DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					O. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COM	E SURVEY PLETED
		345263	B. WING				C
	ROVIDER OR SUPPLIER	545205		STREET ADDRESS, CITY, STATE, ZIP CODE			/23/2018
	NOVIDER ON SUIT LIER				95 OLD MURPHY ROAD		
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER			RANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	;	F 0	000			
	was conducted on 10 Immediate jeopardy v	ation (Event ID #J78Q11) //09/18 through 10/12/18. was identified at: 584 at a scope and severity					
		ed on 10/18/18 of additional identified after management					
	of J.	580 at a scope and severity 600 at a scope and severity					
	of J.	607 at a scope and severity					
	CFR 483.45 at tag F7 of J.	760 at a scope and severity 335 at a scope and severity					
	of J.						
	Tag F684, F600, F60 substandard quality c						
	An extended survey	was completed on 10/23/18.					
	11/20/18 Changes we BW	ere made to the CMS 2567					
F 550 SS=D			F 5	50			12/5/18
	self-determination, an access to persons an	Rights. ght to a dignified existence, nd communication with and id services inside and cluding those specified in					
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE
Electroni	cally Signed						11/16/2018

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.

		ID HUMAN SERVICES MEDICAID SERVICES			FORM	11/30/2018 APPROVED 0.0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE COMPI	
		345263	B. WING		( 10/2	C 23/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	Continued From page	21	F 5	50		
	§483.10(a)(1) A facilit with respect and dign resident in a manner promotes maintenanch her quality of life, reco individuality. The facil promote the rights of §483.10(a)(2) The facil access to quality care severity of condition, a must establish and m practices regarding tra- provision of services of residents regardless of §483.10(b) Exercise of the resident has the rights as a resident of or resident of the Unit §483.10(b)(1) The fac resident can exercise interference, coercion from the facility. §483.10(b)(2) The res free of interference, c reprisal from the facili rights and to be suppor exercise of his or her subpart. This REQUIREMENT by: Based on observation resident and staff inter	ey must treat each resident ity and care for each and in an environment that be or enhancement of his or ognizing each resident's ity must protect and the resident. cility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source. of Rights. right to exercise his or her if the facility and as a citizen teed States. cility must ensure that the his or her rights without a, discrimination, or reprisal sident has the right to be oercion, discrimination, and ty in exercising his or her orted by the facility in the rights as required under this is not met as evidenced ins, record review, and reviews, the facility failed to		Macon Valley Nursing and Rehabilitation		
		on the urinary catheter bag viewed for urinary catheters		Statement of Deficiencies and propose this Plan of Correction to the extent tha		

Facility ID: 923019

If continuation sheet Page 2 of 140

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/30/ FORM APPRO OMB NO. 0938-0
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345263	B. WING		C 10/23/2018
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD BE COMPLET TO THE APPROPRIATE DATE
F 550	Continued From page	e 2	F 55	50	
	(Resident #14).	:		the summary of findings correct and in order to n compliance with applica provisions of quality of c	naintain ble rules and are of residents.
	06/16/15 and most re diagnoses which inclu- behaviors, hypertens urinary retention, and	mitted to the facility on ecently on 09/21/18 with uded: dementia without ion, coronary artery disease, I benign prostatic er urinary tract symptoms.		The Plan of Correction i written allegation of com Valley Nursing and Reha Center Is response to th Deficiencies does not de with the Statement of De	npliance. Macon abilitation his Statement of enote agreement
	The admission Minim 09/28/18 revealed the moderately cognitivel was coded as requiri most activities of dail bathing. The MDS fur	um Data Set (MDS) dated	with the Statement of Defi does it constitute an admi deficiency is accurate. Fu Valley Nursing and Rehat reserves the right to refute deficiencies on this Stater Deficiencies through Infor Resolution, formal appeal and/or any other administ proceedings.	Further, Macon abilitation Center ute any of the ement of ormal Dispute al procedure	
	An observation of Re 7:45 am, revealed the wheelchair beside the	sident #14 on 10/09/18 at e resident was sitting in his e bed in his room with his uncovered on wheelchair just		F550 – Resident Rights How corrective action w accomplished for those have been affected by th practice	residents found to
	revealed he usually p	on 10/09/18 at 7:55 am laced urinary bags under the as unaware of a cover for		On 10/09/18 at 7:45 a.m assistant (NA) #5 hung t urinary catheter bag on wheelchair just below th urine was visible in the u	the uncovered Resident #15's e arm rest. The
	10/09/18 at 11:10 am	nade of Resident #14 on in the facility front hallway ter bag under his wheelchair no privacy cover.		catheter bag. NA #5 sta unaware the urinary cath have a privacy cover to dignity. On 10/09/18 after the di	ated the NA was heter bag should promote resident
	10/09/18 at 12:03 pm	nade of Resident #14 on exiting the therapy room ter bag under his wheelchair		#3 had Resident #15's u bag changed so there w and urine was not visible	as a privacy cover

Event ID: J78Q11

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STATEMENT (	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE	). 0938-039 SURVEY PLETED		
				3		С		
		345263	B. WING	·····		23/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	ZIP CODE			
MACON V	ALLEY NURSING AND R	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)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		I OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE ENCY)	(X5) COMPLETIO DATE		
F 550	Continued From page with urine visible.	e 3	F 55	On 10/09/18, the directo				
1 v 4 f t 1 t	10/09/18 at 12:42 pm	nade of Resident #14 on i in the facility dining room ter bag under wheelchair		(DON) re-educated NA maintaining dignity of re to privacy covers on urin bags.	sidents in relation nary catheter			
	#3 stated urine shoul	9/18 at 4:45 pm with Nurse d not be visible, and she will She further stated urinary vacy cover.		How the facility will iden having the potential to b same deficient practice On 10/09/18, the quality nurse and DON audited bags to ensure privacy of	e affected by the mprovement (QI) urinary catheter			
	10/09/18 at 4:05 pm i	ector of Nursing (DON) revealed a urinary catheter ue privacy cover over it and isible.		and/or urine was not vis bags. The audit reveale resident dignity issues r urine in catheter bags h wheelchairs.	ible in catheter ed no other elated to visible			
				What measures will be systemic changes made the deficient practice will On 11/6/18, the staff fac initiated a 100% re-educ registered nurses (RNs) practical nurses (LPNs) agency staff titled "Fole	e to ensure that Il not recur cilitator (SF) cation of ), licensed , NAs, and all			
				re-education instructs si bags should have a priv times" related to the imp maintaining residents' d in-service was complete During the new employe process the SF, quality nurse, DON or administ resident rights – dignity	taff "All drainage vacy cover at all portance of ignity. The ed 11/28/18. ee orientation improvement (QI) rator will provide			
				training. Beginning 11/6/18, the I SF, unit manager, activi social worker (SW), adn	ities director,			

Event ID: J78Q11

Facility ID: 923019

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CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES	-1			RM APPROV NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	TE SURVEY MPLETED C
		345263	B. WING		1	0/23/2018
IAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP COD	E	
IACON V	ALLEY NURSING AND R	EHABILITATION CENTER	-	195 OLD MURPHY ROAD RANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 550 F 558 SS=D	Reasonable Accomm CFR(s): 483.10(e)(3) §483.10(e)(3) The rig services in the facility accommodation of re- preferences except w	odations Needs/Preferences ht to reside and receive with reasonable sident needs and	F 550	<ul> <li>manager on duty, and corporations consultant began administratii ensure urinary catheter bags privacy cover. The results of the administrative rounds is being documented the administrative sheet. The administrative rounincluding monitoring for urinary bag privacy covers, will be cold (5) times weekly for four (4) wo once weekly times eight (8) wo once monthly for one month.</li> <li>How the facility plans to monitive performance to make sure that are sustained</li> <li>Beginning 11/7/18, the QI number of the audition monthly QI committee for four to identify trends, corrective at to determine the need for and frequency of continued monitor maintain compliance. The QI present trends and QI committive for further recommendations to the quartassurance and performance in (QAPI) Committee for further recommendations and oversigned.</li> </ul>	ve rounds to have a he e rounds nds, y catheter mpleted five reeks, then eeks, then eeks, then tor its at solutions se will s with the t (4) months ctions, and /or pring to nurse will tee terly quality mprovement	12/5/18

Facility ID: 923019

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/30/20 FORM APPROVE OMB NO. 0938-039
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED	
		345263	B. WING		C 10/23/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
		REHABILITATION CENTER		3195 OLD MURPHY ROAD	
	ALLET NORSING AND IN			FRANKLIN, NC 28734	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETION
F 558	Continued From page	e 5	F 55	8	
	other residents. This REQUIREMENT by:	is not met as evidenced			
		ns, record review and family le facility failed to maintain		F 558 – Reasonable Accommo	odations
	fluids within the reach	-		How corrective action will be	
	residents. (Residents	s #1, #4, and #13).		accomplished for those residen	
	<b>-</b> ,			have been affected by the defic	cient
	The findings included	:		practice:	
	1. Resident #1 was a	admitted to the facility on		On 10/9/18, geriatric care assis	tant (GCA)
		ses included Parkinson		#1 filled the cooler with a new i	
	Disease, diabetes, co	onvulsions and dysphagia.		and nectar thick liquids. Reside not offered fluids. On 10/10/18	
		et, an admission dated		assistant (NA) #4 revealed Res	
		as having severely impaired		was becoming more independe	
		ring extensive assistance f daily living including eating.		never saw Resident #1 access	
	with most activities of	daily living including eating.		from the cooler and was unable the cartons of thickened liquids	-
	The care plan initiate	d 07/16/18 for eating was		waited for Resident #1 to ask for	
		ve no choking or aspiration		Beginning on 10/24/18, the unit	
	•	ons were to set up the tray		and/or director of nursing (DON	
		and provide pureed and		Resident #1 was offered thicke	ned liquids
	thickened liquids.			during and in between meals.	
	Resident #1 was obs	erved to feed himself very		On 10/9/18, Resident #4 was a	ble to feed
		akfast meal on 10/09/18 and		himself breakfast independently	
	the noon meal on 10/	10/18.		main dining room. On 10/9/18,	Resident
				#4 fed himself lunch in the dinir	
		erved in bed with no liquids at 6:53 AM and at 10:33 AM.		On 10/9/18 the GCA filled the w pitcher but left the water pitcher	
		bcated on the bedside table		reach. Beginning on 10/24/18,	
		and warm pudding and no		manager, assigned department	
		, a care giver assistant		DON, and/or administrator ensu	
	•	d filled the cooler with a new		Resident #4's water pitcher was	
	ice pack and plenty o			On 10/9/18, NA #1 removed Re	
		offered any fluids at this		#13's tray and sippy cup of fluid	
	time. Fluids remaine			the resident without fluids within	
	10/09/18 at 11:28 AN	I, 12:06 PM, 12:24 PM, 1:08		On 10/9/18, Resident #13 was	observed

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		MEDICAID SERVICES			i	<u>VO. 0938-03</u>	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G		TE SURVEY MPLETED	
		345263	B. WING			C 10/23/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		0/23/2010	
				3195 OLD MURPHY ROAD			
MACON V	ALLEY NURSING AND R	REHABILITATION CENTER		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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 558	Continued From page	2.6		59			
1 330	Continued From page		F 5				
		PM, and again on 10/10/18		with a sippy up in her room			
	at 11:29 AM, at 11:58	Awi and at 2:02 PWI.		over-the-bed table and put			
		se Aide #4 on 10/10/18 at		resident's reach. Beginnir the unit manager, assigne			
		sident #1 was becoming		head, DON and/or adminis			
		She stated she never saw		Resident #13's tray and si			
		from the cooler and that he		were within reach.	ppy cup of huid		
		he cartons of thickened		were within reach.			
		tated that she did not leave					
		hickened liquids would		How the facility will identify	v other residents		
		attracted bugs and he often		having the potential to be			
	<b>u</b>	She stated she waited for		same deficient practice:			
	Resident #1 to ask fo						
				On 10/29/18, the staff faci	litator (SF)		
	The Director of Nursi	ng stated during an interview		initiated an education on li			
		PM that she expected water		thickened liquids: Nectar a	and Honey		
	to be in reach for resi	dents to access it.		Consistency must be withi resident when placed at be	n reach of the		
	2. Resident #4 was a	dmitted to the facility on					
	03/30/18. His admiss	sion Minimum Data Set		On 11/1/18, the DON perfo			
		d him with severely impaired		audit on residents receivin			
	cognition, requiring se	et up and supervision for		liquids to ensure their liqui	ds were within		
	eating and extensive			reach. The audit identified			
	activities of daily living	g skills.		liquids out of reach. The c			
				nursing immediately place			
		erved feeding himself		thickened liquids within rea	ach of the		
	independently in the			resident.			
		After he was finished, he					
	•	his room at 8:37 AM he was		On 11/1/18, the DON perfe			
	left sitting in his broda			audit on residents receivin	-		
		ter pitcher and cup was on		liquids to ensure the reside			
		ross the room. He was		appropriate adaptive equip			
		ds out of his reach on		consume the beverage. T			
		at 9:36 AM, 9:57 AM, 10:09 . Resident #4 fed himself		determined residents did h equipment for drinking liqu			
		om at 12:21 PM. He was			103.		
	-	his fluids across the room		On 11/1/18, the administra	ator approved		
		PM and at 4:41 PM. After the		the dietary manager and the			
		GCA) #1 filled the water		to order additional adaptiv			

Facility ID: 923019

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			a			_	IO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	· /	E SURVEY IPLETED
			A. DOILDING			с	
		345263	B. WING			10/23/2018	
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				319	95 OLD MURPHY ROAD		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		FR	ANKLIN, NC 28734		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTIONREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO TH		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 558	Continued From page	7	F 55				
1 000			F 55	00	ongura there was avtra suns with lide		
	the room out of Resid	ther and cup were left across			ensure there was extra cups with lids available. The order of extra specialty		
		1011 77 3 10001.			cups and lids was received.		
	An interview with Nur	se Aide #4 on 10/10/18 at					
		sident #4 needed a small					
		from. She further stated			What measures will be put into place or	r	
	that sometimes when				systemic changes made to ensure that		
	residents back from a	a meal in the dining room,			the deficient practice will not recur:		
	they failed to ensure t	the fluids are in their reach.					
	She stated there was	not enough staff to keep up			On 10/29/18, the staff facilitator (SF)		
	with all the residents'	needs.			initiated a 100% in-service on "Liquids t	to	
					include Thickened Liquids Example:		
		ng stated during an interview			Nectar and Honey Consistency must be		
		PM that she expected water			within reach of the resident when place	d	
	to be in reach for resi	dents to access it.			at bedside." The in-service was for		
	3 Decident #13 was	admitted to the facility on			registered nurses (RNs), licensed practical nurses (LPNs), nursing		
		admitted to the facility on I Minimum Data Set dated			assistants (NAs), geriatric care assistar	nte	
		is requiring set up and			(GCAs), and agency staff. No RN, LPN		
	supervision for eating				NA, GCA, or agency staff were allowed		
					work after 11/19/18 until the in-service		
	On 10/09/18 at 8:31 A	AM Nurse Aide (NA) #1			was completed. Starting 10/29/18, the		
		unfinished sippy cups of			in-service will be included with orientati	on	
	fluid and left the resid	lent in bed without fluids in			for all newly hired RN, LPN, NA, GCA,		
		observed without fluids in			and agency staff.		
		d on 10/09/18 at 9:36 AM,					
		AM. Resident #13 was			On 11/8/18, the DON completed a 1009		
		3 at 10:55 AM in a recliner in			audit of residents on thickened liquids t		
	her room without fluid	is in ner reach.			ensure the residents' drinks were cold,		
	On 10/00/19 at 11.44	AM family stated during an			a cooler at the bedside within reach, an		
		AM, family stated during an nt #13 needed a sippy cup			had a cold ice pack. No negative finding were noted upon the audit.	ys	
		for her fluids because she			were noted upon the addit.		
		e water pitcher. Family			On 11/8/18, the DON completed a 1009	%	
		nily tried to take a sippy cup			audit of residents with adaptive equipm		
		put it in a drawer so the			to ensure all appropriate equipment wa		
	resident would have d				readily accessible with extra supplies o		
					hand so residents can drink their liquids		

Facility ID: 923019

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVE	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		345263	B. WING		C 10/23/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10/23/20	10
				3195 OLD MURPHY ROAD		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMP	(X5) PLETIO DATE
F 558	Continued From page	2.8	5.55			
1 330			F 558			
		e no sippy cup in sight.		How the facility plans to monitor its performance to make sure that solu	tions	
	On 10/09/18 at 3:00 F	Pm and at 4:47 PM fluids		are sustained:		
	and a sippy cup were	observed in her room on				
	the overbed table. The			Starting 11/26/18, the DON initiated		
	pushed out of Reside	nt #14's reach.		Thickened Liquid audit tool. The DO		
	A			unit manager, and quality improvem		
		se Aide #4 on 10/10/18 at sident #4 needed a small		nurse (QI) will monitor the residents thicken liquids using the thickened I		
		from. She further stated		audit tool five times per week for fou		
	-	the care giver assistants		weeks, then weekly for four weeks,		
		dents back from a meal in		monthly for four months.		
	the dining room, they	failed to ensure the fluids				
		he stated there was not		Beginning 11/26/18, the QI nurse w		
		up with all the residents'		review the results of the audits with		
	needs.			monthly QI committee for four (4) m to identify trends, corrective actions		
	The Director of Nursi	ng stated during an interview		to determine the need for and/or	, and	
		PM that she expected water		frequency of continued monitoring to	0	
	to be in reach for resi	•		maintain compliance. The QI nurse		
				present trends and QI committee		
				recommendations to the quarterly q		
				assurance and performance improv	ement	
				(QAPI) Committee for further recommendations and oversight.		
F 561	Self-Determination		F 561		12/5/	/18
SS=G	CFR(s): 483.10(f)(1)-	(3)(8)	1 50		12/3/	10
	§483.10(f) Self-deterr					
		right to and the facility must				
		e resident self-determination				
		sident choice, including but ts specified in paragraphs (f)				
	(1) through (11) of thi					
	§483.10(f)(1) The res	ident has a right to choose				
	activities, schedules (	including sleeping and				
		care and providers of health				

Facility ID: 923019

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 11/30/2018 MAPPROVED: O. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345263	B. WING		10	C )/23/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		123/2010	
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER	3195 OLD MURPHY ROAD FRANKLIN, NC 28734				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 561	Continued From page	e 9	F 561				
	care services consist assessments, and pla applicable provisions						
		sident has a right to make ts of his or her life in the cant to the resident.					
	with members of the	ident has a right to interact community and participate in both inside and outside the					
	religious, and commu interfere with the righ facility. This REQUIREMENT	sident has a right to ctivities, including social, unity activities that do not ts of other residents in the 「 is not met as evidenced					
	interviews and record	ns, resident, family and staff I reviews, the facility failed to 7 of 7 sampled residents to		F561 Self-Determination			
	be showered or recei preferred which caus felt miserable and dir	ve baths as often as they ed one resident state they ty and another resident to t (Residents #1, #5, #10,		How corrective action will be accomplished for those resider have been affected by the defic practice On 10/09/18 at 7:45 am, nursir (NA) #1 assisted Resident #21	cient ng assistant		
	The findings included			bath. On 10/12/18, the NA assisted F	Resident #1		
	<ol> <li>Resident #19 was 08/17/18.</li> </ol>	admitted to the facility on		with a shower as requested by On 10/22/18, the NA assisted F with a shower as requested by	Resident #5		
	coded him with havin impairment, scoring a Interview for Mental S	um Data Set dated 08/24/18 g moderate cognitive a 12 out of 15 on the Brief Status. He was coded to tance with most activities of		resident. On 10/15/18, the NA assisted F #10 with a shower as requeste resident. On 10/12/18, the NA assisted F	Resident d by the		

