

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345263</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/12/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>MACON VALLEY NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3195 OLD MURPHY ROAD</b> <b>FRANKLIN, NC 28734</b>	
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F 689 SS=G	<p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff and Physician interviews the facility failed to prevent a cognitively impaired resident from exiting the facility unsupervised into an enclosed courtyard resulting in a fall with a head laceration for 1 of 3 residents reviewed for supervision to prevent accidents.</p> <p>Findings included: Resident #1 was admitted to the facility 09/03/18 with diagnoses including Alzheimer's disease, non-Alzheimer's dementia, and hemiplegia (paralysis of one side of the body). Resident #1's care plan for wandering and/or being at risk for unsupervised exit from the facility related to attempts to leave the unit if not prevented, cognitive impairment, and dementia last updated 03/08/19 revealed her goals were to have no episodes of unsupervised exits from the facility and to wander only within specified boundaries. Interventions included allowing resident to wander on the unit and approaching Resident #1 in a non-threatening manner. Resident #1's significant change Minimum Data</p>	F 689	<p>This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provision of federal and state law.</p> <p>F689</p> <p>How will corrective action be accomplished for those residents found to be affected by the deficient practice?</p> <p>Res #1 sent to the ED for evaluation and treatment on 6/5/2019.</p> <p>How will facility identify other residents having potential to be affected by the same deficient practice?</p> <p>All patients have the potential to be affected by the alleged deficient practice. On 6/5/2019, all facility doors, were</p>	7/3/19

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

TITLE

(X6) DATE

Electronically Signed

07/02/2019

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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F 689	<p>Continued From page 1</p> <p>Set (MDS) dated 03/15/19 revealed she was severely impaired for cognition and did not have any episodes of wandering.</p> <p>A Wandering Risk Evaluation dated 03/08/19 revealed Resident #1 scored 16 on the evaluation and the follow up comment stated a wanderguard (a departure alert system) was placed on Resident #1's left ankle. The Wandering Risk Evaluation stated a resident who scored greater than 5 was at risk for wandering.</p> <p>A review of the medication list for Resident #1 revealed she received Plavix (a medication that prevents platelets from forming blood clots) 75 milligrams (mg) daily at 8:00 AM.</p> <p>The incident report dated 06/05/19 at 8:50 AM completed by Nurse #1 revealed Resident #1 fell on the courtyard patio concrete. Resident #1 fell onto her right side and had a hematoma (bruise) to her right forehead and a laceration beside her right eye temporal (near the temple) area. Resident #1 was bleeding a large amount and was on a blood thinner. Resident #1 did not lose consciousness. A dressing and ice were applied to her forehead and Emergency Medical Service (EMS) was called for transport to the hospital.</p> <p>A Witness Statement from NA #1 regarding Resident #1's fall revealed a therapist (a physical therapy assistant and abbreviated as PTA) came to the dementia unit and asked where Resident #1 was located. NA #1 stated Resident#1 was at the far end of the unit. PTA #1 walked to the far end of the unit and stated Resident #1's chair was there but she was not. NA #1 walked over to PTA #1 and they began looking for Resident #1. NA #1 glanced over and saw Resident #1 on the</p>	F 689	<p>checked by the Maintenance Director for proper functionality with no negative findings.</p> <p>Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>A Logbook Documentation Doors, Locks, and Alarms was initiated, on 6/5/19 to ensure that all doors are routinely checked and doors are functioning appropriately.</p> <p>In-service completed on 6/6/19 with the Maintenance Director by Nurse Consultant regarding checking doors and proper functionality and alarm. All staff were proactively educated beginning 6/6/19 and completed by 6/11/19 on ensuring all doors are fully engaged upon entering and exiting the facility. New hires are trained and will continue to be trained upon general orientation regarding Facility Alarm Systems/Device.</p> <p>Maintenance Director will audit doors 5 times a week for 8 weeks, then 3 times a week for 4 weeks beginning on 6/5/2019 on the Logbook , Doors, Locks, and Alarms.</p> <p>How the facility plans to monitor its performance to make sure that solutions are sustained?</p> <p>Maintenance Director will audit doors 5 times a week for 8 weeks, then 3 times a week for 4 weeks beginning on 6/5/2019</p>		

