

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/12/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/28/2018
NAME OF PROVIDER OR SUPPLIER MACON VALLEY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3195 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 This complaint survey was conducted on 11/19/18 through 11/20/18. The exit date was extended until 11/28/18 in order to obtain resident interviews.	F 000		
F 745 SS=G	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interviews, family interviews, staff interviews and physician interview, the facility failed to provide social services which followed up with families and/or residents in obtaining consent and payment for prescription glasses for 3 of 5 sampled residents. Resident #6 received prescription glasses 8 months following the original order and after expressing concern for the glasses and Residents #13 and #14 had no follow up to assist them in obtaining their prescription eyeglasses. The findings included: 1. Resident #14 was admitted to the facility on 10/13/17. Her diagnoses included diabetes and long term insulin use. Her most recent annual Minimum Data Set dated 10/19/17 coded her as having some cognitive impairment, scoring an 11 out of 15 on the Brief Interview for Mental Status.	F 745	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 this 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, formal appeal procedure and/or any other administrative or legal proceedings.	12/7/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/07/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/28/2018
NAME OF PROVIDER OR SUPPLIER MACON VALLEY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3195 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 745	<p>Continued From page 1</p> <p>On 11/20/18 at 2:48 PM Resident #14 stated during interview that she recalled getting her eyes examined in the facility and she picked out the style of frames at the same time. She stated she has never heard anymore about her prescription glasses and has not received them. Resident #14 stated she was not told about any cost of the glasses or if she needed to do anything else to receive the prescription glasses. She further stated she would like to have the prescription glasses. At this time she was in the lounge not wearing any glasses.</p> <p>Review of Resident #14's medical record revealed her eyes were examined on 03/08/18. The evaluation included a "Payment Worksheet" which included a written prescription for eyeglasses and a cost associated with them of \$126.00. The form included a statement that the glasses would be ordered and delivered to the resident upon full payment.</p> <p>The Minimum Data Sets dated 1/20/18, 4/22/18, 7/20/18 and 10/19/18 coded her as having adequate vision with glasses.</p> <p>Interview with the medical records staff on 11/20/18 at 9:40 AM revealed the social worker was responsible for contacting the family regarding necessary payment for the prescription glasses and then let the eye physician know if they could order the glasses.</p> <p>Interview with the Social Worker on 11/20/18 at 10:31 AM revealed that he was not the designated social worker at the time of the eye exam. He explained that the family should have been told there was a prescription for glasses and explained the payment process. He stated that</p>	F 745	<p>F 745</p> <p>How corrective action will be accomplished for those residents found to have been affected by the deficient practice; On March 08, 2018 Resident 13 & 14 had eye exams performed with written prescription for eyeglasses. On Nov. 20, 2018 Resident # 13 & 14 had no follow up to assist them in obtaining their prescription eyeglasses. On Nov. 28, 2018 Resident # 14 Resident Representative (Son) returned call to facility saying he had no control over his mother's finances that he assumed DSS did for facility to contact them. On Nov. 28, 2018 Resident # 13 stated he did not have funds to pay for his glasses until Dec. when he received his per-capita check. On Nov. 28, 2018 Administrator wrote a facility check to purchase for Resident # 13 & resident #14 glasses and mailed to Dr. Wartman. On Dec. 5, 2018 Social Worker, Medical Records and Scheduler all in-serviced on notifying the Social Worker with all orders and appointments made for Eye Doctors visits.</p> <p>How the facility will identify other residents having the potential to be affected by the deficient; On Nov. 28, 2018 Social Worker performed a 100% audit of all residents seen by Eye doctor who received written prescriptions for glasses, one resident #</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/28/2018
NAME OF PROVIDER OR SUPPLIER MACON VALLEY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3195 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 745	<p>Continued From page 2</p> <p>he did not know why there was no follow up regarding the prescription glasses.</p> <p>An attempt to reach the former social worker by phone was unsuccessful.</p> <p>Review of the medical record revealed no documentation of any further communication with the resident or the family regarding the status of the prescription glasses.</p> <p>A phone interview was conducted on 11/20/18 at 1:55 PM with the physician who examined Resident #14 on 03/08/18. The physician stated that following the exam, the paperwork and payment needed was left with the facility so follow up could be made by the facility. Once payment was received, the physician would order the glasses and then deliver them to the facility.</p> <p>An attempt to call Resident #14's responsible party was unsuccessful.</p> <p>A follow up interview with the social worker on 11/20/18 at 2:34 PM revealed he found the list of who was seen on 03/08/18 in the previous social worker's office. He provided the list which indicated 9 residents were found to need prescription eye glasses, including Resident #14. He further stated he could not say if there had been any follow up with the residents/responsible parties regarding the prescription and monies needed to fill the prescriptions.</p> <p>Interview with the Administrator on 11/20/18 at 3:28 PM revealed that the eye physician comes to the facility and left the documentation which included any prescription and cost with medical records staff and the social worker after the</p>	F 745	<p>5879 was found that his eyeglasses had not been paid.