Facility ID: 923019

If continuation sheet Page 10 of 140

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 11/30/2018 MAPPROVED O. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345263	B. WING			C 10/23/2018	
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
				31	95 OLD MURPHY ROAD		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		FF	RANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 561	Continued From page	a 10	F 5	61			
	daily living including l				#13 with a shower as requested by the	е	
	that he had not receive time he was at the fact was offered a shower get him but they never had never refused a s like a shower at least feels miserable and of Review of the comput				family. On 10/16/18, the NA assisted Resider #16 with a shower as requested by the resident. On 10/18/18, the NA assisted Resider #19 with a shower as requested by the resident. How the facility will identify other resident. How the facility will identify other resident having the potential to be affected by same deficient practice On 11/1/18, the DON audited shower	e nt e	
	evidence he was eve	r provided a shower.			documentation to determine if residen were getting showers as requested by	the	
	AM revealed that the showers on the hall s residents up but not i	Aide #3 on 10/10/18 at 9:54 re is often no time to give o she does her best to wash n the shower. She further en lots of complaints about d.			resident/family. The audit determined showers/bed baths were not being giv as request by the resident/family. Ove 50% of residents were not receiving showers/bed baths as often as the resident/family requested. On 11/2/18 through 11/7/18, the socia	en er	
		Aide #6 on 10/10/18 at 10:29 It #19 was independent with			worker and activities director talked w residents/families to determine what to of bathing was preferred, the frequence requested, and the time of day desired	ith /pe ンy	
	12:52 PM. He stated resident needs and a asking the resident.	terviewed on 10/10/18 at he got information about bilities via word of mouth or He further stated that he Resident #19 did all care for			be assisted with a shower/bed bath. resident s/family s choices for bathin was documented on the Resident Preference Interview Tool.		
	himself. He stated th been at this facility, h	at in the few weeks he has e was finding out that edly could do for themselves			What measures will be put into place systemic changes made to ensure that the deficient practice will not recur On 11/6/18, during the daily interdisciplinary team (IDT) meeting th	ıt	
			211		to the facility honoring the bathing cho of residents. The unit manager and D	rrier bices	

Facility ID: 923019

If continuation sheet Page 11 of 140

		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	ATE SURVEY OMPLETED
			A. DOILDING			С
		345263	B. WING			10/23/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD		
MACONIN				3195 OLD MURPHY ROAD		
MACON	ALLET NURSING AND P	REHABILITATION CENTER		FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 561	Continued From page	e 11	F 56	1		
		ed she has received a lot of	1.50	determined there were two dif	ferent and	
		lies and residents about		conflicting shower schedules		
		ompleted. The DON also		referenced by the staff. On 1	-	
		cted the showers and bathing		unit manager and DON clarifie		
	schedules to be follow			shower schedule for nursing s		
				reference.		
	2. Resident #5 was a	admitted to the facility on		On 11/6/18, also during the ID	T meeting,	
		ses of chronic obstructive		the administrator reviewed op	-	
		espiratory failure and muscle		obtaining additional staff assis		
	weakness.			providing showers/bed baths.	The facility	
				administrator arranged for ass	sistance	
	-	rly Minimum Data Set dated		from one outside staffing ager	-	
		esident #5 was cognitively		ensure residents bathing ch	oices are	
	intact and required lir	mited assistance with		honored.		
	bathing.			On 11/6/18, the staff facilitator	. ,	
				initiated a 100% re-education		
	-	lan dated 08/27/18 revealed		titled Right to Make Choices.		
		assistance to restore or		initiated a 100% re-education		
		unction of self-sufficiency for		registered nurses (RNs), licen		
	bathing related to phy	-		practical nurses (LPNs), NAs		
	-	was for Resident #5 to be		staff regarding following resident		
		free daily. The interventions from staff for bathing,		plans/resident care guides an resident bathing choices. The		
		hed and nails manicured on		re-education instructs staff Re		
	bathing days.	ned and hais maniculed on		should be allowed to have a b		
	sating adys.			shower based on their choice		
	Review of the 200 ha	all facility shower sheets		self-determination through su		
		5 received four showers from		resident choice. The in-service	•	
		09/18 on 09/11/18, 09/18/18,		completed by 11/19/18. No st		
		18. There were no refusals		allowed to work until in-service		
	of showers noted on			the new employee orientation	-	
				SF, quality improvement (QI)	•	
	An interview conduct	ed on 10/09/18 at 8:10 AM		or administrator will provide re	esident	
		NA) revealed he was the only		Self-Determination training.		
		or the 7:00 AM to 3:00 PM		Beginning 11/6/18, the DON,		
		was no way to do showers,		SF, unit manager, activities di		
		pass trays, assist with		social worker (SW), administra		
		d get residents dressed and		manager on duty, and corpora		
	out of bed for 28 resid	dents when he was by		consultant began administrativ	ve rounds to	

Facility ID: 923019

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION	(X3) DA	NO. 0938-03 TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CO	MPLETED
		345263	B. WING			С
	ROVIDER OR SUPPLIER	545205		STREET ADDRESS, CITY, STATE, ZIP CODI		0/23/2018
	NOVIDER ON SUIT LIER			3195 OLD MURPHY ROAD	-	
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER		FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 561	Continued From page	a 12	F 56	1		
1 001		le stated showers didn't get	F 50	ensure the facility is promoting	hand	
		re usually only done once a		facilitating resident self-detern		
	day.			through support of resident ch		
				including honoring bathing cho	pices. The	
		ed on 10/09/18 at 10:47 AM		results of the administrative ro		
	with Resident #5 reve			being documented the admini		
		receiving two showers a e facility was short staffed		rounds sheet. The administra including monitoring provision		
		time to help her with her		showers/bed baths, will be co		
	showers.			(5) times weekly for four (4) w		
				once weekly times eight (8) w		
		ed on 10/10/18 at 11:55 AM		once monthly for one month.		
		she all halls and when she				
		by herself she was not able stated she usually worked a				
	hall by herself 3 to 4	-		How the facility plans to monit	or its	
				performance to make sure that		
	An interview conduct	ed on 10/10/18 at 6:30 PM		are sustained		
		ursing revealed she was				
		s there wasn't enough staff		Beginning 11/7/18, the QI nurs		
		vers and she has had many		review the results of the bathin		
		lies and residents regarding ven. She further stated it		with the monthly QI committee months to identify trends, corr		
		that shower schedules be		actions, and to determine the		
	followed.			and/or frequency of continued		
				to maintain compliance. The		
		admitted to the facility on		present trends and QI commit		
	08/21/18 and most re	ecently on 09/10/18.		recommendations to the quart		
	The admission Minim	num Data Set dated 08/28/18		assessment and assurance (C Committee for further recomm	-	
	coded her as having			and oversight.		
		2 out of 15 on the Brief				
	Interview for Mental S	Status. She was coded as				
		ssistance with most activities				
	of daily living skills in	cluding bathing.				
	On 10/09/18 at 8:31	AM, a family member left				
		and was observed to ask				
	Nurse Aide (NA) #1 1	to give Resident #21 a				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 11/30/2018 MAPPROVED D. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345263	B. WING				/23/2018	
	Rovider or Supplier Alley Nursing and R	EHABILITATION CENTER		31	TREET ADDRESS, CITY, STATE, ZIP CODE 195 OLD MURPHY ROAD RANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 561	during interview that a approximately 2 more showers while in the second During a follow up int AM, Resident #21 state baths and would like Resident #21 stated as bed bath a week and complained about it. wanted a bed bath or Review of the comput documentation of sho revealed Resident #2 09/03/18, refused on bed bath on 10/05/18 evidence provided to received more than 3 admission. On 10/09/18 at 9:01 / usually worked the ha get all the care comp baths, washing the un when getting resident full baths/showers. S Administration about completed. Interview with the Dir 10/10/18 at 6:33 PM was not enough staff completed. She state	d he would check the give her a bath. AM, Resident #21 stated she had been here ths and only received 3 facility. erview on 10/10/18 at 8:20 ated that she preferred bed a bed bath once a week. she was not receiving one last Friday a family member She stated again she nce a week. ter and handwritten owers/bathing provided 1 was bathed on 08/28/18, 09/29/18 and received a 5. There was no other show Resident #21 had showers/baths since AM, NA #4 stated she all alone and was unable to leted. She did quick bed nderarms and peri-area ts up but was unable to give she stated that she has told the care not being ector of Nursing (DON) on revealed some days there	F	561				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345263	B. WING				C 23/2018
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER			3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 561	showers not being co stated that she expect schedules to be follow 4. Resident #13 was 03/10/16. The annual Minimum coded her with severe She was coded as re with most activities of bathing. During the a coded that she had n the 7 day look back p On 10/09/18 at 11:30 and stated today was follow up interview or family stated she pref receive 2 showers pe On 10/09/18 at 9:01 A usually worked the ha get all the care compl baths, washing the ur when getting resident full baths/showers. S Administration about completed. Review of the comput documentation revea have showers on day Since 08/28/18 she m 08/31/18, 09/07/18, 0 09/28/18, and 10/05/ evidence provided to	mpleted. The DON also ted the showers and bathing ved. admitted to the facility on Data Set dated 09/12/18 ely impaired cognitive skills. quiring extensive assistance daily living skills including assessment period, the MDS ot had a bath/shower during eriod. AM, family was interviewed her shower day. Upon 10/10/18 at 11:25 AM, erred for Resident #13 to r week. AM, NA #4 stated she all alone and was unable to eted. She did quick bed nderarms and peri-area is up but was unable to give he stated that she has told the care not being ter and hand written shower led she was scheduled to shift Tuesdays and Fridays.	F	561			

Facility ID: 923019

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDIN	IG _			C
		345263	B. WING				23/2018
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER			195 OLD MURPHY ROAD RANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 561	Continued From page	9 15	F 5	61			
	Interview with the Dire 10/10/18 at 6:33 PM r was not enough staff completed. She state complaints from famil showers not being co stated that she expect schedules to be follow 5. Resident #16 was a 06/27/18. Per review of the Mini admission dated 07/0 moderately impaired of extensive assistance On 10/09/18 at 9:06 A	ector of Nursing (DON) on revealed some days there to get the bathing ed she has received a lot of ies and residents about mpleted. The DON also ted the showers and bathing ved. admitted to the facility on imum Data Set, an 4/18, Resident #16 had cognitive skills and required with bathing.					
		the resident she would try to					
	an interview that she every two weeks. Sh putting her off when s	AM, Resident #16 stated in only received a shower once e stated the staff keep he asked for her shower. upposed to be showered on					
	records revealed she 08/31/18, 09/07/18, o 09/21/18, 09/28/18, a documentation to sup	nd 10/05/18. There was no port that she received for these missed showers.					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM APPROVED B NO. 0938-0391
STATEMENT OF	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		) DATE SURVEY COMPLETED
		345263	B. WING				C 10/23/2018
NAME OF PRO	OVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
MACON VA	A: BUILDING						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFI		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
	usually worked the ha get all the care compl baths, washing the un when getting resident full baths/showers. S Administration about to completed. Interview with the Direct 10/10/18 at 6:33 PM m was not enough staff completed. She state completed. She state complaints from famili showers not being con- stated that she expect schedules to be follow 6. Resident #1 was a 07/09/18. The admission Minimi- coded him with severa requiring total assistan On 10/10/18 at 10:32 conducted with family Resident #1 only rece she wanted him to ha Review of the comput records revealed he w Monday 08/27/18 but on Monday 09/03/18 at week, once during the week of 09/17/18, onl 10/01/18. On 10/09/18 at 9:01 A	Il alone and was unable to eted. She did quick bed iderarms and peri-area s up but was unable to give he stated that she has told he care not being ector of Nursing (DON) on evealed some days there to get the bathing d she has received a lot of es and residents about mpleted. The DON also ted the showers and bathing yed. dmitted to the facility on um Data Set dated 07/16/18 ely impaired cognition, and nee with bathing. AM, a phone interview was . Family stated at that time ived 1 shower per week and ye 2 showers a week. er and handwritten shower /as given a shower on none the rest of the e week of 9/10/18, none the y once the week of	F	561			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/30/2018 APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345263	B. WING		_		C 23/2018
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		195 OLD MURPHY ROAD RANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 561	baths, washing the ur when getting resident full baths/showers. S Administration about completed. Interview with the Dire 10/10/18 at 6:33 PM r was not enough staff completed. She state complaints from famil showers not being co stated that she expect schedules to be follow 7. Resident #10 was a 08/03/17 with diagnos non-Alzheimer's demo weakness. Review of the signific Set dated 07/17/18 re moderately cognitivel assistance with bathir Review of the care pla Resident #10 required maintain maximum fu bathing related to cog mobility, and physical for Resident #10 to be The interventions incl physical assist/mecha Encourage resident to ability permits .Ensure are manicured on bat	eted. She did quick bed hderarms and peri-area is up but was unable to give he stated that she has told the care not being ector of Nursing (DON) on revealed some days there to get the bathing ed she has received a lot of ies and residents about mpleted. The DON also ted the showers and bathing ved. admitted to the facility on ses of heart failure, entia, and muscle ant change Minimum Data evealed Resident #10 was y impaired and required total ng. an dated 08/01/18 revealed d assistance to restore or nction of self-sufficiency for initive impairment, impaired limitations. The goal was e neat, clean, and odor free. uded: bathing - one person anical lift for transfer only. o participate in self-care as e hair is washed and nails	F 561				

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	S FOR MEDICARE &					8-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		345263	B. WING		C 10/23/20 <sup>-</sup>	18
AME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	CODE	
ACON V	ALLEY NURSING AND F	REHABILITATION CENTER		3195 OLD MURPHY ROAD		
				FRANKLIN, NC 28734	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMP THE APPROPRIATE D	(X5) PLETIO DATE
F 561	Continued From page	<b>1</b> 8	F 56	1		
		09/18 revealed Resident #10	1.50			
		09/08/18, 09/17/18, and				
	09/27/18. There was					
	refusals or bed baths	on the shower sheets.				
	An interview conduct	ed on 09/10/18 at 3:30 PM				
		vealed she was very upset				
		getting her showers as				
		d she was supposed to have d most weeks she received				
		t they didn't have enough				
	staff to give showers.					
	A					
		ed on 10/10/18 at 2:10 PM NA) revealed she worked the				
		and the 3:00 PM to 11:00 PM				
		She stated she often				
		erself and there was no way				
	by herself.	rs when she was on the hall				
	An interview conduct	ed on 10/10/18 at 11:55 AM				
		she worked all halls and				
		k the hall by herself she was				
	-	ers. She stated she usually self 3 to 4 days a week.				
	worked a nall by here	ich o to 4 days a week.				
		ed on 10/10/18 at 6:30 PM				
		ursing revealed she was				
		s there wasn't enough staff ers and she has had many				
	•	lies and residents regarding				
	showers not being give	ven. She further stated it				
	-	that shower schedules be				
F 580	followed.	iun/Decline/Poomsta.)	F 58	n	12/5/	10
F 580 SS=J	CFR(s): 483.10(g)(14	jury/Decline/Room, etc.) l)(i)-(iv)(15)	г 38		12/5/	10
00-0		· / · · / · · · / · · · /				

Facility ID: 923019

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/30/20 FORM APPROVI OMB NO. 0938-03	
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		345263	B. WING		C 10/23/2018	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF 0	CORRECTION (X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE COMPLETIO HE APPROPRIATE DATE	
F 580	Continued From page	e 19	F 58	0		
	§483.10(g)(14) Notifi		1 00			
		nediately inform the resident;				
		lent's physician; and notify,				
		her authority, the resident				
	representative(s) who	ving the resident which				
		has the potential for requiring				
	physician intervention					
		nge in the resident's physical,				
	mental, or psychosod deterioration in health	h, mental, or psychosocial				
		reatening conditions or				
	clinical complications	\$);				
		eatment significantly (that is,				
	a need to discontinue	e an existing form of erse consequences, or to				
	commence a new for					
	(D) A decision to tran	sfer or discharge the				
	resident from the fact	ility as specified in				
	§483.15(c)(1)(ii).	ification under paragraph (g)				
		, the facility must ensure that				
		ion specified in §483.15(c)(2)				
		ided upon request to the				
	physician. (iii) The facility must	also promptly notify the				
	. ,	dent representative, if any,				
	when there is-					
		n or roommate assignment				
	as specified in §483.	10(e)(6); or lent rights under Federal or				
	· · / ·	ons as specified in paragraph				
	(e)(10) of this section					
		record and periodically				
	update the address ( phone number of the	mailing and email) and				
	phone number of the		1			
	representative(s).					

