabeled bath basin resting upside down on the sink. Observations in room #316 on 1/26/17 at 8:22 AM revealed an unlabeled bath basin resting upside down on the sink. b. Observations in room #318 on 1/24/17 at 11:24 AM revealed an unlabeled bath basin resting upside down on the sink.	F 253	Macon Valley 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. Macon Valley Nursing and Rehabilitation Center's response to the statement of deficiencies does not denote agreement with the statement of deficiencies, nor does it constitute an admission that any deficiency is accurate. Further, Macon Valley Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this statement of deficiencies through informal dispute resolution or formal appeals procedure and/or any other administrative or legal proceeding.	2/24/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/19/2017

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F 253	Continued From page 1 Observations in room #318 on 1/25/17 at 8:43 AM revealed an unlabeled bath basin resting upside down on the sink. Observations in room #318 on 1/26/17 at 8:31 AM revealed an unlabeled bath basin resting upside down on the sink. c. Observations in the bathroom for rooms 318 and 320 on 1/24/17 at 11:24 AM revealed 3 unlabeled and uncovered bed pans hanging on a wire rack above the back of the commode. Observations in the bathroom for rooms 318 and 320 on 1/25/17 at 8:43 AM revealed 3 unlabeled and uncovered bed pans hanging on a wire rack above the back of the commode. Observations in the bathroom for rooms 318 and 320 on 1/26/17 at 8:31 AM revealed 3 unlabeled and uncovered bed pans hanging on a wire rack above the back of the commode. d. Observations in the bathroom for room 210 on 1/25/17 at 3:06 PM revealed an unlabeled urinal and an uncovered, unlabeled bedside commode insert hanging on a wire rack above the back of the commode. Observations in the bathroom for room 210 on 1/26/17 at 8:20 AM revealed an unlabeled urinal and an uncovered, unlabeled bedside commode insert hanging on a wire rack above the back of the commode. During a tour and interview with the Director of Nursing (DON) on 1/26/17 at 8:45 AM she revealed the wash basins resident's received upon admission were either used by the resident	F 253	Upon identification on 01-26-17 the nursing staff was advised of the issue. The entire population of residents were checked for this deficient practice. Upon identification the current items not marked as required were replaced, new replacement items were marked with the resident□s name. The Central Supply Clerk was in-serviced on the requirement to ensure all personal items are to be marked before issuance. Upon notification of any new admission or re-admission or upon issuing any personal items, the items will be marked as applicable. The nursing staff members were in-serviced about the requirement to mark all personal items for all residents. The quality team monitors that perform daily rounds were in-serviced on this requirement and are to check daily for compliance. The Administrator/Designee will also monitor for compliance. The monitoring for compliance will occur weekly, for three months for 100% of all residents, then bi-monthly for three months for 75% of all residents, then one time per month for six months for 50% of all residents. An audit tool has been developed to be utilized to record the findings to ensure compliance. The findings of the audits will be reported monthly to the QAPI committee to reflect identifications of patterns, additional concerns, and analysis of the progress of training and tools to ensure compliance.	

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F 253	Continued From page 2 to store personal items or used by staff when the resident requested a bed bath. The DON explained personal care items stored to the left of the sink were used for the resident in the A bed and personal care items stored to the right of the sink were used for the resident in the B bed. She indicated the Nurse Aides (NA) were responsible for ensuring resident care items were properly labeled and confirmed the wash basins resting on the sinks in resident rooms 316 and 318 had not been labeled with the resident's name. The DON acknowledged the urinal and bed pans stored in the shared bathrooms for rooms 210, 318 and 320 were not labeled with the resident's name and had been stored inappropriately. She indicated urinals were stored in the resident's room at bedside for their use and bed pans stored in the bathrooms should be labeled with the resident's name and individually covered. She further indicated the insert for the bedside commode should have been removed by housekeeping and not stored in the shared bathroom. The DON stated it was her expectation that all resident personal items would be labeled with the resident's name and stored appropriately. During an interview on 1/26/17 at 9:46 AM NA #1 revealed wash basins were used when a bed bath was given to a resident. NA #1 confirmed NA's were responsible for labeling all resident personal items and acknowledged the wash basins in rooms 316 and 320 had not been labeled. During an interview with the Administrator on 1/26/17 at 2:30 PM he stated it was his expectation all resident personal care items were labeled with the resident's name and stored	F 253	The LNHA is responsible to ensure communication and implementation of any Quality Assurance and Performance Improvement Committee recommendations.	