</p> <p>On Dec. 5, 2018 Social Worker spoke with resident's family and they stated they did not have the money for the glasses. Facility mailed check on Dec. 7, 2018 for this resident # 5879 eyeglasses. Social Work and /or designee will perform monthly audits X 12 months on all Residents seeing the Eye Doctor for prescriptions and contact families immediately about cost.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Social Work and /or designee will perform monthly audits X 12 months on all Residents seeing the Eye Doctor for prescriptions and contact families immediately about cost.</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed. The Social Worker will bring the monthly audits to daily IDT Meeting every month X 12 months to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The Administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/28/2018
NAME OF PROVIDER OR SUPPLIER MACON VALLEY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3195 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 745	<p>Continued From page 3</p> <p>evaluation. The social worker was responsible for following up with the resident/family including informing them of the cost of the glasses. Once the payment was received then the glasses would be ordered. The Administrator stated she believed the breakdown occurred because of a changes in social workers. She further stated she would have expected a social work note in the record to reflect steps taken in attempts to obtain the prescription glasses.</p> <p>A phone interview with Resident #14 on 11/28/18 at 11:45 AM revealed she used to wear glasses a long time ago but hasn't had any glasses in a very long time. She stated that because she does not have any glasses everything is blurry. The television is blurry and people she talks to are blurry. She further stated that it made her feel "really bad" that it has taken so long to get glasses. She still wants to get the glasses.</p> <p>2. Resident #13 was admitted to the facility on 01/24/18. His diagnoses included diabetes. He was his own responsible party.</p> <p>The most recent Minimum Data Set, a quarterly dated 10/26/18 coded him with some cognitive impairment scoring a 12 out of 15 on the Brief Interview for Mental Status.</p> <p>During an interview on 11/20/18 at 3:20 PM, Resident #13 stated he had an eye exam a while ago. He stated he had picked out frames for the prescription but never got any glasses and never heard another word about it. Resident #13 stated no one ever discussed the need for money or what was further needed for him to do in order to obtain his prescription glasses. When asked if he was interested in still obtaining the glasses, he</p>	F 745			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/28/2018
NAME OF PROVIDER OR SUPPLIER MACON VALLEY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3195 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 745	<p>Continued From page 4</p> <p>stated he was not sure how much money he had currently and stated he got money at the beginning of the month. At this time, Resident #13 was not wearing glasses.</p> <p>Review of the medical record revealed Resident #13 received an eye examination on 03/08/18. The evaluation included a "Payment Worksheet" which included a written prescription for eyeglasses and a cost associated with them of \$86.00. The form included a statement that the glasses would be ordered and delivered to the resident upon full payment.</p> <p>Review of the Minimum Data Sets dated 1/24/18, 4/26/18, 7/27/18 and 10/26/18 he was coded as having adequate vision without glasses.</p> <p>Interview with the medical records staff on 11/20/18 at 9:40 AM revealed the social worker was responsible for contacting the family regarding necessary payment for the prescription glasses and then let the eye clinic know if they could order the glasses.</p> <p>Interview with the Social Worker on 11/20/18 at 10:31 AM revealed that he was not the designated social worker at the time of the eye exam. He explained that the family should have been told there was a prescription for glasses and explained the payment process. He stated that he did not know why there was no follow up regarding the prescription glasses.</p> <p>An attempt to reach the former social worker by phone was unsuccessful.</p> <p>Review of the medical record revealed no documentation of any further communication with</p>	F 745			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/28/2018
NAME OF PROVIDER OR SUPPLIER MACON VALLEY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3195 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 745	<p>Continued From page 5</p> <p>the resident regarding the status of the prescription glasses.</p> <p>A phone interview was conducted on 11/20/18 at 1:55 PM with the physician who examined Resident #13 on 03/08/18. The physician stated that following the exam, the paperwork and payment needed was left with the facility so follow up could be made. Once payment was received, the physician would order the glasses and then deliver them to the facility.</p> <p>A follow up interview with the social worker on 11/20/18 at 2:34 PM revealed he found the list of who was seen on 03/08/18 in the previous social workers office. He provided the list which indicated 9 residents were found to need prescription eye glasses, including Resident #13. He further stated he could not say if there had been any follow up with the resident/responsible parties regarding the prescription and monies needed to fill the prescriptions.</p> <p>Interview with the Administrator on 11/20/18 at 3:28 PM revealed that the eye physician comes to the facility and left the documentation which included any prescription and cost with medical records staff and the social worker after the evaluation. The social worker was responsible for following up with the resident/family including informing them of the cost of the glasses. Once the payment was received then the glasses would be ordered. The Administrator stated she believed the breakdown occurred because of a changes in social workers. She further stated she would have expected a social work note in the record to reflect steps taken in attempts to obtain the prescription glasses.</p>	F 745			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/28/2018
