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 03/12/2020

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MACON VALLEY NURSING AND REHABILITATION CENTER	3195 OLD MURPHY ROAD FRANKLIN, NC 28734

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E 000	Initial Comments An unannounced recertification survey was conducted on 03/09/20 through 03/12/20. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 91CS11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey and complaint investigation was conducted on 03/09/20 through 03/12/20. A total of 2 allegations were investigated and both were unsubstantiated. Event ID# 91CS11.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 578		3/27/20

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

Electronically Signed | 03/31/2020

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F 578	Continued From page 1 (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to clarify the code status for 1 of 1 resident reviewed for advanced directives (Resident #37). Findings included: Resident #37 was admitted to the facility on 06/02/17 with multiple diagnoses that included dementia with behavioral disturbance, chronic kidney disease, anxiety disorder, and depression. Resident #37's Electronic Medical Record (EMR) revealed a physician's order dated 06/02/17, with an end date marked as indefinite, that indicated he was a "Full Code" (direction to implement Cardiopulmonary Resuscitation (CPR) should respirations and heartbeat stop). Resident #37's advanced directive care plan, last	F 578	The advanced directive was clarified and corrected on 3/11/20 by the Unit Manager. An audit was completed on all residents by the Social Worker and Unit Managers on 3/17/20 to ensure the code status listed on EMAR, written order, and care plan were all congruent. The Unit Managers, Licensed Nursing staff, Ward Clerk, Social Worker, Admissions Coordinator were inserviced by the Administrator/Staff Development Coordinator on 3/23/20 on ensuring the physician's order, yellow DNR or full code request, EMAR, and care plan for any admitting resident is the same. Inservice also provided to the same staff to ensure when there is a change of code status, the previous code status inromation is	

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F 578	Continued From page 2 revised on 01/08/20, revealed a focus of end of life/planning directives: Full Code/Hospice with the goal his wishes would be honored. Interventions included Full Code and for staff to review code status quarterly and at care plan meetings. The significant Minimum Data Set (MDS) dated 01/21/20 assessed Resident #37 with severe impairment in cognition. The MDS noted Resident #37 had a prognosis of a life expectancy of less than 6 months and received hospice services. Resident #37's paper medical record revealed a Resident Request Do Not Resuscitate (DNR) Form signed by Resident #37's guardian on 02/28/20 authorizing facility staff to withhold CPR in the event of an emergency situation. Further review revealed a DNR form signed by the Nurse Practitioner (NP) with an effective date of 03/02/20 and no expiration date. During an interview on 03/11/20 at 9:16 AM, Nurse #1 stated she referred to the advanced directive information documented in the resident's EMR when determining code status. Nurse #1 reviewed Resident #37's EMR and confirmed his code status was listed as Full Code. During an interview on 03/11/20 at 2:30 PM, the Social Worker (SW) explained he reviewed a resident's code status quarterly and/or during care plan meetings and initiated code status changes when hospice services were elected if the resident was a Full Code or requested by the resident or their family. He added once the DNR form was signed, he gave the form to the Nurse to write the order and update code status in the	F 578	removed from the chart. Code status for new admits and change in code Status will be reviewed daily during Cardinal (department head) meetings. The Social Worker will audit 10 charts each week for eight weeks, then 5 charts for 4 weeks to ensure code status information , including written physician orders, EMAR, code request, and care plan are all the same. The Social Worker will report any findings to the Quality Assurance and Performance Improvement Committee monthly for 3 months. The Social Worker will continue to audit Code Status for each Resident monthly ongoing to ensure the accuracy of Resident Code Status.	

