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

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 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACON VALLEY NURSING AND REHABILITATION CENTER	**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
E 000	Initial Comments An unannounced recertification survey was conducted on 06/13/22 through 06/16/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 4W6K11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey and complaint investigation was conducted on 06/13/22 through 06/16/22. A total of 5 allegations were investigated and all were unsubstantiated. NC00178255 and NC001176937. Event ID # SDR411.	F 000		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those	F 582		7/13/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/08/2022

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345263	A. BUILDING ______ B. WING ______	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACON VALLEY NURSING AND REHABILITATION CENTER	**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 582	Continued From page 1 services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a CMS-10055 SNF ABN (Centers for Medicare and Medicaid Services Skilled Nursing Facility Advanced Beneficiary Notice) prior to discharge from Medicare Part A skilled services to 2 of 3 residents reviewed for beneficiary protection notification review (Residents #16 and #52).	F 582	F 582 Medicaid/Medicare Coverage/Liability Notice The facility will protect Residents #16 and 52 and all Medicare Part A beneficiaries by providing a CMS-10055 SNF ABN prior to discharge from Medicare Part A skilled services as required.	

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 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACON VALLEY NURSING AND REHABILITATION CENTER	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 582	Continued From page 2	F 582		

Findings included:

1. Resident #16 was admitted to the facility on 4/13/22.

A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was discussed with Resident #16's Responsible Party (RP) on 6/1/22 which indicated Medicare Part A coverage for skilled services would end on 6/7/22. Resident #16 remained in the facility.

A review of the medical record revealed a CMS-10055 SNF ABN was not provided to Resident #16 or her RP.

An interview was conducted with the Business Office Manager on 6/14/22 at 2:38 PM. The Business Office Manager revealed he was not aware that the resident and/or their RP should be given a SNF ABN in conjunction with the NOMNC. The Business Office Manager confirmed Resident #16 nor her RP was issued a SNF ABN.

An interview was conducted with the Administrator on 6/14/22 at 4:33 PM. The Administrator stated she expected whatever form that was required should be completed and she had just become aware the SNF ABN form should have been issued to the resident and/or their RP as of that day.

2. Resident #52 was admitted to the facility on 1/12/22.

A review of the medical record revealed a

The facility Administrator educated the BOM, MDS Coordinator, Admissions Coordinator, and Therapy Director on 6/7/22 regarding the proper forms to be used when Residents are discharged from Medicare Part A skilled services.

The facility Administrator or Designee/IDT Member will monitor Liability Notice (SNF ABN) issuance during IDT meetings 1x/week for 4 weeks and then 2x/month for 1 month. Any deviations from the standard will be addressed at that time.

The auditing information will be reviewed by the Quality Assurance Performance Improvement (QAPI) Committee monthly for 2 months or until substantial compliance is achieved. The Committee will make necessary recommendations for continued regulatory compliance.

The allegation of compliance date is 7/13/22.

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 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACON VALLEY NURSING AND REHABILITATION CENTER	**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 582	Continued From page 3 CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was discussed with Resident #52 on 3/31/22 which indicated Medicare Part A coverage for skilled services would end on 4/4/22. Resident #52 remained in the facility. A review of the medical record revealed a CMS-10055 SNF ABN was not provided to Resident #52. An interview was conducted with the Business Office Manager on 6/14/22 at 2:38 PM. The Business Office Manager revealed he was not aware that the resident and/or their RP should be given a SNF ABN in conjunction with the NOMNC. The Business Office Manager confirmed Resident #52 was not issued a SNF ABN. An interview was conducted with the Administrator on 6/14/22 at 4:33 PM. The Administrator stated she expected whatever form that was required should be completed and she had just become aware the SNF ABN form should have been issued to the resident and/or their RP as of that day.	F 582		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to maintain a	F 759	F759 Medication Error Rate <5%	7/13/22