Facility ID: 923019

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TATEMENT C	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	OMB NO. 0 (X3) DATE SUF COMPLET	RVEY
	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING		C	
		345263	B. WING		10/23/	2018
NAME OF PF	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CO	DE	
		REHABILITATION CENTER		3195 OLD MURPHY ROAD		
	ALLET NORSING AND R			FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE C E APPROPRIATE	(X5) OMPLETION DATE
F 580	Continued From page	e 20	F 58	o		
	§483.10(g)(15)					
		osite distinct part. A facility				
		stinct part (as defined in				
		e in its admission agreement				
		tion, including the various				
		se the composite distinct				
		y the policies that apply to en its different locations				
	under §483.15(c)(9).	en its different locations				
		is not met as evidenced				
	by:					
		iews, Nurse Practitioner		F 580 – Notification of Chan	iges	
	interview, and record	reviews, the facility failed to				
	notify the physician o	-		How corrective action will be		
		used the resident to be sent		accomplished for those resid		
		abetic ketoacidosis (DKA), a		have been affected by the de	eficient	
		of diabetes, for 1 of 3		practice		
		r notification of change ilure of the facility to notify		On 9/12/18, Resident #2 exp	perienced at	
	the physician resulted			FSBS reading of "HI." The re		
		tions he needed to prevent		received two doses of 6 units		
	admission to the hos			insulin; however the resident		
				reading would not drop below		
		began on 09/11/18 when		Resident #2 was sent to the		
		fy the physician of the		room, where the resident wa		
		hysician ordered insulin's		with diabetic ketoacidosis, ar	•	
		sident #2 developing DKA.		an insulin drip to lower his bl	ood sugar.	
		was removed on 10/22/18		On 10/11/10 10/10/10 the	director of	
	when the facility imple	emented a credible ite Jeopardy removal. The		On 10/11/18 - 10/19/18, the onursing (DON) and quality in		
	-	compliance at a lower		(QI) nurse audited Resident	-	
	-	vel D (no actual harm with		progress notes and interview	<b>u</b>	
		than minimal harm that is		nurses regarding what was a		
		dy) to complete employee		not reported to the physician		
	÷ .	e monitoring systems in		Resident #20's accident. R		
	place are effective.			no longer resides at the facil	ity.	
	Based on record revie	ew, staff, and Physician, the				

Facility ID: 923019

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		MEDICAID SERVICES					<u>O. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		E SURVEY IPLETED
							С
		345263	B. WING			10	)/23/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
		REHABILITATION CENTER		319	95 OLD MURPHY ROAD		
	ALLET NORSING AND I			FR	RANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETIC DATE
F 580	Continued From page	e 21	F 58	30			
		inwitnessed fall and was on			having the potential to be affected by t	he	
	a blood thinner for or	ne of three sampled			same deficient practice		
		or notification of change. The					
	failure of the facility to				On 10/19/18, the DON and unit manage	-	
		bed to the floor and blood ysician resulted in the high			reviewed all facility residents receiving insulin to ensure insulin was available		
		njury or death (Resident			had been administered as ordered. The		
	#20).				review compared each resident's curre		
	<i>"</i>				insulin orders with the medication	5110	
	Immediate Jeopardy	began on 09/22/18 for			administration record (MAR) and the		
	Resident # 20 when t	-			insulin available in the medication cart	s.	
	communicate to the p	physician that the resident			On 10/22/18, the unit manager notified	the	
		fall and was on a blood			medical director of the audit results		
		eopardy was removed on			including insulin omission for affected		
		cility implemented a credible			residents. No new orders were receiv	ed.	
		ate Jeopardy removal. The			On 10/11/19 10/10/19 the DON and		
		f compliance at a lower evel D (no actual harm with			On 10/11/18 – 10/19/18, the DON and nurse audited 100% of nurse progress		
		e than minimal harm that is			notes for all residents looking for any	)	
		dy) to complete employee			documented incidents/accidents. The		
		e monitoring systems in			audit revealed no other incidents		
	place are effective.	3 - ,			accidents that had not been previously	/	
					identified and the physician properly		
	The findings included	1:			notified of an unwitnessed fall, includir		
					residents taking medications with bloo	d	
		dmitted to the facility on			thinning properties.		
		es which included: diabetes,					
		c kidney disease, and					
	peripheral vascular d	135035.			What measures will be put into place of	or.	
	A review of the nurse	practitioner (NP) progress			systemic changes made to ensure the		
		indicated Resident #2 was			deficient practice will not recur		
		er a capillary blood glucose					
		HI'. The progress note			On 10/11/18, the QI nurse initiated a		
	indicated Resident #2	2 had also developed nausea			100% in-service with all registered nur		
		was clammy and anxious.			(RNs), licensed practical nurses (LPNs		
		y the NP to transfer the			nursing assistants (NAs), geriatric care		
	resident to the emerg				assistants (GCAs) and agency staff.		
	possible diabetic keto	bacidosis (DKA).			in-service included the nurse must not	ify	1

Facility ID: 923019

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		ND HUMAN SERVICES				FO	ED: 11/30/20 RM APPROVE
STATEMENT (	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DA	IO. 0938-039 TE SURVEY MPLETED
		345263	B. WING				C 0/23/2018
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
				31	195 OLD MURPHY ROAD		
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER		FI	RANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	Continued From page	e 22	E!	580			
					the physician immediately of resident	c	
	Review of the nurse i	notes for 09/12/18 at 2:05			with unwitnessed falls that are on	0	
		G taken at 7:30 AM read "HI".			medications with blood thinning		
		dent #2 12 units of regular			properties. Neurological checks must	be	
		admission orders. The CBG			started and the nurse must follow the		
	was rechecked at 9:3	30 AM which read "HI". The			facility's policy on neurological checks	s. If	
	note further revealed	Resident #2 was vomiting			the resident is sent to the ER for		
		ind was seen by the NP who			evaluation and treatment due to an in		
		insfer to the emergency			the neurological checks must be resta		
	department for evaluation	ation of possible DKA.			when the resident returns to the facili	-	
					the appropriate time. The DON must		
	-	nber 2018 Medication			notified of all falls with injuries, espec	-	
		d (MAR) revealed Resident physician ordered insulin's			residents on blood thinners, within 2 l of the incident to ensure the intervent		
		B at 5:00 PM and 10 units at			appropriate.	101115	
		ng scale insulin coverage at			On 10/19/18, the DON, QI nurse and	staff	
		f 206 that required 2 units of			facilitator (SF) began education with a		
		M for a CBG of 240 that			registered nurses (RNs), licensed		
	required 2 units of co				practical nurses (LPNs), and agency		
					nurses licensed nurses on the import	ance	
	A record review of the	e September 2018 MAR			of following insulin orders This educa	tion	
	further revealed Resi				included: 1) the physician must be no	tified	
		units of regular insulin on			anytime the prescribed insulin is not		
		Resident #2 also received 6			available to administer as ordered, 2)		
	AM to cover a CBG c	nsulin on 09/12/18 at 7:30			contents of the EDK are available for if the medication ordered for the resid		
		Glucose Monitoring Sheet			is not available, 3) insulin cannot be	ent	
	for 09/11/18 for Resid	6			missed, the nurse must address		
	following readings:				immediately. No nurse is allowed to	work	
					until the education is completed.		
	09/11/18 1:00 PI	M CBG 236			On 10/19/18, the DON, QI nurse and	staff	
					facilitator (SF) began education for 10	00%	
	09/11/18 4:12 PI	M CBG 206			of RNs, LPNs, and agency nurses. T	he	
					education covered the importance of		
	09/11/18 8:50 PI	M CBG 240			communicating to the physician if a		
					resident has an unwitnessed fall and	if the	
		and based on CBG reading			resident is on a blood thinner.		
		should have received 2 units					
	regular insulin on 09/	11/18 at 4:30 PM.					

Event ID: J78Q11

Facility ID: 923019

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STATEMENT (	F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	O. 0938-039
and plan of	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED C
		345263	B. WING		10	0/23/2018
NAME OF PR	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 580	Continued From page	e 23	F 580			
	<ul> <li>Continued From page 23</li> <li>Per physician order and based on CBG reading of 240, Resident #2 should have received 2 units regular insulin on 09/11/18 at 8:30 PM.</li> <li>An interview with Nurse #4 on 10/10/18 at 9:06 AM revealed she did not give Resident #2 his physician ordered insulin's on 09/11/18 at 4:30 PM and 09/11/18 at 5:00 PM or 09/11/18 at 8:30 PM. She further stated she did not give Resident #2 his Detemir insulin scheduled for 09/11/18 at 9:00 PM. She stated she did not look for the insulin and just did not give it.</li> <li>An interview with the NP on 10/10/18 at 10:00 AM revealed she was unaware Resident #2 had not received his insulin's the evening before he was sent to the hospital. Further interview with the NP revealed her expectation was for the facility nurse to contact the on-call physician if the insulin was not available.</li> </ul>			How the facility plans to monitor performance to make sure solut sustained Beginning 10/19/18, the DON, C SF, or unit manager will audit ea resident receiving insulin to ens insulin was available and given ordered, and if the MD was notif insulin was not administered as This audit will be completed five weekly and recorded on the Insi Sheet. Any concerns identified auditor will have corrective action the auditor immediately. The co audits will be reviewed at the dat interdisciplinary team (IDT) meet additional corrective measures. Beginning 10/19/18, the IDT (administrator, DON, QI nurse, I	tions are QI nurse, ach ure their as fied if ordered. e times ulin Audit by the on taken by mpleted aily eting for	
	physician to notify the insulin or for further of During an interview w PM she revealed she contact the physician On 10/18/18 at 8:30 / and the Administrator Jeopardy via telepho	with DON on 10/09/18 at 4:05 e expected facility staff to a for all missing medications. AM the Director of Nursing r were notified of Immediate ne. tion will be accomplished for		data set (MDS) nurse, treatmen unit manager, weekend supervis corporate consultant will review incident/accident reports, 24 hor and nurse progress notes five (& weekly to ensure the facility has communicated to the physician resident has had an unwitnesse if the resident is on a blood thim physician has not been notified, QI nurse, or weekend superviso the physician immediately. Beginning 11/7/18, the DON or	sor, and/or ur reports, 5) times that a that a d fall and ner. If the the DON, or will notify QI nurse	
		d to have been affected by		will present the results of the au IDT reviews to the monthly QI c	idits and	

Facility ID: 923019

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/30/2018 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345263	B. WING				C 23/2018
NAME OF PF	ROVIDER OR SUPPLIER		- I	STI	REET ADDRESS, CITY, STATE, ZIP CODE	•	
MACON V	ALLEY NURSING AND R	REHABILITATION CENTER			95 OLD MURPHY ROAD		
				FR	RANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	e 24	F 5	80			
	Decident #2 was adm	itted to the facility on			for four (4) months to identify trends,		
	Resident #2 was adm 09/11/18, with a prima	ary diagnosis of uncontrolled			corrective actions, and to determine the need for and/or frequency of continued		
	diabetes mellitus with	hyperglycemia. Resident #2			monitoring to maintain compliance. The	ne	
		6 units of Regular insulin of Detemir (Levemir) at			DON or QI nurse will present trends an QI committee recommendations to the		
		scale of Regular insulin			quarterly quality assurance and		
	before meals and at b	pedtime.			performance improvement (QAPI)		
	On 9/11/18 at approx	imately 4:12 pm, Resident			Committee for further recommendation and oversight.	าร	
		d sugar (FSBS) was 206.					
		ninister 2 units of Regular					
		(SS), as ordered by the did not follow the system					
		ation is not available. Nurse					
	#4 should have obtain						
		EDK) or contacted the physician opportunity to alter					
	treatment. Nurse #4	failed to follow the system in					
	•	ommunication during Nurse rientation; upon accessing					
	the EDK, Nurse #4 fa medication.						
		imately 5 pm, Resident #2's e dose of Regular insulin 6					
		imately 8:50 pm, Resident 2 Units of SS Regular insulin					
	-	sident #2's bedtime dose of e not given.					
	resident received two	12/18, Resident #2 Freading of "HI." The Odoses of 6 units of Regular resident's FSBS reading					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345263	B. WING			C 10/23/2018	
NAME OF PF	OVIDER OR SUPPLIER			Ş	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER			3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 580	to the emergency roo admitted with Diabetic on an insulin drip to lo On 10/17/18, the direct interviewed Nurse #4 for date of service 09/ Nurse #4 did not give unavailable. The imm situation was created notify the physician the #2 was not available, physician the opportu for Resident #2. 2. How the facility will having the potential to deficient practice: On 10/19/18, the DON reviewed all current re no other doses were of The review identified administration of insu according to physician On 10/22/18 the unit of physician regarding u insulin. The physician On 10/19/18, the DON to ensure all residents available in the facility available to match or 3. What measures will	<ul> <li>"HI." Resident #2 was sent m, where the resident was c Ketoacidosis, and placed over his blood sugar.</li> <li>ctor of nursing (DON) assigned to Resident #2, (11/18, which revealed the insulin because it was hediate jeopardy (IJ) when Nurse #4 failed to hat the insulin for Resident which did not allow the nity to alter treatment orders</li> <li>identify other residents to be affected by the same</li> <li>N and unit manager esidents on insulin to ensure omitted in the last 30 days. 28 occurrences where the lin was not documented n's orders.</li> <li>manager contacted the ndocumented doses of n gave no new orders.</li> <li>N and Unit Manager audited s on insulin have the insulin <i>X</i>. All Residents had Insulin der.</li> </ul>	F	580			

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CENTERS FOR MEDICARE & MEDICAID SERVICES     OMB NO. 0938-0       STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION     (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:     (X2) MULTIPLE CONSTRUCTION A. BUILDING     (X3) DATE SURVEY COMPLETED       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       MACON VALLEY NURSING AND REHABILITATION CENTER     STREET ADDRESS, CITY, STATE, ZIP CODE       MACON VALLEY NURSING AND REHABILITATION CENTER     STREET ADDRESS, CITY, STATE, ZIP CODE       10/23/2018     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)     COMPLET DATE       F 580     Continued From page 26 practice will not recur:     F 580     F 580	FORM A			ID HUMAN SERVICES		
A. BUILDING     C       C       10/23/2018       NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       3195 OLD MURPHY ROAD       FRANKLIN, NC 28734       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION     (X5)       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION SHOULD BE     COMPLET       (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     (EACH CORRECTIVE ACTION SHOULD BE     COMPLET       TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG     CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY     DATE       F 580     Continued From page 26     F 580     F 580     F 580     F 580	(X3) DATE SU	PLE CONSTRUCTION	(X2) MULTI	(X1) PROVIDER/SUPPLIER/CLIA	OF DEFICIENCIES	STATEMENT C
Image: Name of provider or supplier     Street address, city, state, zip code       MACON VALLEY NURSING AND REHABILITATION CENTER     STREET ADDRESS, CITY, STATE, ZiP CODE       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG     ID     PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID     PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     (S5) COMPLET CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       F 580     Continued From page 26     F 580		3	A. BUILDIN	IDENTIFICATION NUMBER.	CORRECTION	AND PLAN OF
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         MACON VALLEY NURSING AND REHABILITATION CENTER       3195 OLD MURPHY ROAD         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX         TAG       (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION)       ID         F 580       Continued From page 26       F 580	_		B. WING	345263		
MACON VALLEY NURSING AND REHABILITATION CENTER       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) COMPLET DATE         F 580       Continued From page 26       F 580		STREET ADDRESS, CITY, STATE, ZIP COD	· ·		ROVIDER OR SUPPLIER	NAME OF PF
PREFIX TAG     (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PREFIX TAG     (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     COMPLET DATE       F 580     Continued From page 26     F 580				EHABILITATION CENTER	ALLEY NURSING AND R	MACON V
	E ACTION SHOULD BE	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PREFIX	Y MUST BE PRECEDED BY FULL	(EACH DEFICIENC)	PREFIX
On 10/19/18, the DON, QI nurse and staff         facilitator (SF) began education with all licensed         nurses on the importance of following insulin         orders. This education included: 1) the physician         must be notified anytime the prescribed insulin is         not available to administer as ordered, 2) the         contents of the EDK are available for use if the         medication ordered for the resident is not         available, 3) insulin cannot be missed, the nurse         must address immediately.         On 10/21/18, the education was 50% completed         with all registered nurses (RNs) and licensed         practical nurses (LPNs). No nurse is allowed to         work until the education is completed.         4. How the facility plans to monitor its         performance to make sure solutions are         sustained (include dates when corrective action         will be completed)         Beginning 10/19/18, the DON, QI nurse, SF, or         unit manager will audit each resident receiving         insulin to ensure their insulin was available and         given as ordered, and if the MD was notified if         insulin to ensure their builts weekly and         recorded on the Insulin Audit Sheet. Any         concerns identified by the auditor         immediately. The completed audits will be			F 5	N, QI nurse and staff education with all licensed ance of following insulin on included: 1) the physician ime the prescribed insulin is hister as ordered, 2) the are available for use if the or the resident is not annot be missed, the nurse iately. cation was 50% completed reses (RNs) and licensed ls). No nurse is allowed to on is completed. the DON, QI nurse, SF, or it each resident receiving insulin was available and d if the MD was notified if histered as ordered. This ed five times weekly and in Audit Sheet. Any y the auditor mpleted audits will be interdisciplinary team (IDT) I corrective measures.	practice will not recur: On 10/19/18, the DOM facilitator (SF) began nurses on the importa orders. This educatio must be notified anytin not available to admin contents of the EDK a medication ordered for available, 3) insulin ca must address immedia On 10/21/18, the educ with all registered nur- practical nurses (LPN work until the educatio 4. How the facility plan performance to make sustained (include dat will be completed) Beginning 10/19/18, tt unit manager will audi insulin to ensure their given as ordered, and insulin was not admin audit will be complete recorded on the Insuli concerns identified by corrective action taken immediately. The com reviewed at the daily i meeting for additional The daily IDT's role in	F 580

Facility ID: 923019

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
		345263	B. WING			C 10/23/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER			3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID         SUMMARY STATEMENT OF DEFICIENCIES           PREFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL           TAG         REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 580	also makes recomme needed. The daily II brought to the next qu and performance imp for additional review a 10/22/18, the adminis committee of the audi plan of correction, inc committee's role in the Beginning 10/19/18, tr responsible for impler corrective measures to sustained. Macon Valley Nursing alleges compliance of 10/22/18. Facility staff were inter demonstrated they has of medication adminis pharmacy for medicatio Immediate jeopardy w 10/22/18. 2. Review of the Neu each nurse's station r should be done as fol for 4 hours, every hou for 3 days once initiat Resident #20 was adh 09/17/18 with diagnos repair, high blood pre- peripheral vascular di obstructive pulmonary	ndations for revisions as DT review findings will be varterly quality assurance rovement (QAPI) meeting and recommendations. On trator notified the QAPI t results and the facility's luding the QAPI e plan of correction. The administrator will be nenting and monitoring o ensure solutions are and Rehabilitation Center f removal of IJ as of rviewed 10/23/18 and to been trained on the topics stration, and how to call the tions, and to notify the ns weren't available. vas removed effective ro Checks Guide located at evealed neuro checks lows: every thirty minutes in for 4 hours and every shift ed. mitted to the facility on ses included hip fracture ssure, atrial fibrillation, sease, and chronic	F	580			

Facility ID: 923019

If continuation sheet Page 28 of 140

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPI	LE CONSTRUCTION		<u>D. 0938-039</u> E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,		COMPLETED	
						С
		345263	B. WING		10/23/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 580	dated 09/17/18 revea to person, place and Review of the On-Ca Revision Date of 03/0 station revealed the f on-call provider: Plea information ready bef current medications, condition, have a des symptoms associated synopsis, relevant pa report.	aled Resident #20 was alert time. II Provider sheet with a 05/15 located at each nurse's following when calling an use have the following fore calling which included if reporting a change in scription of the signs and d with the change, a brief ust history, and incident	F 58	0		
	fibrillation. An interview conduct with Nurse Aide (NA) started his shift and v rounds when he hear around 3:45 PM. He and she was lying on arm underneath her a floor facing the bed. I was bleeding from sk	(mg) once a day for atrial ed on 10/10/18 at 11:07 AM #1 revealed he had just vas doing his first set of rd Resident #20 screaming stated he went to her room her right side with her right and her head lying on the NA #1 stated Resident #20 tin tears to both sides of her				
	and there were no fall stated he called a coor Resident #20 was ye NA #2, NA #3, and N NA #1 stated Nurse # then the 4 of them mo bed using a sheet un he did not ask and dir Resident #20 if she h	bed was in the high position II mats on the floor. NA #1 de green for help and Iling out in pain. He stated urse #1 came into the room. #1 assessed the resident and oved Resident #20 back to derneath her. NA #1 stated d not hear Nurse #1 ask hit her head on the floor but on the floor when he found				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345263	B. WING				
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1	
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER			95 OLD MURPHY ROAD RANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	with NA #3 revealed s Resident #20 from the 09/22/18 close to shif and then went back to heard the code green to Resident #20's roo was lying on the floor facing her bed that wa #3 stated she helped to bed and then went stated Resident #20 v before, during and aft An interview conducte with NA #2 revealed h #20 from the chair to change on 09/22/18 a desk and heard the c he went to Resident # lying on the floor on h arm twisted undernea lying on the floor with He stated she was ye bleeding from some s helped Nurse #1, NA	ed on 10/10/18 at 12:05 PM she helped NA #2 transfer e chair to the bed on t change around 2:45 PM o her hall. She stated she around 4:00 PM and went m. She stated Resident #20 with her head on the floor as in the high position. NA transfer Resident #20 back back to her hall. She further was yelling out in pain	F 5	80			
	An interview conducte with Nurse #1 reveale Resident #20's room she went in the room her left side with her h stated she didn't reme was in. Nurse #1 state	ed on 10/11/18 at 1:39 PM ed she was called to by a code green and when Resident #20 was lying on head on the ground. She ember what position the bed ed Resident #20 was yelling assessed her but she had					