NAME OF PROVIDER OR SUPPLIER MACON VALLEY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3195 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 745	<p>Continued From page 6</p> <p>A phone interview was conducted on 11/28/18 at 11:48 AM with Resident #13. Resident #13 stated that he has not had any glasses for years. He stated that he can't see to read very long as his eyes get tired and sentences get blurry and run together. He further stated he was unable to see the television unless he was sitting up close to it. He still wants to get glasses and stated it bothers him that it has taken so long to get his glasses.</p> <p>3. Resident #6 was admitted to the facility on 06/27/02. Her diagnoses included age related nuclear bilateral cataract.</p> <p>The most recent Minimum data Set dated 10/25/18 coded her with cognitive impairment, scoring a 9 out of 15 on the Brief Interview for Mental Status. During interviews conducted with Resident #6 on 11/19/18 at 3:50 PM, on 11/20/18 at 9:26 AM and again on 11/20/18 at 1:09 PM, Resident #6 was observed to be alert and oriented and able to follow and engage thoroughly in the conversations.</p> <p>On 11/19/18 at 3:50 PM, Resident #6 was observed in bed watching television. She was observed to be wearing glasses at this time. Resident #6 stated that her glasses were brand new and she just received them last week. She further stated that it had taken 6 to 7 months to obtain the glasses following her eye examination and she could see well with them now.</p> <p>Review of the medical record revealed Resident #6 had her eyes examined on 03/08/18. The evaluation included a "Payment Worksheet" which included a written prescription for eyeglasses and a cost associated with them of</p>	F 745			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/12/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/28/2018
NAME OF PROVIDER OR SUPPLIER MACON VALLEY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3195 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 745	<p>Continued From page 7</p> <p>\$126.00. The form included a statement that the glasses would be ordered and delivered to the resident upon full payment.</p> <p>Review of the Minimum Data Sets dated 3/21/18, 6/20/18 and 9/03/18, she was coded as having adequate vision with glasses.</p> <p>Interview with the medical records staff on 11/20/18 at 9:40 AM revealed the social worker was responsible for contacting the family regarding necessary payment for the prescription glasses and then let the eye clinic know if they could order the glasses.</p> <p>Interview with the Social Worker on 11/20/18 at 9:07 AM revealed the ward clerk scheduled the eye exams and the physician came to the facility. He stated that for some reason, after the eye exam, the glasses were never ordered. He stated he was not in the role as the social worker at the time of her exam. He stated he came back to work at the facility in July 2018. He was unaware of any problems with the eye exam or need for glasses until Resident #6's family started questioning when the resident was going to get her glasses. The Social Worker stated this was around mid October 2018. He then contacted the eye physician, obtained the prescription for the eyeglasses presented 03/08/18 and subsequently obtained payment for them and ordered the glasses on 10/19/18. He stated Resident #6 received the glasses on 11/15/18.</p> <p>Upon follow up interview on 11/20/18 at 10:31 AM the social worker explained that the family should have been told there was a prescription for glasses and explained the payment process. He stated that he did not know why there was no</p>	F 745			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/28/2018
NAME OF PROVIDER OR SUPPLIER MACON VALLEY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3195 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 745	<p>Continued From page 8 follow up regarding the prescription glasses.</p> <p>An attempt to reach the former social worker by phone was unsuccessful.</p> <p>Family, who visited daily, was interviewed on 11/20/18 at 1:09 PM and revealed she was never informed there was a payment needed in order to obtain the glasses. Family stated there was a breakdown in the communication as she never was contacted by the former social worker about needing to pay. She stated she found out about the necessary payment when she spoke to the current social worker and asked him about the prescription and status of the glasses.</p> <p>A phone interview was conducted on 11/20/18 at 1:55 PM with the physician who examined Resident #13 on 03/08/18. The physician stated that following the exam, the paperwork and payment needed was left with the facility so follow up could be made. Once payment was received, the physician would order the glasses and then deliver them to the facility.</p> <p>Interview with the responsible party via phone on 11/20/18 at 2:13 PM revealed no one ever called him to inform him of the needed monies to purchase Resident #6's glasses.</p> <p>Interview with the Administrator on 11/20/18 at 3:28 PM revealed that the eye physician comes to the facility and left the documentation which included any prescription and cost with medical records staff and the social worker after the evaluation. The social worker was responsible for following up with the resident/family including informing them of the cost of the glasses. Once the payment was received then the glasses would</p>	F 745			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/12/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/28/2018
NAME OF PROVIDER OR SUPPLIER MACON VALLEY NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3195 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 745	Continued From page 9 be ordered. The Administrator stated she believed the breakdown occurred because of a changes in social workers. She further stated she would have expected a social work note in the record to reflect steps taken in attempts to obtain the prescription glasses.	F 745		