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F 253	Continued From page 3 appropriately.	F 253		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove 1 container of expired chocolate pudding for resident use in 1 of 3 nourishment room refrigerators and failed to date or label 3 bags of sliced cheese for resident use in 3 of 3 nourishment room refrigerators. Findings included:	F 371	Upon identification on 01-25-17, the Dietary Manager removed the identified items from the refrigerator. All nourishment rooms were check for this deficient practice. Upon identifications an in-service was conducted with the dietary staff on the	2/24/17

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F 371	Continued From page 4 1. a. Observations of the nourishment room refrigerator located on Sub-acute Hall on 1/24/17 at 10:13 AM revealed one 4-quart container of chocolate pudding with a use by date of 1/20/17. An interview with the Director of Nursing (DON) #2, who was present during the observation on 1/24/17 at 10:13 AM, revealed the container of chocolate pudding was used by the nurses for the residents' medication administration. DON #2 confirmed the chocolate pudding was past the expiration date and should have been removed from the refrigerator on 1/20/17. 2. a. Observations of the nourishment room refrigerator located on Brown hall on 1/24/17 at 10:05 AM revealed 1 bag containing sliced cheese that was not dated or labeled. Observations of the nourishment room refrigerator located on Brown hall on 1/25/17 at 8:40 AM revealed 1 bag containing sliced cheese that was not dated or labeled. b. Observations of the nourishment room refrigerator located on Sub-acute hall on 1/24/17 at 10:13 AM revealed 1 bag containing sliced cheese that was not dated or labeled and 1 pitcher of cranberry juice with a use by date of 1/24/17. Observations of the nourishment room refrigerator located on Sub-acute hall on 1/25/17 at 8:25 AM revealed 1 bag containing sliced cheese that was not dated or labeled and 1 pitcher of cranberry juice with a use by date of 1/24/17.	F 371	facility policy on 01-25-2017. The policy now has been posted on each refrigerator in each identified nourishment room to remind/educate staff on the requirement. All staff of the facility was also in-service on the policy. The quality team monitors that perform daily rounds were in-serviced on the requirement, and are to to check daily for compliance. The Administrator/Designee will also monitor for compliance. The monitoring for compliance will occur weekly, for three months; then bi-monthly for three months; then one time per month for six months. An audit tool has been developed to be itemized to record the findings to ensure compliance. The findings of the audits will be reported monthly to the QAPI committee to reflect identifications of patterns, additional concerns, and analysis of the progress of training and tools to ensure compliance. The LNHA is responsible to ensure communication and implementation of any Quality Assurance and Performance Improvement Committee recommendations.	

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F 371	Continued From page 5 c. Observations of the nourishment room refrigerator located in the Spark unit on 1/24/17 at 10:28 AM revealed 1 bag containing sliced cheese that was not dated or labeled. Observations of the nourishment room refrigerator located in the Spark unit on 1/25/17 at 8:33 AM revealed 1 bag containing sliced cheese that was not dated or labeled. During an interview and tour of the nourishment rooms with the Dietary Manager (DM) on 1/25/17 at 9:18 AM, she explained the nourishment room refrigerators were for resident use only and checked by staff on a daily basis. She confirmed the cranberry juice had expired as of 1/24/17 and the bags containing sliced cheese were not dated. She indicated all items stored in the nourishment room refrigerators should be dated or labeled with the resident's name and all expired items removed. During an interview with the Administrator on 1/26/17 at 2:30 PM, he confirmed the refrigerators located in the nourishment rooms were for resident use only. He stated it was his expectation all expired items were removed and resident items stored in the nourishment refrigerators were labeled or dated.	F 371		
F 463 SS=D	483.90(f)(2) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH (f) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff	F 463		2/24/17