Facility ID: 923019

If continuation sheet Page 30 of 140

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE		
		345263	B. WING			C 10/23/2018		
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				3	195 OLD MURPHY ROAD			
MACON	ALLEY NURSING AND R	EHABILITATION CENTER		F	RANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 580	#20's Responsible Pa assessment and felt li her right shoulder/arm the hospital. She state could have an x-ray di would be quicker than he was good with doin stated she didn't reme provider and thought called them but after is she stated, "I guess I physician and got the shoulder." She stated physician Resident #2 the unwitnessed fall b sent Resident #20 ou neuro checks and mo #1 stated she did not reported off to the on- She stated she did not	urse #1 stated Resident arty (RP) came in during the ike the resident had broken in and wanted her sent out to ed she told the RP they lone at the facility and it in going to the hospital and ing it that way. Nurse #1 ember calling the on-call the on-coming nurse had reviewing her nurse's notes probably called the order for the x-ray of her is he would not have told the 20 was on Coumadin after because she wouldn't have t, she would have started onitored her condition. Nurse start neuro checks but -coming nurse about the fall. ave NA #1 obtain vital signs. It note dated 09/22/18 6:44 tt #20 had multiple skin tears d and treated. The right and Responsible Party in and wanted the resident to room. The note revealed er arm/shoulder was broken ge of motion and was using oving. The Physician was for an x-ray was called into as done at 6:00 PM in the	F	580				
	4:00 PM an order was Nurse #1 and signed	s written for Resident #20 by						

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345263	B. WING			C 10/23/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER			3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	31	F	580	,		
	Review of the x-ray right shoulder results dated 09/22/18 revealed there was no evidence of an acute fracture or dislocation.						
	1:39 PM revealed she on 09/23/18 on the 7: the resident was alert morning of 09/23/18. yelled for her and wh assessed Resident #2 breathing. She stated	Nurse #1 on 10/11/18 at e was Resident #20's nurse 00 AM to 7:00 PM shift and c, and talking during the Nurse #1 stated the NA en she got to the room and 20 she had stopped she checked her code DNR so she didn't initiate					
	-	nsuccessful to interview n 10/11/18 at 2:00 PM and					
	with the facility Physic recall being called ab 09/22/18. He stated if resident having an un Coumadin he would h out to the hospital for tomography, a scan to out a bleed.	ed on 10/11/18 at 3:57 PM cian revealed he did not out Resident #20's fall on the had been called about a witnessed fall was on have expected her to be sent evaluation and a Computed to see inside the body, to rule					
	with the Director of Ni expectation for nurse that a resident's fall w witnessed and what n	nedications they were on. e expected neuro checks to					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345263	B. WING				_ 23/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	
MACONIN				;	3195 OLD MURPHY ROAD		
WACON V	ALLET NURSING AND R	EHABILITATION CENTER			FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	On 10/11/18 at 3:49 F and the Corporate Co Immediate Jeopardy. On 10/12/18 the facilit credible allegation of removal that included 1. How corrective a for those residents for by the deficient practic On 9/22/18 at approxi #20 was on the floor r Resident #20 was on floor, and demonstrate nursing assistant calle resident's fall in the re On 9/22/18 at approxi directed the nursing a Resident #20's vital si pressure 143/86, puls tympanic temperature saturation 95%. On 9/22/18, Nurse #1 assistants assisted Re On 9/22/18 at approxi treatment nurse noted (5) skin tears on Resi right forearm, right kn foot second toe. After treatments, the treatm (5) individual flow she conditions in the elect the assessment tab. On 9/22/18 at approxi noted Resident #20's The nurse notified the	PM the Director of Nursing onsultant were notified of ty provided an acceptable Immediate Jeopardy : ction will be accomplished und to have been affected ce: imately 3:50 pm, Resident next to the resident's bed. her side, head was on the ed signs of pain. The ed a code to announce the esident's room. imately 3:55 pm, Nurse #1 issistant to take vital signs. igns post fall were blood as 88, respirations 20, e 97.8 F, and oxygen and three nursing esident #20 to the bed. imately 4:00 pm, the d, cleaned, and dressed five dent #20: right upper arm, ee/leg, right lower leg, left er completing the skin tear nent nurse completed five sets of non-ulcer skin tronic health record under	F	580			

Facility ID: 923019

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/30/2018 FORM APPROVED OMB NO. 0938-039		
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345263	B. WING		C 10/23/2018		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	•		
		REHABILITATION CENTER		3195 OLD MURPHY ROAD			
	RELET NORSING AND I			FRANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE COMPLETION D THE APPROPRIATE DATE		
F 580	that the resident had notify the physician th Coumadin. On 9/22/18 at approx #1 initiated neurologi On 9/22/18, the Nurs	did not notify the physician a fall and Nurse #1 did not nat Resident #20 was taking timately 4:30 pm the Nurse cal checks on Resident #20. e #1 completed five (5)	F 58	80			
	5:00 pm, 5:30 pm, 6: #1 documented the m Resident #20's electr nurse progress notes observations. Nurse approximately 7:00 p	onic health record under s type: neurological					
	any neurological cher On 9/23/18 at approx documented a skilled neurological: alert an rate and rhythm, tach	urse #2 did not document cks. imately 1:48 am, Nurse #2 l post-acute note stating d oriented, cardiac: regular nycardic at times, peripheral atory rate clear, several					
	wounds with dressing On 9/23/18 at approx completed a discharg #20's electronic healt included: the assigned	gs intact, clean, and dry. cimately 12:45 pm, Nurse #1 ge summary in Resident ch record. The summary ed nursing assistant was					
	unable to attain vital a contacted 911. Resid bedside. Resident #2 (DNR). Resident #20	dent #20's husband was at 20 was a Do Not Resuscitate ) was pronounced dead at					
	regarding resident ind assessments, neurol unobserved falls, doo report, and reporting	N re-educated Nurse #1 cident/accidents, post-fall					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/30/2018 FORM APPROVED OMB NO. 0938-0391			
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
		345263	B. WING		10/23/2018			
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3195 OLD MURPHY ROAD FRANKLIN, NC 28734					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE			
F 580	On 10/11/18, the DOI regarding resident ind assessments, neurolu unobserved falls, doo report, and reporting the physician, nurse 2. How the facility of having the potential t deficient practice: On 10/11/18, the qua audited 100% of resid administration record residents with curren Coumadin. The audi with Coumadin listed On 10/11/18, the dire performed an audit o receiving Coumadin. any Coumadin reside past 60 days. The au resident currently tak within the past 60 day 3. What measures systemic changes ma practice will not recur On 10/11/18, the QI r initiated a re-educatio NAs, and contracted re-education that has b physician must be ca including Nurse #1 au instructed to use the	N re-educated Nurse #2 cident/accidents, post-fall ogical checks for all cumentation, shift change all relevant information to practitioner, and DON. will identify other residents o be affected by the same lity improvement (QI) nurse dent current medication s (MARs) to identify all t orders to receive t identified one (1) resident on the MAR. ctor of nursing (DON) n 100% of residents The audit was to identify ent having a fall within the udit identified zero/no ing Coumadin who had a fall ys. will be put into place or ade to ensure the deficient treated to an staff facilitator on for all RNs, LPNs, MAs, therapy personnel. The l: In the event of any/all falls,	F 58					

Facility ID: 923019

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/30/2018 FORM APPROVEL OMB NO. 0938-039		
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345263	B. WING		C 10/23/2018		
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZI 3195 OLD MURPHY ROAD FRANKLIN, NC 28734	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE		
F 580	document relevant in report sheets and rep the on-coming shift n Nurses must follow th PT/INRs when reside are being instructed to follow the posted neu- details the frequency neuro-check; only lice licensed practical nur neuro-checks, NAs m Repeat PT/INR after the physician/nurse p has to be sent out for due to an injury post- to the facility the neu- re-started at the appr be notified within two to ensure proper inter re-education was corr staff working; no RN, therapy personnel wil including Nurse #1 ar re-education is comp added to the new sta LPNs, MAs, NAs, and personnel. On 10/11/18, the QI m for all RNs and LPNs, in #2, to enter all neurol electronic medical rep neurological observations documents are availar physician, nurse prace	for all falls. Nurses will formation on the 24 hour port relevant information to urse regarding all falls. he facility's policy on ent is on Coumadin. Nurses o start neuro-checks and tro-check guidelines which of performing the ensed registered nurses and rese will perform the hay take the vital signs. three days or as ordered by practitioner. If the resident revaluation and treatment fall and the resident returns rological checks must be opriate time. The DON must hours of all falls with injuries riventions are in place. The npleted on 10/11/18 with all LPN, MA, NA, or contracted II be allowed to work, nd Nurse #2, until the leted. The re-education is ff orientation for all RNs, d contracted therapy hurse initiated a re-education . This re-education instructs nocluding Nurse #1 and Nurse ogical checks into the cord (PCC) under tion. By having neurological ented in the PCC system, the	F 5				

Facility ID: 923019

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFI	CIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345263	B. WING				C 23/2018
NAME OF PROVIDE	R OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
MACON VALLEY	NURSING AND R	EHABILITATION CENTER			3195 OLD MURPHY ROAD		
				F	FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
work inclue re-ec for al On 1 inter- all fa blood verify imme pract inforn was blood outsi the fa 4. If perfor susta will b Begin revie Begin staff progu repol with findir asse pract sistar findir asse pract	ding Nurse #1 an ducation is added II RNs and LPNs. 0/11/18, the DON disciplinary team Ils, to include res d-thinning propert ying that an asses ediately post-fall, titioner was notifie mation provided. notified, if the res d-thinning propert de treatment, and all. How the facility p prmance to make ained (include dat be completed) nning 10/11/18, th facilitator will revi ress notes. Begin rt sheet review fir the 24 hour PCC ngs to ensure all f ssments and rep- titioner which incl blood-thinning pro- madin. These revion pro- nonths.	ation is completed, d Nurse #2. The to the new staff orientation	F	580			

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/30/201 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED C
		345263			10/23/2018
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	319	REET ADDRESS, CITY, STATE, ZIP CO 5 OLD MURPHY ROAD ANKLIN, NC 28734	•
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 580 F 584 SS=D	performance improved daily QAPI team's rol includes implementat the interventions are also making recommon needed. The daily (0 brought to the next quadditional review and Beginning 10/11/18, for responsible for imple corrective measures sustained. Macon Valley alleges removal as of 10/11/1 On 10/12/18 facility s demonstrated they has of using the PCC E-In nurses provided the p information after falls neuro checks, DON r to on-coming nurse, a hour report sheets. In removed effective 10 Safe/Clean/Comforta CFR(s): 483.10(i)(1)- §483.10(i) Safe Envir The resident has a rig comfortable and hom but not limited to rece supports for daily livir The facility must prov §483.10(i)(1) A safe, homelike environment	laily quality assurance and ement (QAPI) team. The e in this plan of correction tion and monitoring, ensuring effective. The QAPI team endations for revisions as QAPI review findings will be uarterly QAPI meeting for I recommendations. the administrator will be menting and monitoring to ensure solutions are a credible allegation of IJ 18. taff were interviewed and ad been trained on the topics nteract forms to ensure ohysician with all relevant , when and how to perform notification, reporting of falls and documenting on the 24 mmediate jeopardy was /11/18. ble/Homelike Environment (7) ronment. ght to a safe, clean, helike environment, including eiving treatment and ng safely.	F 580		12/5/18

Facility ID: 923019

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345263	B. WING			C 10/23/2018	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER			195 OLD MURPHY ROAD		
_		-		F	RANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 584	receive care and serv physical layout of the independence and do (ii) The facility shall ex- the protection of the r or theft. §483.10(i)(2) Housek services necessary to and comfortable inter §483.10(i)(3) Clean b in good condition; §483.10(i)(4) Private resident room, as spe §483.10(i)(5) Adequa levels in all areas; §483.10(i)(5) Adequa levels in all areas; §483.10(i)(6) Comfort levels. Facilities initial 1990 must maintain a 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMENT by: Based on observatio interviews, the facility clean in 1 of 17 samp affected Resident #1. The findings included	ring that the resident can rices safely and that the facility maximizes resident uses not pose a safety risk. xercise reasonable care for esident's property from loss eeping and maintenance maintain a sanitary, orderly, for; ed and bath linens that are closet space in each ecified in §483.90 (e)(2)(iv); te and comfortable lighting table and safe temperature ly certified after October 1, temperature range of 71 to maintenance of comfortable is not met as evidenced ins, staff and family failed to keep the floor oled resident rooms. This	F	584	F584 How corrective action will be accomplished for those residents found have been affected by the deficient practice	d to	
	Resident #1 was adm	itted to the facility on					

Event ID: J78Q11

Facility ID: 923019

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		MEDICAID SERVICES				0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL	
					c	;
		345263	B. WING		10/2	3/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
MACON V	ALLEY NURSING AND R	REHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	COMPLETION
F 584	Continued From page	e 39	F 58	4		
	07/09/18. The admis	sion Minimum Data Set		On 10/10/18, the housel	keeping	
	dated 07/16/18 revea	aled he had severe cognitive		supervisor and houseke		
	impairment.			cleaned Resident #1's re		
				floor. After the floor was		
		AM, the floor between		was no sticky residue, d	-	
		id the door was observed ue and smudges and two		debris on the floor. Star housekeeping superviso		
	-	d residue in front of the		Resident #1's room floor		
	bedside table. On 10			daily to remove sticky re		
	Housekeeper #1 swe	pt and mopped the floor.		spill, and debris.	,	
	She stated that this re	oom had some messes at				
		s spitting and so she always				
		d in the afternoon to check				
	-	aning needs. If she found he usually cleaned them up.		How the facility will iden having the potential to b		
		ne usually cleaned them up.		same deficient practice	e allected by the	
	On 10/09/18 at 1:08 I	PM, the floor was still sticky				
		d red food spill was still		On 11/2/18, the houseke	eping supervisor	
	present and there wa	is a napkin on the floor. This		in-serviced the houseke		
		r to the lunch meal being		housekeeping policies a		
		nd soiled floor remained next		ensure a safe/clean/com		
		on the floor when observed		environment. After 11/2/		
	on 10/09/18 at 3:02 F	SIM.		housekeeping staff were		
	Observations on 10/1	10/18 at 8:30 AM revealed		before completing the in 11/12/18, the housekeep		
		ky, smudged and with red		completed the in-service		
	dried food debris by F			housekeeping staff. The		
				included with orientation		
		family on 10/10/18 at 10:30		housekeeping staff.		
		ily was concerned that the				
	tioor was always dirty	/ in Resident #1's room.				
	The floor remained so	oiled when observed on		What measures will be p	out into place or	
	10/10/18 at 11:58 AM	1.		systemic changes made the deficient practice wil	to ensure that	
		PM Housekeeper #2 was				
		and mopping Resident #1's		On 11/12/18, the house		
	room. The housekee			supervisor completed a		
	wheelchairs in the roo	om or the overbed tables.		resident rooms inspectir	ig for spills and	

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	S FOR MEDICARE &	MEDICAID SERVICES		PLE CONSTRUCTION	OMB N	RM APPROVE IO. 0938-039 TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G		<b>IPLETED</b>	
		345263	B. WING		1	C 10/23/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
MACON V	ALLEY NURSING AND I	REHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
F 584	bed but because no dried food spill rema another day was on Housekeeper #2 stat 10/10/18 at 1:58 PM furniture as she coul mopping but this roo Housekeeper #2 obs the floor and stated s debris up next to Res The Housekeeping s interview on 10/10/18 expected furniture to	o mop along Resident #1's furniture was moved, the red ined. A lunch ticket form the floor under the bed. ted during interview on she tried to move as much d during sweeping and m was very crowded. served the spill and paper on she would have to scrape the	F 5	<ul> <li>dried food on floors. The au spills and dried food debrist resident room floors. The hor supervisor and housekeepe resident room floors, includi #1's floor.</li> <li>On 11/12/18, the director or (DON), and quality improved (QI) began an in-service with staff (registered nurses, lice nurses, medication aides, n assistants, geriatric care assimmediately cleaning up spit the floors. The in-service al the nursing staff to remove the place a new liner in the trast exiting the resident's room. was completed 11/25/18. Af no nursing staff will be allow until the in-service is complet in-service will be part of the new nursing staff.</li> <li>On 11/12/18, the housekeep supervisor in-serviced the h staff on: 1) increasing the met rounds made to ensure the resident rooms are free of s food debris, including movin and mobility devices and 2) cleaning of the resident room 11/12/18, the in-service bect the orientation for any new femployee.</li> </ul>	on multiple busekeeping rs cleaned the ng Resident nursing ment nurse h all nursing nsed practical ursing sistants) on Ils, including so instructed trash and h can upon This in-service fer 11/25/18, ved to work eted. This orientation for Ding ousekeeping umber of floors in the pills and dried og furniture proper ms. Starting ame part of		
				How the facility plans to mo performance to make sure t			

Facility ID: 923019

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CENTER STATEMENT ( AND PLAN OF NAME OF P	S FOR MEDICARE & I DF DEFICIENCIES CORRECTION	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345263 EHABILITATION CENTER	A. BUILDING B. WING S 3	CONSTRUCTION TREET ADDRESS, CITY, STATE, ZIP CODE 195 OLD MURPHY ROAD RANKLIN, NC 28734	PRINTED: 11/30/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED C 10/23/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 584	Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment,	Neglect m Abuse, Neglect, and right to be free from abuse, tion of resident property, efined in this subpart. This ited to freedom from involuntary seclusion and ical restraint not required to	F 584	are sustained The administrator, DON, weekend nur supervisor, social worker, maintenance director, accounts receivable, payroll, social worker, activity director, weeker manager on duty, and/or licensed nurs will audit 10 resident rooms weekly x 1 weeks, including bathrooms, to ensure resident room floors are free of dried fd debris. This audit will be documented of the Department Head Round audit too The housekeeping supervisor will revise the results of the Department Head Round audit tool monthly. The housekeeping supervisor will report to monthly quality improvement (QI) committee to identify trends, the need an increase or decrease of frequency auditing for continued compliance. The administrator and/or housekeeping supervisor will take the recommendation of the monthly QI committee to the quarterly quality assurance and performance improvement (QAPI) committee for additional recommendations and oversight.	e  nd  se  l2  ood on  l.  ew  the for of e

