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	345263	A. BUILDING _____ B. WING _____	C 06/28/2017

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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 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if	F 225		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on record review, resident interview and staff interviews, the facility failed to report an allegation of misappropriation of resident property to the local law enforcement agency and North Carolina Health Care Personnel Registry (NCHCPR) as required for 1 of 1 resident (Resident #3) reviewed for misappropriation of resident property and failed to submit 24 hour and 5 day working reports to the NCHCPR within the required time frame for 1 of 1 resident (Resident #15) reviewed for abuse.

Findings included:

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1. Resident #3 was admitted to the facility on 02/25/14 with diagnoses that included diabetes, end stage renal disease, anxiety disorder, and depression. The most recent Minimum Data Set (MDS) dated 04/5/17 coded Resident #3 with mild cognitive impairment and displayed no behaviors.

Review of the facility's grievance logs for the period February 2017 through June 2017 revealed Resident #3 had filed a grievance on 02/19/17. Review of the Resident Concern Form (RCF) dated 02/19/17 revealed Resident #3 reported to the nurse $400.00 was missing from his safe. The RCF was received by the Social Worker (SW) on 02/20/2017 who then referred the RCF to the Administrator. There was no documentation the allegation had been reported to the local law enforcement agency or NCHCPR.

During an interview on 06/25/17 at 8:22 AM Resident #3 confirmed someone had taken approximately $400 from the locked safe in his room. Resident #3 stated he had kept the key to the safe hidden in the dresser drawer in his room and when he had returned to his room on 02/19/17 he noticed "someone had been messing in my drawer so I got the key out and when I checked the safe, the money was gone." Resident #3 added he immediately reported the missing money to the Nurse and SW.

During an interview on 06/25/17 at 4:25 PM Nurse #1 confirmed she had spoken to Resident #3 on 02/19/17 who had reported $400 dollars missing from the locked safe in his room. Nurse #1 indicated she had assisted Resident #3 with a search of his room but the money had not been found. Nurse #1 added she had filled out a RCF and forwarded copies to the SW and

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Administrator.

During an interview on 06/25/17 at 4:40 PM the SW confirmed he had spoken to Resident #3 on 02/20/17 regarding the money he had reported missing from his personal safe. The SW indicated the money was not found after he had searched Resident #3's room. The SW added he had forwarded the RCF, which included a written report of his discussion with Resident #3, to the Administrator. The SW stated the Administrator was responsible for conducting investigations and reporting allegations to the appropriate agencies.

The Administrator was on medical leave and unavailable for an interview.

A joint interview on 06/27/17 at 5:09 PM with the Interim Administrator (IA) and Vice President of Operations (VPO) revealed it was corporate policy for all abuse, neglect and misappropriation allegations to be investigated which included notification of local law enforcement and submission of 24 hour and 5 day reports to the NCHCPR. The IA added the Administrator was responsible for conducting all investigations. The VPO reviewed the RCF dated 02/19/17 for Resident #3 and stated on 02/20/17 the Administrator wrote Resident #3 had withdrawn the issue. The VPO added since Resident #3 had withdrawn the issue, the Administrator had not notified the police or submitted 24 hour and 5 day working reports to NCHCPR.

During a follow-up interview on 06/27/17 at 5:58 PM Resident #3 stated he had never informed the Administrator he wanted to withdraw his concern and restated he had reported the missing money because he wanted them "to find out what

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F 225	Continued From page 4 happened and who did it." 2. Resident #15 was readmitted to the facility on 04/22/14 with diagnoses that included Alzheimer's disease, dementia, anxiety disorder, and depression. The most recent MDS dated 06/6/17 coded Resident #15 with moderate, cognitive impairment and displayed no behaviors. A review of the RCF dated 02/15/17 revealed Resident #15 had accused a male staff member of hurting her. The RCF was signed by the Administrator on 02/16/17 with a handwritten note which read in part, "investigation initiated." The incident was reported to the local law enforcement agency on 02/20/17 at 7:00 PM. An initial 24 hour report was submitted to NCHCPR on 02/20/17 at 8:29 PM. The follow-up 5 day working report was submitted to NCHCPR on 02/27/17 at 6:58 PM. The Administrator was on medical leave and unavailable for an interview. During a joint interview on 06/27/17 at 5:09 PM the IA and VPO both stated the 24 hour and 5 day reports should have been submitted within the required time frame.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that:	F 226		