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F 463	Continued From page 6 work area - (2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure call light systems were functioning in 2 resident rooms (Rooms 316 and 320) on 1 of 4 halls. Findings included: 1. a. Observations of the bedside call bell in resident room #316B on 1/24/17 at 3:30 PM revealed the light in the hallway above the resident's door or on the call system unit in the resident's room did not turn on when the call bell button was pushed. Observations of the bedside call bell in resident room #316B on 1/25/17 at 8:54 AM revealed the light in the hallway above the resident's door or on the call system unit in the resident's room did not turn on when the call bell button was pushed. Observations of the bedside call bell in resident room #316B on 1/26/17 at 8:22 AM revealed the light in the hallway above the resident's door or on the call system unit in the resident's room did not turn on when the call bell button was pushed. b. Observations of the bedside call bell in resident room #320B on 1/24/17 at 8:22 AM revealed the light in the hallway above the resident's door or on the call system unit in the resident's room did not turn on when the call bell button was pushed. Observations of the bedside call bell in resident	F 463	Upon identification on 01-26-17, the Maintenance Director inspected the identified rooms and corrected the problem at that time. A 100% audit was conducted to ensure the call light system was functioning properly elsewhere was conducted. An in-service was conducted with all staff that they need to inform/alert the Maintenance Director of any issues they identify with the call light system as well. An in-service was conducted with the Maintenance Director at which time the review of the requirement of a functioning call light system is working properly and the review of the monitoring tool was explained. A monitoring tool was developed for the Maintenance Director to complete weekly audits to ensure that all call lights are tested weekly. The Administrator/Designee will also monitor for compliance. The monitoring for compliance will occur weekly, for three months; then bi-monthly for three months; then one time per month. An audit tool has been developed to be utilized to record the findings to ensure compliance.	

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F 463	Continued From page 7 room #320B on 1/25/17 at 8:45 AM revealed the light in the hallway above the resident's door or on the call system unit in the resident's room did not turn on when the call bell button was pushed. Observations of the bedside call bell in resident room #320B on 1/26/17 at 8:33 AM revealed the light in the hallway above the resident's door or on the call system unit in the resident's room did not turn on when the call bell button was pushed. An interview and tour conducted on 1/26/17 at 9:00 AM with the Maintenance Director (MD) revealed a procedure in place for the reporting of needed repairs within the facility but had no current system of checking call light systems to ensure they were functioning properly. He explained work orders were located at the nurses' desk for staff to fill out and then place in his box which he checked daily. He indicated he would make repairs as he noticed them but also relied on notification from staff or residents when repairs were needed. The MD checked the call lights in rooms 316B and 320B and confirmed they were not functioning. The MD agreed that they should have both been reported and repaired. During an interview on 1/26/17 at 9:46 AM Nurse Aide (NA) #1 revealed a process in place for reporting needed repairs to maintenance. NA #1 was unaware the call lights in rooms 316B and 320B were not functioning and confirmed no work order had been filled out to notify maintenance. During an interview on 1/26/17 at 2:30 PM the Administrator confirmed there was no system in place for maintenance staff to routinely check the call light systems in resident rooms to ensure	F 463	The findings of the audits will be reported monthly to the QAPI committee to reflect identifications of patterns, additional concerns, and analysis of the progress of training and tools to ensure compliance. The LNHA is responsible to ensure communication and implementation of any Quality Assurance and Performance Improvement Committee recommendations.	

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F 463	Continued From page 8 they were functioning properly. The Administrator was unware the call lights in rooms 316B and 320B were not functioning and stated it was his expectation when staff noticed things in need of repair they would fill out a work order and report it to the Maintenance Director.	F 463		