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/3 FORM APPI OMB NO. 093	ROVED
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		345263	B. WING		C 10/23/20	18
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMP	X5) PLETION ATE
F 600	Continued From page	e 42	F 60	o		
	§483.12(a) The facilit	y must-				
	physical abuse, corpo involuntary seclusion; This REQUIREMENT by: Based on record revi facility failed to protect from physical and ver reviewed for abuse (F Immediate jeopardy b Nurse Aide (NA) #1 o trying to make Reside and yelling at her for Jeopardy was remove facility implemented a Immediate Jeopardy remains out of compli	is not met as evidenced iew and staff interviews the ct a resident's right to be free bal abuse 1 of 3 residents Resident #3). began on 10/01/18 when beserved NA #8 forcibly ent #3 sit down on the toilet being soiled. Immediate ed on 10/22/18 when the a credible allegation of		F 600 How corrective action will be accomplished for those residen have been affected by the defice practice On 10/11/18, the treatment nurs completed a head-to-toe physic emotional assessment of Reside The assessment revealed no n changes in Resident #3's skin of behavior. On 10/11/18, the DC	cient se cal and dent #3. ew condition or	
	jeopardy) to complete ensure monitoring sys Based on record revie Nurse Practitioner inte administer insulin per	I harm that is not immediate e employee education and stems in place are effective. ew, resident, staff, and erviews the facility failed to physician order's or contact		Nursing Assistant #1 was not w the facility and Nursing Assistan re-educated on abuse and imm in-person reporting. On 10/11/ approximately 5pm the DON in resident abuse re-education for staff, including contracted staff.	nt #8 was nediate 18 at itiated r all facility . On	
	out to the hospital wit (DKA), a serious com	ed the resident to be sent h diabetic ketoacidosis plication of diabetes, for 1 of with insulin dependent 2).		10/15/18 Nursing Assistant # 1 re-educated on abuse, both ver physical abuse. On 09/12/18, Nurse #3 notified	rbal and the nurse	
	Nurse #4 did not adm	ontact physician which		practitioner that Resident #2's I was reading "HI". The nurse pr gave a verbal order for Resider be sent to emergency room. R was sent to the emergency roo	ractitioner ht # #2 to esident #2	

Facility ID: 923019

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		MEDICAID SERVICES				NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · ·	ATE SURVEY OMPLETED	
						С	
		345263	B. WING			10/23/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE		
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 600	Continued From page	0.43	F 60	0			
1 000			F 60	the resident was admitted wit	th diabatia		
	when the facility impl	was removed on 10/22/18		ketoacidosis, and placed on a			
		ate Jeopardy removal. The		drip to lower the blood sugar			
		f compliance at a lower			- •		
	-	evel D (no actual harm with					
1		e than minimal harm that is					
		dy) to complete employee		How the facility will identify o			
		e monitoring systems in		having the potential to be affe	ected by the		
	place are effective.			same deficient practice			
	The findings included	1:		On 10/11/18, the treatment n	urse		
				performed a head-to-toe skin			
		admitted to the facility on		100% of dementia unit reside	ents to		
		ses of Alzheimer's disease,		identify any residents with			
	non-Alzheimer's dem	ientia, and anxiety.		signs/symptoms of abuse. T			
	Review of the quarter	rly Minimum Data Set (MDS)		identified no findings. On 10. DON instructed the Social Sector			
	dated 07/06/18 revea	, , , , , , , , , , , , , , , , , , ,		Director (SSD) to perform Re			
		mpaired. The MDS further		Abuse/Neglect Questionnaire			
		had delusions, physical and		alert and oriented residents.			
		ard others, rejection of care		questionnaires revealed no fu	urther		
	-	days during the assessment		allegations of abuse.			
	period.			On 10/19/18, the DON and u			
	Review of the nurse's	s notes from 09/30/18		reviewed all facility residents insulin to ensure insulin was	•		
		ealed no documentation of		had been administered as or			
		naving concerns that NA #8		review compared each reside			
	had been physically of			insulin orders with the medica			
	Resident #3 on the m	norning of 10/01/18.		administration record (MAR)			
				insulin available in the medic			
	Review of the facility			On 10/22/18, the unit manage			
		12/18 revealed there was no eged physical/verbal abuse		medical director of the audit i including insulin omission for			
	of Resident #3 by NA			residents. No new orders we			
	An interview conduct	ed on 10/11/18 at 10:36 AM		What measures will be put in	to place or		
		he worked the 7:00 AM to		systemic changes made to e	nsure the		
		Sparks Unit on 10/01/18. NA		deficient practice will not recu	ır		
	#1 stated when he we	ent onto the unit that					

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S FOR MEDICARE &					OWR N	<u>O. 0938-03</u>
OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			Сом	E SURVEY IPLETED
	345263	B. WING			C 10/23/2018	
ROVIDER OR SUPPLIER	1		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1	
MACON VALLEY NURSING AND REHABILITATION CENTER						
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD I	3E	(X5) COMPLETIC DATE
Continued From page	- 44	Гес	20			
		FOL	50	On 10/11/10, the Olympic and staff		
	-					
-						
				• •		
				•	nt #1	
				-		
				· · · ·	not	
	-			-		
-				-		
for her to leave the ro	oom because he thought she			residents safe at all times.		
was being too rough	with the resident and he			On 10/19/18, the administrator, DON,	QI	
would finish taking ca	are of Resident #3 but she			nurse, and staff facilitator initiated sma	all	
refused and told him	she wasn't finished with her			group meetings with 100% of staff,		
yet. He stated he left	the room to get some gloves			including contracted and agency staff	to	
to go back in to help I	NA #8 and Medication Aide			discuss the facility's zero tolerance for	•	
(Med Aide) #9 and M	ed Aide #10 were at the					
medication cart count	ting meds and he told them			abuse discussions were presented with	h	
· · · •				the burnout in-service to help staff		
					will	
					~	
	-				-	
	inuise that covered the					
Sparks Unit.						
An interview conduct	ad an 10/11/19 at 11:01 AN			· · ·	ווע	
					inted	
				and agency stan.		
	-			On 10/20/18 the DON OLDURG SE		
				administrator, and/or licensed nurse		
	ROVIDER OR SUPPLIER ALLEY NURSING AND F SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page morning the 11:00 PM out on the floor and h resident. He stated h and he heard Reside immediately went to H Resident #3's normal out. NA #1 stated wh #3's room she was in who was yelling at he make her sit down or NA #8 was yelling at had been incontinent down her legs and we commode. NA #1 stated wh commode. NA #1 stated the make her sit down or NA #8 was yelling at had been incontinent down her legs and we commode. NA #1 stated the make her sit down or NA #8 was yelling at had been incontinent down her legs and we commode. NA #1 stated the make her sit down or NA #1 stated he left to go back in to help (Med Aide) #9 and M medication cart count what was happening. back in Resident #3's leave. NA #1 stated f nurse's station and w happened and had M of what she heard an hall to Nurse #1 and because she was the Sparks Unit. An interview conducts with Med Aide #9 rev Medication Swith the	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/CLIA (EACH DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPLIE/SUPLIE/SUPLIE/SUPLIER/SUPLIER/SUPLIER/SUPLIER/SUPLIER/SUPLIE/SUP	F DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTII A BUILDIN         345263       B. WING	F DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE A. BUILDING	F DEFICIENCIES CORRECTION         (X1) PROVIDERSUPPLICELLA IDENTIFICATION NUMBER:         (X2) MULTIPLE CONSTRUCTION A BULLDING           2040DER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST RE PRECEDED OF FULL REGULATORY OR LSC IDENTIFING INFORMATION)         STREET ADDRESS, CITY, STATE, ZIP CODE           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST RE PRECEDED OF FULL REGULATORY OR LSC IDENTIFING INFORMATION)         TO PREFIX TAG         PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY (EACH CORRECTIVE ACTION SHOULD (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY (EACH CORRECTIVE ACTION SHOULD (EACH CORRECTIVE ACTION SHOULD (EACH CORRECTIVE ACTION SHOULD (EACH CORRECTIVE	IP GEFICIENCIES CORRECTION         (x1) PROVIDERINGUPUERCLLA IDENTIFICATION NUMBER:         (x2) MLTIPLE CONSTRUCTION A BUILDING         (x2) MLTIPLE CONSTRUCTION A BUILDING         (x2) MLTIPLE CONSTRUCTION A BUILDING           OVIDER OR SUPPLIER         345263         E. WING         3195 OLD MURPHY ROAD FRANKLIN, NC 28734         100           SUMMARY STATEMENT OF DEFICIENCIES RECULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX RECULATORY OR LSC IDENTIFYING INFORMATION)         PROPRESS. CITY, STATE, 2IP CODE 3195 OLD MURPHY ROAD FRANKLIN, NC 28734         PROPRESS. CITY, STATE, 2IP CODE 3195 OLD MURPHY ROAD FRANKLIN, NC 28734           Continued From page 44         F 600         COn 10/11/18, the QI nurse and staff facilitator initiated a re-education for all staff including agency staff and contracted threapy staff. The re-education covered: Abuse/Neglect and reporting any abuse allegation immediately to the Administrator or Director of Nursing 24 hours a day. All staff, all departments, all Contracted threapy staff. The re-education covered: Abuse/Neglect and reporting any abuse allegation immediately to the Administrator or Director of Nursing 24 hours a day. All staff are responsible for Keeping our resident safe at all times. If you sus being too rough with the resident and he would finish taking care of Resident #3 but she refused and took time to the sub-acute that back in to heip NA #3 and Medication Aide to go back in to heip NA #3 and Medication Aide to go back in to heip NA #3 and Medication Aide to go back in to heip NA #3 and back with her retused and toak the to for heip Atff including contracted and agency staff, including contracted and in-service were

Facility ID: 923019

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/3 FORM APPI OMB NO. 0933	ROVEI
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVE COMPLETED	Y
		345263	B. WING		C 10/23/20 <sup>-</sup>	18
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMP	X5) PLETION ATE
F 600	F 600 Continued From page 45 pain, which wasn't normal behavior for her and then NA #1 came out of her room and told her NA #8 had Resident #3 in the bathroom and was being rough with her, trying to make her sit on the commode and yelling at her for having feces running down her legs because she had to clean		F 600	insulin once daily 5 times week weeks to ensure insulin is avail administration as ordered. This be documented on the insulin a On 10/20/18, the DON, QI nurs administrator, and/or licensed in	able for audit will audit tool. se, SF,	
	her up. Med Aide #10 tried to get NA #8 to l refused and he came go back in to help he NA #1 go back into R come back out and h	) stated NA #1 told her he leave the room but she out to get some gloves to r. She stated she observed lesident #3's room and then e told her NA #8 told him to		began auditing audit 100% of r insulin. The auditing will be co once daily 5 times weekly x 12 ensure insulin was administere ordered. This audit will be docu the insulin audit tool.	esidents on mpleted weeks to ed as umented on	
	told by NA #1 and he Nurse #1 on the sub-	e heard, observed, and was took the statements to acute hall to report the also was the nurse covering		On 10/20/18, the DON, QI nurs and/or administrator began rev referrals to ensure if a potentia would be on insulin and the me available prior to resident admi audit will be documented on the referral audit tool. This audit wi	iewing all I resident edication is ssion. This e insulin	
	with Nurse #1 reveale hall receiving report f 7:00 AM shift Nurse # and told her there ha	ed on 10/11/18 at 1:39 PM ed she was on the sub-acute rom the off-going 7:00 PM to #5, when NA #1 came to her d been an incident of abuse dent #3 on the Sparks Unit n statements.		completed on each referral for How the facility plans to monito performance to make sure solu sustained	or its utions are	
	Two attempts were u #8 via phone on 10/1 10/11/18 at 4:00 PM.			Starting on 10/19/18, the Social (SW) began weekly rounds ask and oriented residents if staff a good to the residents. The we will be completed for 6 months	king all alert ire being ekly rounds	
	with Nurse #5 reveale Nurse #1 on 10/01/18 pulled Nurse #1 to th and Resident #3 had	ed on 10/11/18 at 2:18 PM ed she was giving report to 3 when NA #1 came up and e side and told her NA #8 an incident and he thought ally and physically abusive		Starting on 10/19/18, the admin nursing staff (DON, quality imp nurse, treatment nurse, unit ma weekend supervisor, minimum nurse) will monitor direct care of residents daily from varied shift weeks, then weekly for 4 week monthly for 6 months to ensure	nistrative rovement anager, data set of 10 % of ts for 4 s, then	

Facility ID: 923019

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		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 11/30/2018 RM APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345263	B. WING		1	C D/23/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE # DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	On 10/18/18 at 8:30 , and the Administrator Jeopardy via telepho On 10/22/18 the facil credible allegation of removal that included 1. How corrective a for those residents fo by the deficient pract " On 10/1/18 at ap Resident #3 was yell (NA) #1 went to check Nursing Assistant #8 taking Resident #3's the toilet. Nursing As # 3. NA #1 asked NA and NA #8 refused.	AM the Director of Nursing r were notified of Immediate ne. ity provided an acceptable Immediate Jeopardy 1: action will be accomplished und to have been affected ice: oproximately 7:15am, ing and Nursing Assistant k on Resident #3 and abused the Resident by hand and pushed her onto sistant # 8 yelled at Resident #8 to leave the bathroom	F 60		API) API) and QI nurse, each sure their as tified if s ordered. te times sulin Audit eekly for dentified by action ely. The ved at the T) meeting	
	Assistant #1 returned resident's room. "On 10/11/18 at a director of nursing (D an allegation of abus occurred when Nursin providing incontinent dementia unit bathroo occurred when Nursin Resident #3's hand a the toilet. "On 10/11/18 at a treatment nurse com	opproximately 4:10 pm the ON) determined there was e and abuse potentially ng Assistant #8 was care to Resident #3 in the pm on 10/01/18. The abuse		<ul> <li>Beginning 10/20/18 the DON we the Insulin Audit Sheet results interdisciplinary team (IDT) we review for six months. This rewinclude ensuring insulin was an as ordered and insulin is availate administration. Presentation of Audit Sheet to the IDT will service second verification.</li> <li>Beginning 10/20/18, the DON we the insulin referral audit tool re IDT weekly for review for six more review will ensure potential administration available upon administration available upon administration of the insulin reference and the insulin reference and the insulin have the medication available upon administration of the insulin reference and the insulin reference and the insulin have the medication available upon administration of the insulin reference and the i</li></ul>	to the ekly for iew will dministered able for the Insulin ve as a will present sults to the ionths. This missions e nission.	

Facility ID: 923019

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		MEDICAID SERVICES	(X2) MI II TI		NSTRUCTION		NO. 0938-03 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · /		NEROCHON		DMPLETED
							С
		345263	B. WING			10/23/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
		REHABILITATION CENTER		3195 OLD MURPHY ROAD			
	ALLET NORSING AND IN			FRAM	NKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 600	Continued From page	e 47	F 6	00			
	assessment revealed Resident #3's skin co	I no new changes in			ool to the IDT will serve as a secor erification.	nd	
	<ul> <li>On 10/11/18 at approximately 4:30pm, the DON ensured Resident #3 was safe from abuse; the DON ensured Nursing Assistant #8 was not working at the facility and Nursing Assistant #1 was re-educated on abuse and immediate in-person reporting. On 10/11/18 at approximately 5pm the DON initiated resident abuse re-education for all facility staff, including contracted staff.</li> <li>On 10/15/18 at 3:00pm Nursing Assistant # 8 was re-educated on abuse, both verbal and physical abuse.</li> <li>On 10/19/18, the administrator held an emergency interdisciplinary team (IDT) meeting</li> </ul>			CC m ai re ne w as (C	he daily IDT's role in this plan of prrection includes implementation, nonitoring, and ensuring the interve- re effective. The IDT also makes ecommendations for revisions as eeded. The daily IDT review find ill be brought to the next quarterly ssurance and performance improv QAPI) meeting for additional review ecommendations.	entions lings quality vement	
	Nursing Assistant #8 how the facility can fir reviewed Nursing Ass the previous two wee assistant had worked	se analysis to know why the abused Resident #3 and x the problem. The IDT sistant #8's work hours for ks and noted the nursing overtime. The IDT also					
	plan and noted the re behaviors. The IDT of was Nursing Assistar and didn't receive ass	B's progress notes and care esident has on-going difficult determined the root cause at #8 was tired, frustrated, sistance needed to meet the response to the root cause,					
	the IDT determined the on resident abuse an recognizing burnout a addition, the administ to the staff assignment	ne staff required re-training d new training on and working as a team. An trator added additional staff nts. The DON, the					
	recognizing burnout a addition, the administ to the staff assignmen Administrator, the Fa	and working as a team. An trator added additional staff nts. The DON, the cility Consultant, and the erations interviewed Nursing					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COMF	PLETED
		345263	B. WING				C
NAME OF PI	ROVIDER OR SUPPLIER	040200		s	STREET ADDRESS, CITY, STATE, ZIP CODE	10/	23/2018
					3195 OLD MURPHY ROAD		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		F	FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	feel is being abused a from other staff. Nurs re-educated on calling Director of Nursing to abuse/neglect allegat 2. How the facility w having the potential to deficient practice: On 10/11/18, the treat head-to-toe skin audit residents to identify a signs/symptoms of ab findings. On 10/11/18, the DON Services Director (SS Abuse/Neglect Quest The questionnaires re allegations of abuse. Starting on 10/19/18, do weekly rounds ask residents if staff are b The weekly rounds ask residents if staff are b The weekly rounds wit months. On 10/19/18, the adm monitor direct care of daily from varied shift for 4 weeks, then mor no abuse is occurring results will be taken to performance improve monthly for discussion recommendations.	leaving a resident who they and to yell for assistance ing Assistant # 1 was also g the Administrator or never leave notes for any ion. will identify other residents to be affected by the same treat nurse performed a c on 100% of dementia unit ny residents with buse. The audit identified no N instructed the Social D) to perform Resident ionnaires on the residents. Evealed no further the Social Worker (SW) will ing all interview able eing good to the residents . Il be completed for 6 inistrative nursing staff will 10 % of residents s for 4 weeks, then weekly hthly for 6 months to ensure . Starting 10/19/18, the o the quality assurance and ment (QAPI) meeting n and further	F	600			
	3. What measures v	vill be put into place or de to ensure the deficient					

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		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 11/30/201 RM APPROVEI IO. 0938-039	
CENTERS FOR MEDICARE & I STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION					CONSTRUCTION	(X3) DAT	E SURVEY IPLETED	
		345263	B. WING			C 10/23/2018		
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
MACONIN				31	95 OLD MURPHY ROAD			
MACON	ALLET NURSING AND P	REHABILITATION CENTER		FF	RANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 600	Continued From page	e 49	F	500				
	practice will not recur							
		e QI nurse and staff facilitator on for all staff including						
		re-education covered:						
		eporting any abuse allegation						
	•	dministrator or Director of						
	Nursing 24 hours a day. All staff, all departments, all contracted employees, including Nursing Assistant #1 and Nurse #1, are being							
		sident safe at all times. If you						
	suspect a resident is	in harm's way do not leave						
	the resident and call	•						
		ng our residents safe at all						
	times.	e administrator, DON, QI						
		tator initiated small group						
		of staff, including contracted						
		liscuss the facility's zero						
		nd not abusing residents.						
		sions were presented with						
		e to help staff recognize es that will ensure residents						
		eated with dignity and						
		uding contracted and						
	agency staff will be a	-						
	participating in the sn	nall group discussions and						
		ut education. The small						
		burnout in-service will be						
		18. The discussion and						
	in-service will be add	contracted and agency staff.						
	•	B, the Social Worker (SW)						
		asking interview able						
	residents if staff are r	not abusing resident but						
		h dignity and respect. The						
	weekly SW rounds w	-						
		ts taken to the monthly QAPI						
	meetings for review a							