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F 226	Continued From page 5 (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interviews, the facility failed to specify in their abuse policy the state requirement for reporting allegations of abuse, including misappropriation of resident property, to the local law enforcement agency and failed to implement their abuse policy and procedure by not investigating and reporting an allegation of missing money for 1 of 1 resident (Resident #3) reviewed for misappropriation of resident property.	F 226		

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Findings included:

A review of the facility policy entitled "Abuse, Neglect, or Misappropriation of Resident Property", with a revised date of 03/10/17, stated the following:

1. "Allegations of abuse, neglect, exploitation or misappropriation of resident property and injuries of unknown origin will be investigated by the facility. The Administrator is responsible to direct the investigation process and to ensure that appropriate agencies are notified, as indicated."

2. "The facility will thoroughly investigate and document all allegations of resident abuse or neglect, misappropriation of resident or facility property ..."

3. "The Administrator will ensure for all allegations that involves abuse or results in serious bodily injury, the Division of Health Service Regulation (DHSR), Health Care Personnel Registry (HCPR), and Adult Protective Services are notified immediately but no later than 2 hours after the allegation is received and determination of alleged abuse is made. For all allegations that do not involve abuse or result in serious bodily injury, the Administrator will ensure that the DHSR, HCPR, and other appropriate agencies are notified no later than 24 hours. A written report must be sent to DHSR and HCPR within 5 working days of the date the facility becomes aware of the alleged incident."

Resident #3 was admitted to the facility on 02/25/14 with diagnoses that included diabetes, end stage renal disease, anxiety disorder, and

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depression. The most recent Minimum Data Set (MDS) dated 04/5/17 coded Resident #3 with mild cognitive impairment and displayed no behaviors.

Review of the facility's grievance logs for the period February 2017 through June 2017 revealed Resident #3 had filed a grievance on 02/19/17. Review of the Resident Concern Form (RCF) dated 02/19/17 revealed Resident #3 reported to the nurse $400.00 was missing from his safe. The RCF was received by the Social Worker (SW) on 02/20/2017 who then referred the RCF to the Administrator. The RCF indicated the SW and Administrator had both spoken to Resident #3 regarding the incident but did not indicate further investigation had been conducted. There was no documentation the allegation had been reported to the local law enforcement agency or NCHCPR.

During an interview on 06/25/17 at 8:22 AM Resident #3 confirmed someone had taken approximately $400 from the locked safe in his room. Resident #3 stated he had kept the key to the safe hidden in the dresser drawer in his room and when he had returned to his room on 02/19/17 he noticed "someone had been messing in my drawer so I got the key out and when I checked the safe, the money was gone." Resident #3 added he immediately reported the missing money to the Nurse and SW.

During an interview on 06/25/17 at 4:25 PM Nurse #1 confirmed she had spoken to Resident #3 on 02/19/17 who had reported money missing from the locked safe in his room. Nurse #1 indicated she had assisted Resident #3 with a search of his room but the money had not been found. Nurse #1 added she had filled out a RCF

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and forwarded copies to the SW and Administrator.

During an interview on 06/25/17 at 4:40 PM the SW confirmed he had spoken to Resident #3 on 02/20/17 regarding the money he had reported missing from his personal safe. The SW indicated the money was not found after he had searched Resident #3's room. The SW added he had forwarded the RCF, which included a written report of his discussion with Resident #3, to the Administrator. The SW stated the Administrator was responsible for conducting investigations and reporting allegations to the appropriate agencies.

The Administrator was on medical leave and unavailable for an interview.

A joint interview on 06/27/17 at 5:09 PM with the Interim Administrator (IA) and Vice President of Operations (VPO) revealed it was corporate policy for all abuse, neglect and misappropriation allegations to be investigated which included notification of local law enforcement and submission of 24 hour and 5 day reports to the NCHCPR. The IA added the Administrator was responsible for conducting all investigations. The VPO reviewed the RCF dated 02/19/17 for Resident #3 and stated on 02/20/17 the Administrator wrote Resident #3 had withdrawn the issue. The VPO added since Resident #3 had withdrawn the issue, the Administrator had not notified the police or submitted 24 hour and 5 day working reports to NCHCPR.