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F 689	<p>Continued From page 2</p> <p>ground outside the dementia unit. PTA #1 went outside to check on Resident #1 and NA #1 paged overhead the code for a fall.</p> <p>Review of Resident #1's medical record revealed a nurse's note dated 06/05/19 at 11:22 AM by Nurse #1 stated Resident #1 fell on the courtyard patio concrete on her right side. Resident #1 had a hematoma to her right forehead and a laceration beside her right eye and was bleeding a large amount. EMS came and transferred Resident #1 to the hospital.</p> <p>Review of Resident #1's EMS report dated 06/05/19 at 9:06 AM stated Resident #1 was found outside the Spark unit (dementia unit) lying on a concrete pad. Staff stated it was unknown why the resident was outside or why she fell. It was also unknown if the resident had lost consciousness.</p> <p>Review of Resident #1's hospital record dated 06/05/19 revealed she came to the Emergency Department after a fall with details unknown and had a laceration and bruising to the right side of her head. Resident #1 received sutures (stitches) to her head laceration and was admitted to the Intensive Care Unit (ICU) with a diagnosis of urinary tract infection (UTI).</p> <p>An interview with Nurse #1 on 06/11/19 at 11:20 AM revealed she was working in the dementia unit 06/05/19 on the 7:00 AM to 3:00 PM shift and was caring for Resident #1. Nurse #1 stated she had to leave the unit to obtain a medication for another resident when Resident #1 fell. Nurse #1 stated when she left the unit Nurse #2 stayed on the unit until she could return. Nurse #1 stated she heard the overhead code paged for a fall in</p>	F 689	<p>on the Logbook , Doors, Locks, and Alarms.</p> <p>The Maintenance Director will submit the audits to the monthly QAPI committee for review for 3 months or as needed for sustained compliance. Any door found to have functionality issues, will be reported to the Maintenance Director and the Administrator immediately. Door functionality audit directs staff to document functionality problems and corrective action taken. Administrator and Maintenance Director are responsible for sustained compliance.</p> <p>Date of Compliance 7/3/19</p>		

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F 689	<p>Continued From page 3</p> <p>the dementia unit and returned to the dementia unit. Nurse #1 stated when she returned to the dementia unit Resident #1 was outside on the patio ground lying on her right side and her head was bleeding. Nurse #1 stated a dressing and ice were applied to Resident #1's head wound and 911 was called. PTA #1, NA #1, and Nurse #2 were with Resident #1. Nurse #1 stated the double doors at the end of the dementia unit were to remain locked at all times and she was not sure how Resident #1 was able to exit the dementia unit unsupervised. Nurse #1 stated she had not seen anyone enter or exit through the double doors at the end of the dementia unit on 06/05/19 prior to Resident #1's unsupervised exit and fall. Nurse #1 stated she could not recall for certain the last time she saw Resident #1 prior to her unsupervised exit from the unit the morning of 06/05/19 but she had already taken her morning medications.</p> <p>An interview with NA #1 on 06/11/19 at 12:13 PM revealed she was working in the dementia unit on 06/05/19 and was caring for Resident #1. NA #1 stated she was looking at the shower list on the dementia unit with Nurse #2 when PTA #1 entered the unit and asked where Resident #1 was. NA #1 stated Resident #1 was at the far end of the room. PTA #1 went to the end of the unit and said Resident #1's chair was there but she was not. NA #1 stated she went to the far end of the dementia unit to help PTA #1 look for Resident #1. NA #1 stated she glanced at the double doors at the end of the dementia unit and saw Resident #1 outside lying on the patio concrete. PTA #1 went out to check on Resident #1 and NA #1 paged the code for a fall overhead. NA #1 stated Nurse #2 also went out to check on Resident #1. NA #1 stated she did not know how</p>	F 689			

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F 689	<p>Continued From page 4</p> <p>Resident #1 got outside the dementia unit because the double doors at the end of the unit were to be locked at all times and required a key code to be opened. NA #1 stated only staff had the key code to the double doors. NA #2 stated she could not recall for sure the last time she saw Resident #1 before she was found outside the morning of 06/05/19 but she had eaten breakfast in the common area around 7:30 AM that morning. NA #1 stated no one had entered or exited the dementia unit through the double doors prior to Resident #1's unsupervised exit and fall on 06/05/19 that she was aware of.</p> <p>An interview with PTA #1 on 06/11/19 at 12:24 PM revealed he entered the dementia unit the morning of 06/05/19 and asked NA #1 where Resident #1 was. NA #1 stated Resident #1 was close to the end of the unit near the double doors in her wheelchair. PTA #1 stated Resident #1's wheelchair was empty and he told NA #1 he did not see Resident #1. PTA #1 and NA #1 started looking for Resident #1 and saw her outside the dementia unit on the ground in the patio area. PTA #1 stated he went outside to check on Resident #1. PTA #1 stated when opened the door to the patio area he did not have to put in a key code to open the door and the door opened easily.</p> <p>An interview with the Maintenance Director on 06/11/19 at 12:36 PM revealed there were 3 doors alarmed for the wanderguard system and they were the front door to the facility, a service door near the laundry room, and double doors on a unit that did not house residents. He stated the dementia unit was not connected to the wanderguard system. The Maintenance Director stated the double doors on the dementia unit</p>	F 689			