Facility ID: 923019

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	
		345263	B. WING				23/2018
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER			3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 600	nursing staff will moni residents daily from v weekly x 4 weeks, the ensure no abuse is of 10/19/18, the audit re QAPI meeting monthl recommendations. 4. How the facility p performance to make sustained (include da will be completed) " On 10/11/18, the director notified the da performance improve daily QAPI team's role includes implementat the interventions are of also making recomment needed. The daily QA brought to the next qu additional review and " On 10/19/18, The weekly rounds asking staff are being good to months. " On 10/19/18, The will monitor direct care from varied shifts for weeks, then monthly 10/19/2018 to ensure " On 10/19/18, the QAPI meeting monthl	<ul> <li>Alternative administrative iter direct care of 10 % of aried shifts x 4 weeks, then en monthly for 6 months to courring. Starting on sults will be taken to the y for discussion and further</li> <li>Alans to monitor its sure solutions are tes when corrective action</li> <li>DON and corporate clinical aily quality assurance and ment (QAPI) team. The e in this plan of correction ion and monitoring, ensuring effective. The QAPI team endations for revisions as API review findings will be uarterly QAPI meeting for recommendations.</li> <li>e Social Worker will do interview able residents if o the residents for 6</li> <li>e Administrative nursing staff e of 10% of resident's daily 4 weeks, then weekly for 4 for 6 months starting no abuse is occurring.</li> </ul>	F	600			

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 11/30/2018 I APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ONSTRUCTION		X3) DATE COMPI	SURVEY LETED
		345263	B. WING			C 10/23/2018		
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		319	EET ADDRESS, CITY, STATE, ZIP COD 5 OLD MURPHY ROAD ANKLIN, NC 28734	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	E	(X5) COMPLETION DATE
F 600	corrective measures sustained. Macon Valley alleges as of 10/22/18. On 10/23/18 facility s demonstrated they have residents having the and abuse would not Immediate jeopardy v 10/22/18. 2. Resident #2 was a 9/11/18 with diagnose heart disease, chroni peripheral vascular d Review of the Medica (MAR) for September revealed on 09/11/18 units of scheduled re- and an additional 2 u (SSI) for coverage of (CBG) reading of 236 Review of the Septer revealed Resident #2 physician ordered ins at 5:00 PM and 10 ur sliding scale insulin c CBG of 206 that requ 8:30 PM for a CBG o coverage. A record review of the further revealed Resi physician ordered 6 u 09/12/18 at 8:00 AM.	menting and monitoring to ensure solutions are a compliance of removal of IJ taff were interviewed and ad been trained on the topics right to be free from abuse be tolerated at the facility. was removed effective admitted to the facility on es which included: diabetes, c kidney disease, and isease. ation Administration Record r 2018 for Resident #2 Resident #2 was given 6 gular insulin at 12:00 PM nits of sliding scale insulin capillary blood glucose be compliance of gular solutions on 09/11/18 hits at 9:00 PM and his overage at 4:30 PM for a hired 2 units of coverage and f 240 that required 2 units of e September 2018 MAR	Fé	800				

Facility ID: 923019

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	-	ID HUMAN SERVICES MEDICAID SERVICES			I	INTED: 11/30/2018 FORM APPROVED IB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		) DATE SURVEY COMPLETED
		345263	B. WING			C 10/23/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	10/20/2010
MACONIN		EHABILITATION CENTER		195 OLD MURPHY ROAD		
	ALLET NURSING AND R		1	FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 600	for 09/11/18 for Resid following readings: 09/11/18 1:00 PM 09/11/18 4:12 PM 09/11/18 4:12 PM 09/11/18 4:12 PM 09/11/18 8:50 PM Per physician order a of 206, Resident #2 s regular insulin on 09/7 Per physician order a of 240, Resident #2 s regular insulin on 09/7 An interview with Nur PM revealed she gav regular insulin on 09/7 included the 6 units o and 6 units of regular CBG reading "HI". Nur recheck of Resident # read "HI". Nurse #3 r the facility and she ex ordered him transferre possible DKA. An interview with Nur AM revealed she did physician ordered ins PM and 09/11/18 at 5 PM. She further state #2 his Detemir insulin 9:00 PM. She stated s insulin and just did no	f "HI". Glucose Monitoring Sheet lent #2 revealed the A CBG 236 A CBG 206 A CBG 240 Ind based on CBG reading hould have received 2 units 11/18 at 4:30 PM. Ind based on CBG reading hould have received 2 units 11/18 at 4:30 PM. Ind based on CBG reading hould have received 2 units 11/18 at 8:30 PM. Ind based on CBG reading hould have received 2 units 11/18 at 8:30 PM. Ind based on CBG reading hould have received 2 units 11/18 at 7:30 AM. This f regular scheduled insulin insulin for SSI coverage of urse #3 further revealed the #2's CBG at 9:30 AM still hotified the NP, who was at camined the resident and ed to the hospital for Ise #4 on 10/10/18 at 9:06 not give Resident #2 his ulin's on 09/11/18 at 4:30 :00 PM or 09/11/18 at 8:30 d she did not give Resident ischeduled for 09/11/18 at scheduled for 09/11/18 at sched	F 600			
	CBG reading "HI". Nurecheck of Resident # read "HI". Nurse #3 r the facility and she ex ordered him transferre possible DKA. An interview with Nur AM revealed she did physician ordered ins PM and 09/11/18 at 5 PM. She further state #2 his Detemir insulin 9:00 PM. She stated s insulin and just did no	Irse #3 further revealed the #2's CBG at 9:30 AM still hotified the NP, who was at camined the resident and ed to the hospital for se #4 on 10/10/18 at 9:06 not give Resident #2 his ulin's on 09/11/18 at 4:30 :00 PM or 09/11/18 at 8:30 d she did not give Resident scheduled for 09/11/18 at she did not look for the				

Facility ID: 923019

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DEPARTMENT OF HEALTH CENTERS FOR MEDICAR						FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PF	ROVIDER/SUPPLIER/CLIA			LE CONSTRUCTION	(X3) DATE COMP	
		345263	B. WING				_ 23/2018
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
MACON VALLEY NURSING A	ND REHABII	LITATION CENTER			3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
PREFIX (EACH DEFIC	IENCY MUST I	T OF DEFICIENCIES BE PRECEDED BY FULL ITIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
Review of the nu PM revealed the The nurse gave F insulin per physic was rechecked a note further revea and not feeling w Practitioner (NP) Resident #2 to th evaluation of pos Review of the Nu note dated 9/12/7 seen on 09/12/18 The progress not developed nause clammy and anxi NP to transfer the department for po An interview with revealed she was received his insu sent to the hospit revealed her exp to contact the on- not available. An interview with AM revealed she reported to the 30 had not received not contact the on-	obtained the resident #2 use stock in se notes d CBG taken Resident #2 ian admiss 9:30 AM v aled Reside ell and was who wrote e emergen sible DKA. rse Practiti 8 indicated a and vomi bus. An orce e resident to bus an orce resident to bus an orce resident to bus an orce resident to bus an orce all Further ectation wa call physic Nurse #4 of did not rend shift nurs his insulin. I-call physic	on 09/11/18 and in the emergency box. ated 09/12/18 at 2:05 at 7:30 AM read "HI". 2 12 units of regular ion orders. The CBG which read "HI". The ent #2 was vomiting a seen by the Nurse an order for transfer cy department for oner (NP) progress d Resident #2 was G reading was 'HI'. Resident #2 had also iting and he was der was given by the o the emergency A. 10/10/18 at 10:00 AM Resident #2 had not ening before he was interview with the NP is for the facility nurse ian if the insulin was on 10/10/18 at 10:45 hember if she had we that Resident #2 She stated she did cian to notify them of	F	600	0		

Facility ID: 923019

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391			
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED			
		345263	B. WING				C 23/2018			
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE						
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER			3195 OLD MURPHY ROAD FRANKLIN, NC 28734					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE			
F 600	insulin or look for the box which contains en During an interview w 10/09/18 at 4:05 PM s facility staff to contact medications. She furt staff to check for the of emergency box and to missing medications. Review of the hospita #2 was admitted to th unit for DKA on 09/12 admission to the hospita medications to the hospita admission to the hospita from the morning of 00 discharged on 09/14/ On 10/18/18 at 8:30 A and the Administrator Jeopardy via telephor 1. How corrective action those residents found the deficient practice: On September 11, 20 11:30am, Resident #2 Valley Nursing and Re a hospitalization for d uncontrolled diabetes On September 11, 20 had a blood glucose r glucose procedure was	<ul> <li>insulin in the emergency mergency medications.</li> <li>ith Director of Nursing on she stated she expected the the physician for all missing her stated she expected ordered medications in the contact pharmacy for</li> <li>il records revealed Resident e hospital intensive care (18. Blood sugar on bital was 485. Resident #2 ip which he was weaned 9/13/18. He was 18.</li> <li>AM the Director of Nursing were notified of Immediate he.</li> <li>ion will be accomplished for 1 to have been affected by</li> <li>18 at approximately 2 was admitted to Macon ehabilitation center following iagnosis including type 1.</li> <li>18 at 11:30 am, Resident #2 reading of 236; blood as performed by Nurse #3.</li> <li>18 at 11:30 am, Resident #2</li> </ul>	F	600						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
			A. BUILDI	ING _			C
		345263	B. WING			10/	23/2018
NAME OF PR	OVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MACON VA	ALLEY NURSING AND R	EHABILITATION CENTER			3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	was given regular insu according to physiciar insulin by Nurse #3. On September 11, 20 had a blood glucose r glucose procedure wa On September 11, 20 Resident #2 received blood glucose of 206, On September 11, 20 has no documentation scheduled dose of 6 u ordered by physician. On September 11, 20 had a blood glucose r was performed by Nu On September 11, 20 has no documentation regular insulin for a bl as ordered by physicia On September 11, 20 has no documentation regular insulin for a bl as ordered by physicia On September 11, 20 has no documentation Levemir 10 units, as o On September 12, 20 had a blood glucose r performed by Nurse #	urse #3, according to ood glucose of 236. 18 at 12 noon, Resident #2 ulin 6 units subcutaneously, n order, for scheduled 18 at 4:12 pm, Resident #2 eading of 206; blood as performed by Nurse #4. 18 no documentation that 2 units of regular insulin for as ordered by physician. 18 5:00 pm, Resident #2 n of administration of units of regular insulin, as 18 at 8:50 pm, Resident #2 eading of 240; procedure rse #4. 18 at 8:50 pm, Resident #2 n of administration of 2 units ood glucose reading of 240, an. 18 at 9:00 pm, Resident #2 n of administration of ordered by physician. 18 at 9:00 pm, Resident #2 n of administration of ordered by physician. 18 at 7:30 am, Resident #2 esult of HI; procedure was	F	600			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345263	B. WING				C 23/2018	
NAME OF PI	ROVIDER OR SUPPLIER	-			STREET ADDRESS, CITY, STATE, ZIP CODE			
		EHABILITATION CENTER			3195 OLD MURPHY ROAD			
	ALLET NORSING AND R	ERADICITATION CENTER			FRANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 600	by Nurse #3, as order Resident #2. On September 12, 20 was administered Res subcutaneous by Nur dose as ordered by p On September 12, 20 rechecked Resident # result of HI. On September 12, 20 the nurse practitioner glucose reading rema Nurse #3 of administr insulin for the initial H administering the 6 un scheduled by Nurse # On September 12, 20 gave a verbal order to to be sent to emerger On September 12, 20 the emergency room,	<ul> <li>Itaneous was administered red by the physician, to</li> <li>Ita at 8:00, am Resident #2 gular Insulin 6 units se #3, for schedule insulin hysician.</li> <li>Ita at 9:30 am, Nurse #3 #2's blood glucose with a</li> <li>Ita approximately 9:30, am was notified of blood atining HI, the action taken by rating 6 units of regular I reading, and Nurse #3 hits of regular insulin as #3 for Resident #2.</li> <li>Ita, the nurse practitioner o Nurse #3 for Resident #12</li> </ul>	F	60				
	On October 19, 2018 abuse/neglect re-edu involved in the deficie re-education covered providing medications re-education will be c including Nurse #4 ar	the DON initiated cation to correct the staff ent practice. The neglect that neglect includes not as ordered. The neglect overed with 100% staff, and agency staff. No nurse is the education is completed.						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF D	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CO	RRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG .			LETED
		345263	B. WING				_ 23/2018
NAME OF PROV	IDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MACON VALI	LEY NURSING AND RI	EHABILITATION CENTER			3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
O in ac in ac in ac in ac in ac fo with m O ar Je 2. ha de O (C re with ac ac ur ur ga O au ga O au fo no ne fo so ne fo fo so ne fo so so n fo so ne fo so ne fo so ne fo so ne fo so ne fo so ne fo so ne fo so ne fo so ne fo so ne fo so ne fo so ne fo so ne fo so ne fo so ne fo so ne fo so fo so ne fo so ne fo so ne fo so ne fo so ne fo so ne fo so ne fo so ne fo so ne fo so ne fo so ne fo so ne fo so ne fo so ne fo so ne fo so ne so ne fo so ne fo ne fo n so n s n so so so n so so so so so so so so so so so so so	dministering medicat cluding obtaining me vailable on the medic n October 22, 2018, ot cause of the defice eglect of Resident #2 llow established poli hen the medication i edication cart. n 10/19/18 at 8:30 A nd the Administrator eopardy. How the facility will aving the potential to eficient practice: n October 19, 2018, DON) and Unit Mana esidents on insulin to ere omitted in the lass entified 28 occurrent dministration of insul cording to physiciar hit manager contacted ave no new orders. n October 19, 2018, udited to ensure all m sulin available in the sulin available to ma	all licensed nurses, , were in-serviced on ion per physician orders, edications when not cation cart/in the facility. the facility determined the cient practice that led to 2 was the nurse's failure to cy in obtaining medications s not available on the M the Director of Nursing were notified of Immediate identify other residents be affected by the same the director of nursing ger reviewed all current ensure no other doses st 30 days. The review ces where the in was not documented n's orders. On 10/22/18 the ed the physician regarding of insulin. The physician the DON and Unit Manager esidents on insulin have the e facility. All Residents had atch order. the DON instructed the	F	600			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED
		345263	B. WING				C / <b>23/2018</b>
NAME OF P	ROVIDER OR SUPPLIER		•	1	STREET ADDRESS, CITY, STATE, ZIP CODE		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER			3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 600	abuse/neglect question The questionnaires reallegations of abuse. 3. What measures will systemic changes mapractice will not recur On October 20, 2018 administrator, and/or auditing 100% of resist times weekly x 12 we available for administ will be documented o On October 20, 2018 improvement (QI) nur administrator, and/or auditing audit 100% of auditing will be complex weekly x 12 weeks to administered as order documented on the in On October 20, 2018 and/or administrator to to ensure, if a new add insulin, the insulin me the resident's new ad documented on the In This audit will be complex sustained (include da will be completed)	annaires with the residents. esults revealed no further If be put into place or ide to ensure the deficient the DON, QI nurse, SF, licensed nurse began dents on insulin once daily 5 eks to ensure insulin is ration as ordered. This audit in the insulin audit tool. the DON, quality rese, staff facilitator (SF), licensed nurse began of residents on insulin. The eted once daily 5 times ensure insulin was red. This audit will be isulin audit tool. the DON, QI nurse, SF, began reviewing all referrals imission resident is on edication is available prior to mission. This audit will be isulin Referral Audit tool. upleted for 12 week for each sion.	F	600			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		E CONSTRUCTION	(X3) DATE	
		345263	B. WING				C 23/2018
NAME OF PI	ROVIDER 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	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	receiving insulin to en available and given as was notified if insulin ordered. This audit wi weekly and recorded Any concerns identifie corrective action take immediately. The com reviewed at the daily meeting for additional Beginning October 20 the Insulin Audit Sheet interdisciplinary team This review will include administered as order for administration. Pre Audit Sheet to the IDT verification. Beginning October 20 present the insulin ref IDT weekly for review potential admissions of the medication availa Presentation of the in IDT will serve as a se The daily IDT's role in includes implementat ensuring the intervent also makes recomme needed. The daily II brought to the next qu and performance imp for additional review a	<ul> <li>vill audit each resident isure their insulin was s ordered, and if the MD was not administered as ill be completed five times on the Insulin Audit Sheet.</li> <li>ed by the auditor will have n by the auditor mail to be interdisciplinary team (IDT)</li> <li>e corrective measures.</li> <li>b) 2018 the DON will present et results to the (IDT) weekly for review.</li> <li>le ensuring insulin was red and insulin is available esentation of the Insulin T will serve as a second</li> <li>c) 2018, the DON will ferral audit tool results to the this review will ensure with a need for insulin have ble upon admission.</li> <li>sulin referral audit tool to the cond verification.</li> </ul>	F	600			
	10/22/18, the adminis						

Facility ID: 923019

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/30/20 FORM APPROVE MB NO. 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		(X3) DATE SURVEY COMPLETED C 10/23/2018	
		345263	B. WING			
NAME OF PI	ROVIDER OR SUPPLIER	•	STF	REET ADDRESS, CITY, STATE, ZIP CODE		
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER		95 OLD MURPHY ROAD ANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIO DATE	
F 600	Continued From page	e 60	F 600			
	and the facility's plan	of correction, including the le in the plan of correction.				
	Beginning October 19 will be responsible fo monitoring corrective solutions are sustained	measures to ensure				
		g and Rehabilitation Center f removal of IJ as of October				
	demonstrated they had of medication administration	taff were interviewed and ad been trained on the topics stration, and how to call the tions. Immediate jeopardy re 10/22/18.				
F 607 SS=J		buse/Neglect Policies -(3)	F 607		12/5/18	
	§483.12(b) The facilit implement written po	ty must develop and licies and procedures that:				
	§483.12(b)(1) Prohib neglect, and exploitat misappropriation of re	tion of residents and				
	§483.12(b)(2) Establi to investigate any suc	sh policies and procedures ch allegations, and				
	paragraph §483.95, This REQUIREMENT	e training as required at 「 is not met as evidenced				
	facility failed to imple	iew and staff interviews the ment their abuse policy and		F 607  Implement Abuse/Neglect Police	су	
	procedures in the are identification, protect	•		How corrective action will be		