During a follow-up interview on 06/27/17 at 5:58 PM Resident #3 stated he had never informed the Administrator he wanted to withdraw his concern and restated he had reported the missing money

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F 226	Continued From page 9 because he wanted them "to find out what happened and who did it."	F 226		
F 244 SS=E	483.10(f)(5)(iv)(A)(B) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION (f)(5) The resident has a right to organize and participate in resident groups in the facility. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to resolve and communicate the facility's efforts to address concerns voiced during Resident Council meetings for 5 consecutive months (February 2017, March 2017, April 2017, May 2017, and June 2017). Findings included: The Resident Council minutes for the period February 2017 through June 2017 were reviewed and revealed the following: Resident Council minutes dated 02/07/17 indicated residents had voiced concerns related to missing food and no heat in the transport van.	F 244		

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Resident Council minutes dated 03/07/17 indicated residents had voiced concerns related to not having enough staff, showers not being provided on weekends, laundry services, and call light response. There was no evidence the facility's response to the concerns voiced during the previous meeting had been reviewed or discussed.

Resident Council minutes dated 04/04/17 indicated residents had voiced concerns related to not having enough staff and the facility entrance being blocked by the transport van. There was no evidence the facility's response to the concerns voiced during the previous meeting had been reviewed or discussed.

Resident Council minutes dated 05/02/17 indicated residents had voiced concerns related to not having enough staff. There was no evidence the facility's response to the concerns voiced during the previous meeting had been reviewed or discussed.

Resident Council minutes dated 06/06/17 indicated residents had voiced concerns related to not having enough staff, maintenance issues, showers being provided timely, the facility entrance being blocked by the transport van, and call light response. There was no evidence the facility's response to the concerns voiced during the previous meeting had been reviewed or discussed.

The Resident Council Grievance Follow-up (a form used by the facility to document details of the concern and the facility's response to the concern) forms for the period February 2017

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through June 2017 were reviewed. There was a separate form for each concern voiced during the Resident Council meetings and included the facility's response. There was no indication the responses had been reviewed or reported to the Resident Council.

On 6/25/17 at 3:46 PM an interview with Resident #16 (Resident Council President) revealed staff discussed the issues and concerns brought up during the meetings. Resident #16 was unable to recall if staff reviewed or discussed the facility's response to concerns voiced during previous meetings.

On 06/28/17 at 3:10 PM the Social Worker (SW) was interviewed. The SW confirmed he attended the Resident Council meetings and the minutes were recorded by the Activity Assistant (AA). He explained concerns voiced during the Resident Council meetings were written on concern forms by the AA or himself and were distributed to the appropriate department for response. The SW added old business was always discussed during each meeting but could not confirm if the facility's response to the concerns voiced during the previous meeting were reviewed during the discussion.

On 06/28/17 at 3:38 PM Activity Assistant (AA) #1 and AA #2 were interviewed. AA #1 confirmed she had recorded the Resident Council minutes for the period February 2017 through June 2017. AA #1 and AA #2 both stated the concerns voiced by residents during the meeting were written on a concern form and given to the SW who also attended the meetings. AA #2 added they were not aware of how the concerns were addressed once the concern forms had been given to the

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F 244	Continued From page 12 SW. AA #1 and AA #2 both acknowledged the facility's efforts to address the concerns voiced by residents during previous meetings were not reviewed or discussed during the next Resident Council meeting. AA #2 stated "we didn't realize we were supposed to." On 06/28/17 at 4:00 PM the Interim Administrator (IA) and Vice President of Operations (VPO) were interviewed. The IA and VPO both confirmed all concerns voiced by residents during Resident Council meetings should be documented on a concern form, recorded on the grievance log, investigated and the results of the investigation discussed as old business during the next Resident Council meeting.	F 244		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 441		

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F 441	Continued From page 13 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the	F 441		

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	345263	A. BUILDING _____ B. WING _____	C 06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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spread of infection.

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and staff interviews the facility failed to disinfect a blood glucose meter (glucometer used for blood sugar monitoring) according to manufacturer ' s recommendations for 1 of 1 finger stick blood sugar (FSBS) observed (Resident #7).