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F 578	Continued From page 3 resident's EMR. He confirmed Resident #37 was listed as a Full Code in his EMR and reported he was working on getting a DNR form signed by the facility's physician. The SW was unaware a DNR form, signed by the NP with an effective date of 03/02/20, was in Resident #37's paper medical record. During an interview on 03/11/20 at 3:12 PM, the Director of Nursing (DON) stated the SW typically reviewed a resident's code status during quarterly care plan meetings or as needed and nurses were responsible for getting a signed physician's order and updating the code status change in the resident's EMR. The DON was unsure who had placed the DNR form dated 03/02/20, which was signed by the NP, in Resident #37's paper medical record without updating the physician's orders and code status in his EMR. The DON added she reviewed physician orders daily and stated the change in Resident #37's code status from a full code to a DNR was missed.	F 578		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) in the areas of Hospice (Resident #79) and Falls (Resident #60) for 2 of 5 residents whose MDS assessments were reviewed. The findings included:	F 641	The MDS for resident #79 was corrected and submitted on 3/11/20 by MDS. The MDS for resident #60 was corrected on 3/11/20 by MDS. An audit was completed by MDS on 3/17/20 on all residents who receive hospice services to ensure the MDS	3/27/20

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F 641	Continued From page 4 Resident #79 was admitted to the facility on 12/31/09 with a diagnosis of Non-Alzheimer's Dementia and Alzheimer's Disease. She was re-admitted on 05/25/16 with a diagnosis of Acute Post Hemorrhagic Anemia and Abnormal Results of Liver Function Studies and Jaundice. A Physician's order for Resident #79 dated 01/28/20 revealed an order for Hospice due to disease process. Resident #79's Care Plan updated on 01/28/20 revealed that Resident #79 family had chosen Hospice Care Services for End of Life Care related to decline of Alzheimer's Disease. Resident #79's significant change MDS dated 02/12/20 revealed the resident was not coded as having received Hospice care. An interview with the MDS nurse on 03/11/2020 at 8:52 AM revealed that a significant change MDS would occur for major injury, Hospice, decline in health, or at least 2 declines with activities of daily living and must be done within 14 days after acknowledgement of change. She reported that Hospice should have been coded on any MDS and that it was a mistake that Hospice was not coded on the resident's 02/12/20 significant change MDS. An interview with the Director of Nursing (DON) on 03/11/20 at 11:22 AM revealed that there was a process for significant change MDS that included change in status, doctor decision, change in family dynamics, Hospice, other health related changes that would impact the resident. She reported that Hospice should have been	F 641	indicated the resident was receiving hospice services. An audit was completed by DON and MDS on 3/17/20 on all MDS completed since February 17, 2020 to ensure the MDS was coded correctly, indicating falls where appropriate. There were no other MDS coded incorrectly. The administrator inserviced MDS to ensure hospice services and falls are coded correctly on the MDS on 3/27/20. MDS will audit 10 charts weekly for four weeks , then 5 charts weekly for eight weeks to ensure hospice services and falls are coded correctly on MDS. MDS will report any findings to the Quality Assurenace and Performance Improvement committee monthly for 3 months at which time the QAPI committee will determine if further auditing is needed.	

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F 641	Continued From page 5	F 641		

coded in Section O of the significant change MDS and thereafter and in the case of Resident #79, it was an error that it was not coded.

An interview with the Administrator on 03/12/2020 at 3:24 PM revealed that clearly the 02/12/20 significant change MDS for Resident #79 was because of the order for Hospice and believed it was a clerical error. Her expectation was for the MDS staff to follow the Clinical Guidelines for MDS.

2. Resident #60 was admitted to the facility on 02/27/19 with multiple diagnoses that included left femur (upper thigh bone) fracture.

Review of the nurse progress notes for Resident #60 revealed the following entries:
12/22/19 read in part, Resident #60 was found in her room, sitting on the floor between the wall and bed. Resident #60 was assessed with no injuries observed.
01/17/20 read in part, Resident #60 was found on the floor of her room in a seated position with no visible injuries noted upon nurse assessment.

The quarterly MDS assessment dated 02/14/20 assessed Resident #60 with no memory impairment and independent with making decisions regarding tasks of daily life. The MDS noted Resident #60 displayed no behaviors and required extensive staff assistance with bed mobility and transfers. It was further noted she had no falls during the MDS assessment period.