Event ID: J78Q11

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE SURVEY		
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	. ,		COMPLETED		
					С		
		345263	B. WING STREET ADDRESS, CITY, STATE, ZIP CC		10/23/201		
NAME OF P	ROVIDER OR SUPPLIER						
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		3195 OLD MURPHY ROAD			
				FRANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPL		
F 607	Continued From page	e 61	F 60	7			
		3 residents reviewed for		accomplished for those residents have been affected by the deficient practice:			
	Nurse Aide (NA) #1 o trying to make Reside and yelling at her for the incident to Nurse Resident #3 or report Nursing or the Admin was removed on 10/2 implemented a credib Jeopardy removal. Th compliance at a lowe (no actual harm with the minimal harm that is n complete employee e monitoring systems in The findings included Review of the facility. Misappropriation of R dated 01/2009 with a read in part: The facil have the right to be fr involuntary seclusion, misappropriation of p	n place are effective. Abuse, Neglect, or Resident Property Policy revision date of 03/10/17 ity believes that residents ree from abuse, neglect,		On 10/1/18 at approximately 7:0 Resident #3 was in the dementia bathroom. Resident #3 was sitti clothed, in a wheelchair. Nursing #8 was assisting Resident #1 wi care. On 10/1/18 at approximately 7ar Nursing Assistant #1 observed F #3 in the dementia unit bathroom screaming. Nursing Assistant # Nursing Assistant #8 what she n Nursing Assistant #8 what she n Nursing Assistant #8 replied wip Nursing Assistant #1 then went to linen room and obtained wipes. On 10/1/18 at approximately 7:1 Nursing Assistant #1 states that Nursing Assistant #1 states that Nursing Assistant #1 states that Nursing Assistant #1 reported th observations of Nursing Assistar interactions with Resident #3 in to bathroom to Nurse #1. Nurse #7 collected statements from Medic	a unit ng, g Assistant th ADL n, Resident n loudly 1 asked eeded. es now. to the 5am he saw nts hand yelled at 35 am e nt #8 \B sthe 1		
	neglect, exploitation, or misappropriation o employee who witnes neglect, exploitation, property has occurred alleged incident to the immediately report th	and abuse of our residents f their property. Any sses or suspects that abuse, or misappropriation of d will immediately report the eir supervisor, who will		#9 and Nursing Assistant #1. Nu placed the statements under the administrator □s door at approxir pm before leaving work. The administrator never received the statements from Medication Aide Nursing Assistant #1. On 10/1/18 Nurse #1 did not ass	rse #1 nately 7 e #9 or		

Facility ID: 923019

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TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		NO. 0938-03	
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	. ,	i	ćć	OMPLETED	
			R WING			С	
		345263	B. WING			10/23/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	° CODE		
MACON V	ALLEY NURSING AND R	REHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN (	OF CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	D THE APPROPRIATE	COMPLETIC	
F 607	Continued From page	e 62	F 60	7			
	disciplinary action an	d possible termination of		On 10/11/18 at approximation	ately 3:00 pm,		
		ministrator is responsible to		immediately upon notifica			
	ensure that complain			state surveyor, the direct	•		
		propriation of property and		(DON), the DON initiated			
	injuries of unknown o			On 10/11/18 at approxima	•		
		lemented to prevent further e the investigation is in		DON, corporate clinical fa and corporate clinical dire			
	-	istrator is responsible to		Nursing Assistant #1 The			
		the investigation and report		corporate clinical director			
		o the appropriate agencies in		Assistant #1 a verbal re-e			
	accordance with state	e and federal regulations.		include immediate interve			
				Resident #3, immediate i			
	Resident #3 was admitted to the facility on 03/30/18 with diagnoses of Alzheimer's disease,			Nursing Assistant #8, imr			
	non-Alzheimer's dem			to a supervisor, and prop to the DON and administ On 10/11/18 at approxima	rator.		
	Review of the quarter	rly Minimum Data Set (MDS)		treatment nurse complete	• •		
	dated 07/06/18 revea	,		physical and emotional a			
		mapaired. The MDS further		Resident #3. The assess	sment revealed		
		had delusions, physical and		no findings.			
		ard others, rejection of care		On 10/11/18 at approximation			
	-	days during the assessment		DON contacted the police			
	period.			approximately 5pm, the p the facility. The police of			
	Review of the nurse's	s notes from 09/30/18		statements.			
		ealed no documentation of		On 10/11/18 at approximation	ately 4:15pm, the		
		or NA #9 having concerns		DON contacted Resident	#3⊡s physician		
	that NA #8 had been			and resident representati	. ,		
	abusive to Resident #	#3 on the morning of		physician gave no new o			
	10/01/18.			did not answer. A message	ge was left to		
	Review of the facility	incident reports from		please contact facility. On 10/11/18 at approximation	ately 4·12 nm		
		12/18 revealed there was no		the DON submitted an In			
		eged physical/verbal abuse		Report to the North Carol	•		
	of Resident #3 by NA			Intake and Health Care F			
				Investigation.			
		ed on 10/11/18 at 10:36 AM		On 10/12/18 at approxim			
		he worked the 7:00 AM to		The RR returned the DO			
	່ 3:00 PIVI shift on the S	Sparks Unit on 10/01/18. NA		DON told the RR about the	ne Allegation.		

Facility ID: 923019

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		MEDICAID SERVICES				B NO. 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		DATE SURVEY COMPLETED	
		345263	B. WING			C 10/23/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY		10/23/2016	
			3195 OLD MURPHY ROAD				
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		FRANKLIN, NC 2873			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE	
F 607	Continued From page	. 63	F 60	7			
1 007			FOU		annravinataly 5:40nm		
	#1 stated when he we morning the 11:00 PM			approximately 5:40pm, led by the administrator,			
	out on the floor and h		the incident was	•			
		e was at the nurse's station			e administrator and DON		
		nt #3 start screaming, which			g Assistant #8 and		
		er, and immediately went to			en statement. After		
	her room. NA #1 state				itten statement the		
	Resident #3's room sl	he was in the bathroom with		-	d DON told Nursing		
	NA #8, who was yellir	ng at her and was forcibly			t the investigation would		
	-	down on the commode. He			until the sheriff s		
	stated NA #8 was yell	ing at Resident #3 because		department was	finished and we would		
	she had been incontir		notify her of resu	ults of investigation.			
	down her legs and wo			e sheriff⊡s department			
		ed he told NA #8 it was time		arrested Nursing			
		om because he thought she			e administrator and DON		
		with the resident and he			#1, she was given a		
		re of Resident #3 but she		-	for failing to assess and		
		she wasn't finished with her			# 3. Also for not reporting		
	-	the room to get some gloves NA #8 and Medication Aide			person or by phone to the DON that an allegation of		
	-	ed Aide #10 were at the		abuse had been			
		ing meds and he told them			e administrator and DON		
		NA #1 stated when he went			de #9 and the Med Aide		
		bathroom NA #8 told him to			bal consultation and re-in		
		e left Resident #3's room		-	per procedure to protect		
		the nurse's station and		resident at all tir			
	wrote a statement of	what had happened and had			e Administrator and/ or		
	Med Aide #9 write a s	tatement of what she heard		Director of Nurs	ing.		
	and took them to the	sub-acute hall to Nurse #1		On 10/19/18 the			
		lent to her because she was			cluding immediate actions		
		overing the Sparks Unit. He		and proper repo	-		
	-	vith Resident #3 and NA #8			all staff and contracted		
		to leave and he didn't know		staff by Staff fac			
	-	ty to with them and he			approximately 3:29 pm,		
		ncident right away to the			r submitted a 5-day report		
		ed he was never interviewed			olina Complaint Intake		
	-	ut the incident and NA #8			Personnel Investigation.		
	continued to work on	me Sparks Unit.			approximately 4:30pm, the led the RR with the		

Event ID: J78Q11

Facility ID: 923019

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	. ,	TE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CO	MPLETED	
						С	
		345263	B. WING	STREET ADDRESS, CITY, STATE, ZI		0/23/2018	
NAME OF P	ROVIDER OR SUPPLIER			P CODE			
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER	3195 OLD MURPHY ROAD				
-				FRANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE	(X5) COMPLETIO DATE	
F 607	Continued From page	e 64	F 60	7			
	An interview conduct	ed on 10/11/18 at 11:01 AM realed she worked as a		sheriff⊡s department⊡s	findings.		
	Medication Aide on th	ne Sparks Unit on 10/01/18		How the facility will ident	ify other residents		
	7:00 AM to 7:00 PM	shift and was counting		having the potential to be	e affected by the		
		off-going Med Aide on the		same deficient practice:			
		2:00 AM. Med Aide #9 stated					
		#3 screaming like she was in came out of her room and		On 10/11/18, the treatme performed a head-to-toe			
		esident #3 in the bathroom		100% of dementia unit re			
		with her, trying to make her		identify any residents wit			
		and yelling at her for having		signs/symptoms of abus			
	feces running down h	ner legs because she had to		identified no findings.			
		de #10 stated NA #1 told her		On 10/11/18, the DON p			
	-	to leave the room but she		on 100% of the staff sch			
		e out to get some gloves to		assignment sheets. The			
		r. She stated she observed Resident #3's room and then		identify any assignment Assistant #8 had worked	-		
	•	e told her NA #8 told him to		10/1/18 incident date. T			
	get out. Med Aide #9			audit revealed six shifts.			
	statement of what sh	e heard, observed, and was		immediately after the au			
	-	took the statements to		reported the audit results	s to the		
		acute hall to report the		administrator. The DON			
		also was the nurse covering		the quality improvement			
		Aide #9 further stated		schedule Nursing Assista			
		nave behaviors of yelling or ras doing on the morning of		Also, the DON instructed not to allow Nursing Assi			
	10/01/18.	as doing on the morning of		facility front door entry, if	-		
				Assistant #8 were to con	-		
	An interview conduct	ed on 10/11/18 at 1:39 PM		The DON attempted to c	•		
		ed she was on the sub-acute		Assistant #8 by telephon			
		from the off-going 7:00 PM to		success. The DON conta			
		#5, when NA #1 came to her		authorities who came to	-		
		d been an incident of abuse		10/17/18, the county she	-		
		dent #3 on the Sparks Unit en statements. Nurse #1		arrested Nursing Assista On 10/11/18, the DON in			
		o the Sparks Unit and		Social Services Director			
	-	or talk to NA #8 and didn't		Resident Abuse/Neglect			
		the Director of Nursing or		on the residents. The qu			
				• • • • • • • • • • • • • • • • •		1	

Facility ID: 923019

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TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVE	<u>8-03</u> Y
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	. ,	·	COMPLETED	
				С	С	
		345263	B. WING		10/23/202	18
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MACON VALLEY NURSING AND REHABILITATION CENTER				3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMP	
F 607	Continued From page	e 65	F 60	7		
	wasn't on her shift an	d she thought Nurse #5				
	should take care of the incident. She stated she did not discuss the incident with Nurse #5			What measures will be put into p	blace or	
				systemic changes made to ensu	re the	
		oing to report it. Nurse #1		deficient practice will not recur:		
		ved report she took the				
		nd put them under the		On 10/11/18, the QI nurse and s		
	Administrators door a			facilitator initiated a re-education		
		She stated she met NA #8 her what happened and NA		RNs, LPNs, MAs, NAs, agency s contracted therapy personnel. T		
		a misunderstanding so she		re-education covered: Abuse/Ne		
		juestions. Nurse #1 stated		reporting. All staff, all department	-	
	-	llegation of abuse it should		contracted employees, including		
	be reported to the Ad	ministrator which was what		Assistant #1 and Nurse #1, are b	being	
		e witness statements under		instructed to keep resident safe		
		lurse #1 further stated she		times. If you suspect a resident i		
	did not read the witne	ess statements.		harm⊡s way do not leave the re		
		ad an 10/11/10 2:15 DM		Nurses will document relevant in		
		ed on 10/11/18 2:15 PM with g revealed she was never		on the 24 hour report sheets and relevant information to the on-co		
		ent between Resident #3 and		nurse regarding abuse/neglect.	•	
		stated she should have		and contracted staff must follow		
		diately so an investigation		facility s policy on abuse/negled		
		ted and the 24-hour 5-day		staff become aware of actual or		
	reports could have be	een sent to the state agency.		resident abuse/neglect. The adr	ninistrator	
				and DON must be notified imme	-	
				all abuse/neglect allegation to er		
		ed on 10/11/18 at 2:18 PM		proper interventions are in place		
		ed she was giving report to		re-education was completed on		
		3 when NA #1 came up and e side and told her NA #8		with all staff working; no RN, LP NA, agency staff or contracted th		
		an incident and he thought		personnel will be allowed to worl		
		ally and physically abusive		including Nursing Assistant #1 a		
		rse #5 stated she didn't		#1, until the re-education is com		
		cause NA #1 reported it to		The re-education is added to the		
	Nurse #1 and she as	sumed she would report the		orientation for all staff and contra	acted	
	incident to the Directo	-		therapy personnel		
		#5 further stated Resident		On 10/11/18, the DON initiated in		
	#5 didn't have behavi	iors of yelling and		morning inter-disciplinary team (		
	screaming.			meeting a review of all incidents	, tO	

Facility ID: 923019

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 11/30/201 MAPPROVE D. 0938-039	
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		PLETED	
		345263	B. WING		C 10/23/2018		
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
MACON V	MACON VALLEY NURSING AND REHABILITATION CENTER			3195 OLD MURPHY ROAD FRANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 607	Continued From page	9 66	F 60				
	An interview conduct with the Administrator reported an abuse all #8 and Resident #3 a statements under her stated the surveyor's had heard about the stated NA #1 and Nu this incident to her im wasn't in the building NA #8 should have b an investigation was stated it was her exp allegations to be report of Nursing immediate On 10/18/18 at 8:30 / and the Administrator Jeopardy via telephon On 10/22/18 the facilit credible allegation of removal that included 1. How corrective a for those residents for by the deficient pract On 10/1/18 at approx #3 was in the dement #3 was sitting, clothe	ed on 10/11/18 at 2:22 PM revealed no one had egation to her regarding NA and there were no witness door on 10/01/18. She call was the first time she incident. The Administrator rse #1 should have reported mediately via phone if she and the Director of Nursing een escorted off the hall until completed. She further ectation for all abuse orted to her and the Director dy. AM the Director of Nursing were notified of Immediate ne. Ity provided an acceptable Immediate Jeopardy I: inction will be accomplished und to have been affected fce: imately 7:00 am, Resident tia unit bathroom. Resident d, in a wheelchair. Nursing isting Resident #1 with ADL		<ul> <li>include abuse/neglect. The revincluded verifying that abuse/negations were reported to the administrator and DON, the offer immediately removed from reside an assessment was completed immediately post-incident, that if physician/nurse practitioner was of all abuse/neglect allegations relevant information provided. Tresident representative was not the authorities were contacted. On 10/19/18 An in-service was with Nurse #1 about assessing a immediately if an allegation of a made. In serviced by Director of On 10/19/18, The Administrative staff will monitor direct care of 1 resident is daily X 4 weeks, the 4 weeks, then monthly for 6 mo starting 10/19/2018 to insure no occurring. On 10/19/18, The Social Worke weekly rounds asking interview residents for 6 months.</li> <li>How the facility plans to monitor performance to make sure solut sustained (include dates when o action will be completed)</li> <li>Beginning 10/11/18, the DON, C and/or staff facilitator will review hour PCC progress notes. Beginning</li> </ul>	eglect ender was dent areas, the s notified with all The ified. That completed a resident buse is f Nursing. e nursing 0 % of n weekly X nths o abuse is r will do able to the r its tions are corrective		
				10/11/18, the 24 hour report she findings will be reconciled with t PCC progress note review findin ensure all allegations of abuse/	he 24 hour ngs to		

Facility ID: 923019

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	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION		D. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COM	PLETED
		345263	B. WING			C / <b>23/2018</b>
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				3195 OLD MURPHY ROAD		
MACON VALLEY NURSING AND REHABILITATION CENTER			FRANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 607	Continued From page	e 67	F 607	,		
	"wipes now". Nursing the linen room and of On 10/1/18 at approx Assistant #1 states th #8 take residents har toilet and yelled at he On 10/1/18, at approx Assistant #1 reported Assistant #1 reported Assistant #8's interact bathroom to Nurse # statements from Med Assistant #1. Nurse # under the administrat pm before leaving wo received the stateme or Nursing Assistant On 10/11/18 Nurse #1 after allegation of abo On 10/11/18 at appro- immediately upon no surveyor, the director initiated an investigat On 10/11/18 at appro- corporate clinical faci clinical director interv The DON and corpor Nursing Assistant #1 include immediate in Resident #3, immedia	g Assistant #1 then went to btained wipes. simately 7:15am Nursing nat he saw Nursing Assistant and and push her onto the er. ximately 7:35 am Nursing the observations of Nursing the observation Aide #9 and Nursing the placed the statements tor's door at approximately 7 ork. The administrator never ints from Medication Aide #9 #1. did not assess resident use was made. oximately 3:00 pm, tification from the state of nursing (DON), the DON tion. oximately 3:15 pm the DON, lity consultant and corporate riewed Nursing Assistant #1 rate clinical director gave a verbal re-education to terventions to protect ate isolation of Nursing ate reporting to a supervisor,		<ul> <li>have documented assessments ar reports to the administrator, DON, physician/nurse practitioner, resider representative, and authorities. The reviews and reconciliations will be completed (5) five times a week for period of (6)six months.</li> <li>On 10/19/2018, The Administrative nursing staff will monitor direct car % of resident s daily X 4 weeks, the weekly X 4 weeks, then monthly for months starting 10/19/2018 to insurabuse is occurring.</li> <li>On 10/19/18, The Social Worker weekly rounds times 6 months as interview able residents if staff have abused/neglected them.</li> <li>On 10/11/18, the DON and corporational director notified the daily quassurance and performance improving (QAPI) team. The daily QAPI team role in this plan of correction including implementation and monitoring, end the interventions are effective. The team also making recommendation revisions as needed. The daily Greview findings will be brought to the quarterly QAPI meeting for addition review and recommendations.</li> <li>Beginning 10/11/18, the administration and monitoring and and and and and and and and and and</li></ul>	ent nese r a e of 10 hen or 6 irre no vill do king re ate uality vement n s des suring e QAPI ns for DAPI he next nal	
	nurse completed a he emotional assessment assessment revealed	eximately 4pm, the treatment ead-to-toe physical and nt of Resident #3. The I no findings. eximately 4pm, the DON				
	contacted the police					
		he police arrived at the				1

Facility ID: 923019

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		ND HUMAN SERVICES MEDICAID SERVICES					INTED: 11/30/20 FORM APPROVE B NO. 0938-039
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		ONSTRUCTION		) DATE SURVEY COMPLETED
		345263	B. WING			C 10/23/2018	
NAME OF P	ROVIDER OR SUPPLIER	•	•	STF	REET ADDRESS, CITY, STATE, ZIP COD	E	
				319	5 OLD MURPHY ROAD		
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER		FR	ANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 607	, <u>,</u> ,	fficers obtain statements.	F	607			
	contacted Resident #	oximately 4:15pm, the DON 43's physician and resident The physician gave no new					
	orders. The RR did r left to please contact	not answer. A message was					
	submitted an Initial A Carolina Complaint I	llegation Report to the North ntake and Health Care					
		on. oximately 5:00pm, The RR call. The DON told the RR					
		oximately 5:40pm, The RR ministrator, the incident was					
	discussed. On 10/16/18, the adn	ninistrator and DON met with					
	statement. After obta	and obtained a written aining the written statement I DON told Nursing Assistant					
	#8 that the investigat until the sheriff's dep	ion would not be complete artment was finished and we					
	would notify her of re On 10/17/18, the she Nursing Assistant #8	eriff's department arrested					
	Nurse #1, she was gi	ninistrator and DON met with iven a written warning for					
	not reporting immedia	protect resident # 3. Also for ately in person or by phone or DON that an allegation of					
		le. ninistrator and DON met with e Med Aide was given a					
	verbal consultation a procedure to protect	nd re-in serviced on proper resident at all times and					
	Director of Nursing.	the Administrator and/ or se/neglect re-education,					
		actions and proper reporting,					

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	PLE CONSTRUCTION		IO. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	· /	B		IPLETED	
						С	
		345263	B. WING		1	10/23/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION	
F 607	Continued From page	e 69	F 60	07			
	-	with all staff and contracted					
	staff by Staff facilitator.						
		ximately 3:29 pm, the					
		ed a 5-day report to the					
	· ·	laint Intake and Health Care					
	Personnel Investigation						
	On 10/17/18 at appro	ne RR with the sheriff's					
	department's findings						
		vill identify other residents					
	-	o be affected by the same					
	deficient practice:						
		tment nurse performed a					
		t on 100% of dementia unit					
	residents to identify a						
	findings.	ouse. The audit identified no					
		N performed an audit on					
		edule and staff assignment					
		is to identify any assignment					
	where Nursing Assist	ant #8 had worked since the					
		The scheduling audit					
		On 10/11/18 immediately					
		ON reported the audit results					
		The DON also instructed the (QI) nurse not to schedule					
		to work. Also, the DON					
		staff, not to allow Nursing					
		facility front door entry, if					
		were to come to the facility.					
	-	o contact Nursing Assistant					
		out success. The DON					
		thorities who came to the					
	facility. On 10/17/18,	Nursing Assistant #8.					
		N instructed the Social					
		D) to perform Resident					
		ionnaires on the residents.					