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 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACON VALLEY NURSING AND REHABILITATION CENTER	**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 759	Continued From page 4 medication error rate of less than 5% as evidenced by 1 medication given without a Physician's order and failure to administer 1 medication according to the Physician's order. These errors constituted 2 out of 26 opportunities, resulting in a medication error rate of 7.69% for 2 of 8 residents observed during medication administration pass (Resident #7 and Resident #28). The findings included: 1. Resident #7 was admitted to the facility on 1/14/2013 with diagnoses which included Alzheimer's Disease. An observation was made on 6/15/2022 at 8:50 AM of Nurse #1 while she prepared and administered Resident #7's medications. Nurse #1 did look at the Medication Administration Record (MAR) while she prepared the medications which included Polyethylene Glycol powder 17 grams (medication used to relieve symptoms of constipation) that she pulled from the house stock and mixed in water. Nurse #1 administered the medications which included the Polyethylene Glycol powder to Resident #7. Resident #7's Physician's orders were reviewed and did not reveal an active order for Polyethylene Glycol powder. An interview along with an observation of Resident #7's MAR and Physician's orders with Nurse #1 on 6/15/2022 at 9:07 AM revealed Nurse #1 did not see an active order for the Polyethylene Glycol powder on Resident #7's MAR or in the Physician's orders. Nurse #1 stated she should not have given the Polyethylene	F 759	The facility will protect Residents #7 and 28 by ensuring the medication pass error rate is below 5%. On 6/15/22, Staff Nurse #1 assessed Resident #7 and notified the physician of the medication error; MiraLAX was given after the order had been discontinued. There was no adverse effect experienced by the resident and the physician gave a new order for 6/15/22. On 6/15/22, Staff Nurse #2 assessed Resident #28 and notified the physician of the medication error; one (1) eye drop of Visine was given when the order was for two (2) eye drops. There was no adverse effect experienced by the resident and the physician did not give a new order. The director of nursing (DON) and quality improvement (QI) nurse completed a 100% audit of staff nurses working on 6/15/22 passing medications to verify nurses were: 1) looking at the electronic medication administration records and reading prescription medication labels for prescriber orders prior to administering medications and 2) if an error is made, notification is immediately made to the DON/QI nurse for guidance. Nurse #1 and Nurse #2 again reported their medication error, no further issues were identified during this audit. On 6/15/22, the DON and Nurse Managers initiated a 100% in-service to all nurses, to include Nurse #1 and Nurse #2, regarding the requirement to look at the	

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 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACON VALLEY NURSING AND REHABILITATION CENTER	**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 759	Continued From page 5 Glycol powder to Resident #7 without an order. Nurse #1 further stated Resident #7 used to have an order for the Polyethylene Glycol powder and she had gotten used to administering it to Resident #7, but that was not an excuse for giving the medication without an order. An interview was conducted with the Director of Nursing (DON) on 6/15/2022 at 1:17 PM and revealed Nurse #1 should not have given Resident #7 Polyethylene Glycol powder without a Physician's order. The DON stated Nurse #1 should have obtained an order from the Physician prior to administration of the medication to Resident #7. An interview was conducted with the Medical Director (MD) on 6/15/2022 at 2:43 PM which revealed the Polyethylene Glycol powder should not have been administered to Resident #7 without an order. The MD stated he did not feel there would be any harm to Resident #7 from receiving the Polyethylene Glycol powder. 2. Resident #28 was admitted to the facility on 4/16/2012 with diagnoses which included unspecified dementia without behavioral disturbance. Resident #28's Physician's orders were reviewed and revealed an order dated 11/15/2019 for Polyvinyl alcohol solution (eye drop used to treat symptoms for dry eyes)- instill 2 drops in both eyes three times a day for dry eyes. An observation was made on 6/15/2022 at 11:55 AM of Nurse #2 while she prepared and administered Resident #28's medications. Nurse #2 did look at the Medication Administration	F 759	electronic medication administration records and reading prescription medication labels for prescriber orders prior to administering medications. The Rights of Medication Pass was included during the in-service. All newly hired nurses including agency will be in-serviced by the DON or Nurse Manager on medication administration during orientation. Education will be completed 7/13/22. Nurses who are out on Leave will be educated prior to taking a cart on their next scheduled work day. On 6/17/22, 100% medication pass observation with all nursing staff was initiated by the DON, QI nurse, treatment nurse, and corporate RN. The observations will be completed by Nurse Managers by 7/13/22. Nurses who have not had a medication administration pass reviewed by an administrative nurse by this date due to Leave will be observed on their first shift back to work to ensure the medication error rate is below 5%. Medication pass monitoring will be completed weekly for four (4) weeks by the DON or Designee/Nurse Manager to ensure the medication pass error rate remains less than 5%. The Quality Assurance Performance Improvement (QAPI) Committee will review the audit results monthly at QAPI meeting x3 months to monitor continued compliance in this area and make necessary recommendations to the administrator for continued regulatory	

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 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACON VALLEY NURSING AND REHABILITATION CENTER	**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 759	Continued From page 6 Record (MAR) while she prepared the medications which included polyvinyl alcohol solution. Nurse #2 was observed to instill 1 drop into both eyes of Resident #28. An interview was conducted with Nurse #2 on 6/15/2022 at 12:27 PM in which Nurse #2 stated she had only instilled 1 drop of the eye drop into Resident #28's eyes because she did not realize Resident #28 was supposed to get 2 drops in both eyes. Nurse #2 further stated she had not read the order very well and had assumed Resident #28 was only supposed to receive 1 drop in both eyes. An interview was conducted with the Director of Nursing (DON) on 6/15/2022 at 1:17 PM which revealed Nurse #2 should have read the orders on the MAR and given the eye drop according to the Physician's orders. An interview was conducted with the Medical Director (MD) on 6/15/2022 at 2:43 PM which revealed the MD did want the medications to be given as they have been ordered and Resident #28 probably should have received 2 drops of the eye drop in both eyes. The MD revealed staff should be checking the orders and looking at the details of the order when administering medications.	F 759	compliance. The allegation of compliance date is 7/13/22.	