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F 689	<p>Continued From page 5</p> <p>were locked by a key pad magnetic lock. The Maintenance Director stated he was asked to check the double doors at the end of the dementia unit on 06/05/19 after Resident #1 was found outside. He stated he could not find any problems with the double doors on 06/05/19. The Maintenance Director stated he was asked to check the double doors again on 06/07/19 and when the left double door was allowed to close slowly it did not lock properly. He stated he determined the magnetic lock on the left double door was not contacting all the way when the door was allowed to close slowly. The Maintenance Director stated he tightened up a loose screw on part of the locking mechanism of the left double door and then the door closed correctly on 06/07/19. The Maintenance Director stated prior to Resident #1 being found outside he was not aware of any concerns with the double doors on the dementia unit not closing correctly.</p> <p>An interview with the former Maintenance Director on 06/11/19 at 12:57 PM revealed the double doors on the dementia unit were secured with a magnetic key code lock and were not supposed to be able to be unlocked or opened without a key code. The former maintenance director stated he was not aware of any problems with double doors on the dementia unit prior to Resident #1's unsupervised exit and fall on 06/05/19.</p> <p>An interview with Nurse #2 on 06/11/19 at 2:23 PM revealed she came to the dementia unit the morning of 06/05/19 to check the shower list. Nurse #2 stated she was talking with NA #2 when PTA #1 came to the dementia unit and asked where Resident #1 was. She stated NA #1 told</p>	F 689			

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F 689	<p>Continued From page 6</p> <p>PTA #1 Resident #1 was at the other end of the common room. Nurse #2 stated she left the dementia unit and then heard the code for a fall paged overhead. Nurse #2 stated she immediately returned to the dementia unit and saw Resident #1 outside on the ground in the patio area. Nurse #2 stated she stayed with Resident #1 and applied a pressure dressing and ice to her head. Nurse #2 stated the double doors were already open when she exited the dementia unit to assist Resident #1 due to staff going back and forth outside while assisting Resident #1.</p> <p>An interview with NA #2 on 06/11/19 at 3:40 PM revealed he was assigned to the dementia unit on 06/05/19 for the 7:00 AM to 3:00 PM shift. NA #2 stated he had just returned to the unit from either being on break or taking laundry to housekeeping when he saw several staff members gathered around Resident #1 outside in the courtyard. NA #2 stated he stayed on the dementia unit caring for the other residents while other staff attended Resident #1. NA #2 stated he did not recall the last time he saw Resident #1 the morning of 06/05/19 prior to her unsupervised exit and fall and he was not aware of anyone entering or exiting the dementia unit through the double doors prior to Resident #1's fall 06/05/19.</p> <p>An interview with the Director of Nursing (DON) on 06/11/19 at 4:11 PM revealed the double doors on the dementia unit were to be locked at all times. After Resident #1 was sent to the hospital 06/05/19 maintenance was asked to check the double doors at the end of the dementia unit. The Maintenance Department did not find any concerns with the double doors on 06/05/19. The DON stated Maintenance was asked to check the</p>	F 689			

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F 689	<p>Continued From page 7</p> <p>double doors of the dementia unit again on 06/07/19 and found there was a loose bolt on 1 of the doors and he corrected that. The DON stated an investigation was conducted by the Administrator regarding Resident #1's unsupervised exit and fall but no one knew how she got out of the dementia unit.</p> <p>The Administrator was unavailable for interview during the survey.</p> <p>An interview with the Physician on 06/12/19 at 11:49 AM revealed Resident #1 was at risk for wandering due to her diagnosis of dementia and it was not safe for her to be in the facility's courtyard unsupervised.</p>	F 689			