A record review of a facility document with a revised date 09/04/14 entitled Glucometer Cleaning and Disinfection Procedure indicated (in part):
· 1. a. Use an environmental protection agency (EPA)-registered germicidal disposable cloth/wipe to thoroughly wet entire external surface of the glucometer.
· b. Cover/wrap the entire glucometer with the wipe.
· c. Place cover/wrapped glucometer in a plastic disposable cup on the med cart and allow full minute's exposure time according to manufacturer's product directions for disinfection of the glucometer.
· 4. After full minute's exposure time according to manufacturer ' s product directions, remove cloth wipe and discard and return glucometer to the plastic cup to allow it to thoroughly dry.
· 6. When glucometer is completely dry, it may be used for the next resident.

A review of the label on the germicidal disposable sani-cloth indicated to unfold wipe and thoroughly

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wet the surface of the glucometer. Use additional wipe (s) if needed to assure continuous 2 minutes of wet contact time and allow to air dry.

During a continuous observation on 06/25/17 at 11:33 AM Medication Aide (MA) #1 wheeled a bedside table which contained a box of gloves, lancets in a disposable plastic cup, individual sealed packets of 1 inch sized alcohol prep pads in a disposable plastic cup, sharps container, and glucometer into Resident #8's room. MA #1 obtained a finger stick blood sugar (FSBS) on Resident #8 using the glucometer located on the wheeled bedside table. MA #1 then removed gloves and disposed of in the trash and donned clean gloves. MA #1 opened an individual wrapped alcohol prep pad and wiped the surface of the glucometer. MA #1 placed the glucometer back onto the bedside table. MA #1 tossed the alcohol prep pad and gloves in the trash in Resident #8's room and washed her hands with hand sanitizer. MA #1 wheeled the bedside table with the box of gloves, lancets, individually sealed packets of alcohol perp pads, sharps container, and glucometer into Resident #7's room. MA #1 donned clean gloves and used the glucometer from the wheeled bedside table and performed a FSBS on Resident #7. MA #1 then placed the glucometer on the wheeled bedside table. MA #1 removed gloves and tossed them in the trash and donned clean gloves. MA #1 opened an individual wrapped alcohol prep pad and wiped the surface of the glucometer and placed the glucometer on the wheeled bedside table.

On 06/25/17 at 11:38 AM an interview was conducted with MA#1 who stated she cleaned the glucometer between residents using an alcohol prep pad. MA #1 stated after she had obtained all

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FSBS for residents then she cleaned the glucometer with a germicidal wipe.

On 06/25/17 at 11:42 AM an interview was conducted with Nurse #1 who verified that MA #1 had cleansed the glucometer used on Resident #7 with an alcohol prep pad. Nurse #1 stated the facility policy was to wipe the glucometer after each use with a special sanitizer wipe and the sanitizer wipe had to make contact with the surface of the glucometer for 4 minutes and then allowed to air dry prior to using the glucometer on another resident.

On 6/25/17 at 11:52 AM an interview was conducted with the Director of Nursing (DON) who verified that MA #1 had cleansed the glucometer used to obtain a FSBS on Resident #7 with an alcohol prep pad. The DON stated her expectation was that MA #1 would have followed the facility policy for cleansing and disinfecting the glucometer. The DON stated MA #1 had received training during orientation on the facility policy and procedure for cleansing the glucometer. The DON stated it was unacceptable related to infection control concerns that MA #1 placed supplies on a wheeled bedside table and brought the table and supplies into different resident rooms. The DON stated her expectation was that supplies required to perform FSBS were to be obtained from the medication cart. The DON stated MA #1 would require in service training and return demonstration for cleansing and disinfection of the glucometer prior to performing any further FSBS.

On 6/25/17 at 12:35 PM an interview was conducted with the Administrator who stated her expectation was that MA #1 would have followed

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F 441	Continued From page 17 the facility policy for cleansing and disinfecting the glucometer. The Administrator stated her expectation was that MA #1 would not have placed supplies on a wheeled bedside table and brought the table and supplies into multiple resident rooms because of infection control concerns. The Administrator stated that MA #1 had received training on the facility policy for cleansing and disinfecting the glucometer prior to performing the procedure.	F 441		