During an interview on 03/11/20 at 4:47 PM, the MDS Coordinator confirmed Resident #60 had 2 documented falls that occurred after the MDS assessment dated 12/17/19 that should have

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F 641	Continued From page 6 been coded on the MDS assessment dated 02/14/20. The MDS Coordinator stated when reviewing Resident #60's medical record to code the MDS assessment, they had overlooked the falls documented in the nurse progress notes. She added a modification of the MDS assessment dated 02/14/20 would be submitted to accurately reflect Resident #60 had 2 falls with no injuries since the previous MDS assessment. During an interview on 03/12/20 at 3:39 PM, the Director of Nursing (DON) confirmed she was aware of the issues identified with MDS accuracy and felt it was an honest mistake on the part of the MDS Coordinator who simply overlooked the documented falls for Resident #60 when completing the MDS assessment. The DON stated she would expect for MDS assessments to be accuracy coded. During an interview on 03/12/20 at 4:24 PM, the Administrator stated resident falls were reviewed during daily meetings and felt the missed opportunity for coding Resident #60's falls on the MDS assessment dated 02/14/20 were due to human error. The Administrator stated she would expect for MDS assessments to be accurately coded.	F 641		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to keep the trash compactor free of holes to prevent leaks, the compactor's door	F 814	The administrator contacted the waste disposal contractor and instructed them to remove the container on 3/11/20. The	3/27/20

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F 814	Continued From page 7 closed and area around the compactor free of accumulated medical waste and debris for 1 of 2 dumpsters observed. The findings include: Observations were conducted on 3/9/20 at 10:30 AM, on 3/10/20 at 10:30 AM, and on 3/11/20 at 10:30 AM, of the facility's automatic trash compactor. During each of these observations of the trash compactor an opaque fluid was leaking from the following three rusted areas; the front lower outer edge where the compactor's winch hook was located, the right back lower corner and an inaccessible area underneath the compactor. The fluid leaking from the trash compactor dripped onto the concrete pad the compactor was positioned on, drained down the pad's edges and onto the asphalt parking lot, where it collected and drained into the ground and into a depression in the parking lot. Here, the fluid had pooled to an area measuring approximately 2 feet wide and 4 feet in length. These observations also revealed the compactor's door was open and not securely fastened. The area around the trash compactor contained accumulated debris including; medical blue and white examination gloves, tinfoil, cleaning wipes, white and brown colored paper, hospital masks, assorted metal cans and plastic containers, alcohol pads, foam cups and containers, plastic wear, cardboard containers, smoking paraphernalia, medicine ointment tube, and a plastic syringe. An Interview conducted on 3/10/20 at 11:45 AM with the Director of Maintenance revealed that two months ago he had contacted the refuse contractor and complained the compactor was leaking and that the contractor told the	F 814	container was removed on 3/11/20 and the contractor replaced the container with 4 smaller containers that did not leak. The Maintenance Director and Housekeeping staff cleaned up the trash and debris around the dumpster and along the embankment on 3/11/20. There are no other trash containers on site. All nursing, dietary, and housekeeping staff were inserviced by Staff Development Coordinator by 3/27/20 about ensuring the garbage container doors closed properly and picking up debris around the trash containers, and notifying the maintenance director of trash along the embankment. Beginning March 12, the Maintenance Director began monitoring the trash container 3 times daily for four weeks, then once daily ongoing. The weekend supervisor will monitor containers on the weekends. The maintenance Director will report any findings from monitoring during daily Cardinal meetings (all department heads) and monthly to the Quality Assurance and Performance Improvement Committee ongoing.	

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F 814	Continued From page 8	F 814		

Maintenance Director they would try to fix the leak as soon as possible, as the contractor only had one compactor and could not replace it with another compactor.

An Interview and observations were conducted on 3/11/20 at 11:30 AM of facility's trash compactor and surrounding area with the facility's Administrator and Director of Maintenance. The Administrator stated the Director of Maintenance was responsible for managing the refuse for the facility and monitoring the disposable units, which included leaks, trash found around the compactor and on the grounds. During the observation the facility's Administrator expressed concerned regarding the amount of trash that was on the ground and the fluid leaking from the trash compactor. The Administrator requested the Director of Maintenance to immediately have his staff pick up and dispose of all the trash that was on the ground. The Administrator then contacted the refuse contractor to have the compactor immediately removed from the premises and have four additional refuse bins placed with daily refuse removal by the contractor until the compactor could be repaired and/or replaced.