Facility ID: 923019

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/30/2018 FORM APPROVED OMB NO. 0938-0391	
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345263	B. WING		C 10/23/2018	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3195 OLD MURPHY ROAD FRANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	IN SHOULD BE COMPLETION DATE	
F 607	systemic changes ma practice will not recur On 10/11/18, the QI r initiated a re-educatio NAs, and contracted re-education covered reporting. All staff, al employees, including Nurse #1, are being i safe at all times. If yo harm's way do not lea document relevant in report sheets and rep the on-coming shift n abuse/neglect. All staf follow the facility's po staff become aware of abuse/neglect. The ab be notified immediate allegation to ensure p place. The re-educati 10/18/18 with all staff NA, or contracted the allowed to work, inclu- and Nurse #1, until th The re-education is a orientation for all staff personnel On 10/11/18, the DOI inter-disciplinary team all incidents, to includ review included verify allegations were report	evealed no further will be put into place or ade to ensure the deficient curse and staff facilitator on for all RNs, LPNs, MAs, therapy personnel. The : Abuse/Neglect and Il departments, all contracted Nursing Assistant #1 and nstructed to keep resident u suspect a resident is in ave the resident. Nurses will formation on the 24 hour port relevant information to	F 607			

Facility ID: 923019

If continuation sheet Page 71 of 140

	-	ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 11/30/201 ORM APPROVEI NO. 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRI		(X3) DATE SURVEY COMPLETED	
		345263	B. WING			C 10/23/2018	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		3195 OLD I	DDRESS, CITY, STATE, ZIP COI MURPHY ROAD IN, NC 28734	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 607	physician/nurse pract abuse/neglect allegat information provided. was notified. That the On 10/19/18 An in-se Nurse #1 about asses if an allegation of abu Director of Nursing. On 10/19/18, The Ad monitor direct care of weeks, then weekly > 6 months starting 10/ is occurring. On 10/19/18, The So rounds asking intervie being good to the res 4. How the facility p performance to make sustained (include da will be completed) Beginning 10/11/18, ft staff facilitator will rev progress notes. Beg report sheet review fi with the 24 hour PCC findings to ensure all have documented as the administrator, DC practitioner, resident authorities. These re be completed five tim six months. On 10/19/2018, The / will monitor direct car	an assessment was ely post-incident, that the titioner was notified of all tions with all relevant The resident representative e authorities were contacted. ervice was completed with ssing a resident immediately use is made. In serviced by ministrative nursing staff will f 10 % of resident's daily X 4 K 4 weeks, then monthly for 19/2018 to insure no abuse cial Worker will do weekly ew able residents if staff are idents for 6 months. blans to monitor its e sure solutions are attes when corrective action the DON, QI nurse, and/or view the 24 hour PCC inning 10/11/18, the 24 hour ndings will be reconciled c) progress note review allegations of abuse/neglect sessments and reports to DN, physician/nurse	F6	07			

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		TE SURVEY MPLETED	
		345263	B. WING	1	C 10/23/2018		
NAME OF PI	ROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, ZIP COI			
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER		95 OLD MURPHY ROAD ANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 607	abuse is occurring. On 10/19/18, The So rounds asking intervi being good to the res On 10/11/18, the DO director notified the of performance improve daily QAPI team's rol includes implementat the interventions are also making recomm needed. The daily of brought to the next q additional review and Beginning 10/11/18, 'r responsible for imple corrective measures sustained. Macon Valley alleges as of 10/22/18. On 10/23/18 facility s demonstrated they ho of what to do if a resi to report abuse and r staff burn out. Imme effective 10/22/18. Reporting of Alleged CFR(s): 483.12(c)(1) §483.12(c) In respon neglect, exploitation, must:	10/19/2018 to insure no cial Worker will do weekly ew able residents if staff are sidents for 6 months. N and corporate clinical laily quality assurance and ement (QAPI) team. The le in this plan of correction tion and monitoring, ensuring effective. The QAPI team endations for revisions as QAPI review findings will be uarterly QAPI meeting for d recommendations. the administrator will be menting and monitoring to ensure solutions are a compliance of removal of IJ staff were interviewed and ad been trained on the topics dent was being abused, how heglect, and what to do for diate jeopardy was removed Violations (4) se to allegations of abuse, or mistreatment, the facility	F 607			12/5/18	

Facility ID: 923019

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 11/30/2018 M APPROVEI O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345263	B. WING		10	0/23/2018
NAME OF P	ROVIDER OR SUPPLIER	I	s	TREET ADDRESS, CITY, STATE, ZIP CODE		
MACON V	MACON VALLEY NURSING AND REHABILITATION CENTER			195 OLD MURPHY ROAD RANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 609	are reported immedia hours after the allegat serious bodily injury, the events that cause abuse and do not res the administrator of th officials (including to adult protective servic for jurisdiction in long accordance with State procedures. §483.12(c)(4) Report investigations to the a designated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective This REQUIREMENT by: Based on record rev facility failed to subm to the State Agency fr for abuse (Resident # The findings included Resident #3 was adm 03/30/18 with diagnon non-Alzheimer's dem Review of the quarter dated 07/06/18 revea severely cognitively in revealed Resident #3	priation of resident property, titely, but not later than 2 tion is made, if the events tion involve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to be facility and to other the State Survey Agency and ces where state law provides -term care facilities) in the law through established the results of all administrator or his or her ative and to other officials in the law, including to the State in 5 working days of the eged violation is verified to action must be taken. is not met as evidenced iew and staff interviews the it a 24-hour and 5-day report or 1 of 3 residents reviewed f3).	F 609	F 609 Address how corrective action of accomplished for those residen have been affected by the defice practice. On 10/11/18 at approximately 4 the director of nursing (DON) si an Initial Allegation Report to th Carolina Complaint Intake and 1 Care Personnel Investigation. On 10/17/18 at approximately 3 the administrator submitted a 5- to the North Carolina Complaint and Health Care Personnel Investigation	ts found to ient ::12 pm, ubmitted e North Health 3:29 pm, -day report t Intake	

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		MEDICAID SERVICES			OMB NO. 0938-0
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
				С	
		345263	B. WING		10/23/2018
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	
ACON VALLEY NURSING AND REHABILITATION CENTER				3195 OLD MURPHY ROAD FRANKLIN, NC 28734	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETI
F 609	Continued From page	e 74	F 609		
	•	days during the assessment			
	and wandering 1 to 3 days during the assessment period. Review of the nurse's notes from 09/30/18 through 10/12/18 revealed no documentation of Nurse Aide (NA) #1 or NA #9 having concerns that NA #8 had been physically or verbally abusive to Resident #3 on the morning of 10/01/18. Review of the facility incident reports from 09/30/18 through 10/12/18 revealed there was no incident report for alleged physical/verbal abuse of Resident #3 by NA #8 on 10/01/18. An interview conducted on 10/11/18 at 10:36 AM with NA #1 revealed he worked the 7:00 AM to 3:00 PM shift on the Sparks Unit on 10/01/18. NA #1 stated when he went onto the unit that morning the 11:00 PM to 7:00 AM NA #8 was not out on the floor and he assumed she was with a resident. He stated he was at the nurse's station			Address how the facility will identi residents having the potential to b affected by the same deficient pra On 10/11/18, the DON and corpor consultants reviewed 90 days of in reports to ensure that all alleged v involving abuse, neglect, exploitat mistreatment, including injuries of unknown origin and misappropriat resident property are reported immediately, but not later than two hours after the allegation is made, events that cause the allegation ir abuse or result in serious injury, o later than 24 hours if the events th cause the allegation do not involve and do not result in serious bodily The review did not identify any oth unreported allegations of abuse/ne	e ctice: ate ncident iolations ion or ion of 0 (2) if the ivolve r not at e abuse injury. her
	was not normal for he her room. NA #1 stat Resident #3's room s NA #8, who was yelli trying to make her sit stated NA #8 was ye she had been inconti down her legs and w commode. NA #1 stat for her to leave the ro was being too rough would finish taking ca refused and told him yet. He stated he left to go back in to help	Int #3 start screaming, which er, and immediately went to ed when he went into she was in the bathroom with ng at her and was forcibly c down on the commode. He lling at Resident #3 because nent and had feces running ouldn't sit down on the ted he told NA #8 it was time bom because he thought she with the resident and he are of Resident #3 but she she wasn't finished with her the room to get some gloves NA #8 and Medication Aide led Aide #10 were at the		What measures will be put into pla systemic changes made to ensure deficient practice will not recur On 10/19/18, the staff facilitator completed 100% in-servicing on abuse/neglect, including immediat actions and proper reporting, with facility staff, agency staff, and con therapy staff. The in-service cover Abuse/Neglect and reporting. All departments, all agency staff, all contracted employees, were instru- keep residents safe at all times. If suspect a resident is in harm's wa	e the all tracted ed: staff, all ucted to you

Facility ID: 923019

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TATEMENT C	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE C		(X3) DATE	0. 0938-03 SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G		COMF	LETED
						С	
		345263	B. WING			10/	23/2018
NAME OF PF	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
		REHABILITATION CENTER		319	95 OLD MURPHY ROAD		
				FR	ANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 609	Continued From page	e 75	F 60	าด			
		ting meds and he told them	1.00	55	leave the resident. Nurses will documer	.t	
		NA #1 stated when he went			relevant information on the 24 hour repo		
		s bathroom NA #8 told him to			sheets and report relevant information t		
	leave. NA #1 stated h			the on-coming shift nurse regarding	-		
	and went back out to			abuse/neglect. All staff, all agency staff.			
		what had happened and had			and contracted staff must follow the	,	
		statement of what she heard			facility's policy on abuse/neglect when		
	and took them to the	sub-acute hall to Nurse #1			staff become aware of actual or potentia	al	
	and reported the incid	dent to her because she was			resident abuse/neglect. The administra	itor	
	the Nurse that was co	overing the Sparks Unit. He			and DON must be notified immediately	of	
	stated he didn't stay v	with Resident #3 and NA #8			all abuse/neglect allegations to ensure		
		to leave and he didn't know			proper 24-hour and 5-day reports to the	;	
	-	ty to with them and he			State Agency are submitted and other		
		ncident right away to the			authorities are notified as appropriate.		
		ed he was never interviewed			The in-servicing was completed 11/25/1	8.	
	-	but the incident and NA #8			After 10/19/18, no facility staff, agency		
	continued to work on	the Sparks Unit.			staff, or contracted therapy staff was	_	
	An interview conduct	ad an 10/11/19 at 11:01 AM			allowed to work until they completed the		
		ed on 10/11/18 at 11:01 AM ealed she worked as a			in-service. The in-service was added to the new employee orientation for all fac		
		he Sparks Unit on 10/01/18			staff, agency staff, and contracted thera		
		shift and was counting			staff.	ъру	
		off-going Med Aide on the			Stall.		
		:00 AM. Med Aide #9 stated			On 10/11/18, the DON initiated in the		
	-	3 screaming like she was in			morning inter-disciplinary team (IDT)		
		came out of her room and			meeting a review of all incidents, to		
		esident #3 in the bathroom			include abuse/neglect. The review		
		with her, trying to make her			included verifying that abuse/neglect		
	• •	and yelling at her for having			allegations were reported to the		
		er legs because she had to			administrator and DON, the physician a	nd	
		de #10 stated NA #1 told her			resident representative were notified, th	e	
	•	to leave the room but she			authorities were contacted as appropria		
		out to get some gloves to			and the 24-hour and 5-day report to the	•	
		r. She stated she observed			State Agency were submitted timely.		
		esident #3's room and then					
		e told her NA #8 told him to					
	get out. Med Aide #9				How the facility plans to monitor its		
	statement of what she	e heard, observed, and was			performance to make sure solutions are	3	

Facility ID: 923019

TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	PLE CONSTRUCTION	(X3) DA1	IO. 0938-03	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	§	COM	MPLETED	
		345263	B. WING		1	C 10/23/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		0/20/2010	
				3195 OLD MURPHY ROAD			
VIACON V	ALLET NURSING AND R	EHABILITATION CENTER		FRANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE	
F 609	Continued From page	e 76	F 60	19			
		acute hall to report the	1.00				
		also was the nurse covering		Beginning 10/11/18, the D	ON, QI nurse,		
		Aide #9 further stated		and/or staff facilitator will re			
		ave behaviors of yelling or		hour PCC progress notes.			
	-	as doing on the morning of		10/11/18, the 24 hour repo			
	10/01/18.			findings will be reconciled			
	An interview conduct	ed on 10/11/18 at 1:39 PM		PCC progress note review ensure all allegations of ab	-		
		ed on 10/11/18 at 1.39 FM		have documented assess	-		
		rom the off-going 7:00 PM to		reports to the administrator			
	<b>-</b> .	\$5, when NA #1 came to her		physician/nurse practitione			
	and told her there had	d been an incident of abuse		representative. These revi	iews and		
		lent #3 on the Sparks Unit		reconciliations will be comp			
	-	n statements. Nurse #1		times each week for a peri			
	stated she didn't go to	-		months. Weekly, the admi			
		or talk to NA #8 and didn't the Director of Nursing or		corporate consultant, and/o president of operations will			
	· ·	nat time because NA #8		investigative files to ensure			
		d she thought Nurse #5		Agency and other authoriti			
		ie incident. She stated she		as appropriate.			
	did not discuss the in	cident with Nurse #5					
		oing to report it. Nurse #1		Beginning 11/25/18, the ac	Iministrator will		
		ved report she took the		present the results of the a			
		nd put them under the		reviews to the monthly QI (			
	Administrators door a	She stated she met NA #8		four (4) months to identify to corrective actions, and to c			
		her what happened and NA		need for and/or frequency			
		a misunderstanding so she		monitoring to maintain com			
		uestions. Nurse #1 stated		administrator will present to			
		legation of abuse it should		committee recommendatio			
	-	ministrator which was what		quarterly quality assurance			
		witness statements under		performance improvement			
	her door for review. N did not read the withe	lurse #1 further stated she ess statements.		Committee for further reco and oversight.	mmendations		
	An interview conduct	ed with the Director of					
		was never informed of the					
	-	sident #3 and NA #8 until					
		should have been informed					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	· · ·	E SURVEY	
ID PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			PLETED	
		345263	B. WING			C	
	ROVIDER OR SUPPLIER	545205	STREET ADDRESS, CITY, STATE, ZIP CODE			/23/2018	
				3195 OLD MURPHY ROAD			
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER		FRANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
F 609	Continued From page	e 77	F 609				
		vestigation could have been					
		our 5-day reports could have					
	with Nurse #5 reveale Nurse #1 on 10/01/18 pulled Nurse #1 to th and Resident #3 had NA #8 had been verb with Resident #3. Nu report the incident be Nurse #1 and she as incident to the Directe Administrator. Nurse #5 didn't have behav screaming.	#5 further stated Resident iors of yelling and					
F 656	with the Administrato reported an abuse all #8 and Resident #3 a statements under her stated the surveyor's had heard about the stated NA #1 and Nu this incident to her im wasn't in the building NA #8 should have b an investigation was stated it was her exp allegations to be repo of Nursing immediate	orted to her and the Director	F 656	5		12/5/18	
F D D D	CFR(s): 483.21(b)(1)	-				12/3/10	

If continuation sheet Page 78 of 140

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 093 (X3) DATE SURVE	EY
ID PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	J
		345263	B. WING		C 10/23/20	18
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COM	(X5) IPLETIO DATE
F 656	Continued From page		F 656			
	§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable					
	medical, nursing, and needs that are identifi assessment. The con	ames to meet a resident's mental and psychosocial ied in the comprehensive nprehensive care plan must				
	or maintain the reside	I - are to be furnished to attain ent's highest practicable psychosocial well-being as				
	(ii) Any services that under §483.24, §483. provided due to the re	24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights				
	under §483.10, incluc treatment under §483 (iii) Any specialized so rehabilitative services	.10(c)(6).				
		a facility disagrees with the RR, it must indicate its				
	(iv)In consultation with resident's representation (A) The resident's goa	h the resident and the tive(s)-				
	future discharge. Fac	ference and potential for ilities must document s desire to return to the				
	community was asses local contact agencies entities, for this purpo	ssed and any referrals to s and/or other appropriate se.				
	(C) Discharge plans in plan, as appropriate,	n the comprehensive care				

Facility ID: 923019

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/30/201 FORM APPROVEI OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C
		345263	B. WING		10/23/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 656	section.	e 79 is not met as evidenced	F	656	
	by: Based on record revi facility failed to follow	iew and staff interviews the the care plan for 1 of 4 r falls (Resident #20).		F 656 How corrective action w accomplished for those	
	The findings included	:		have been affected by t practice	
	09/17/18 with diagnost repair, high blood pre- peripheral vascular di obstructive pulmonary Review of the admiss dated 09/17/18 revea to person, place and	y disease. sion nursing assessment led Resident #20 was alert time.		On 10/11/18 - 10/19/18, nursing (DON) and corp reviewed Resident #20' and care plan, witness s incident report during th investigation. The revie care plan for having the position was not followe prior to Resident #20's the Resident #20 no longer	borate consultant s progress notes statements, and be post-accident ew revealed the bed in low ed immediately fall from the bed.
	Resident #20 was at injury, multiple risk fa deconditioning, incon and impaired mobility #20 to be free of falls injury through the ney included having the re position.	tinence, impaired balance r. The goal was for Resident , and not sustain serious ct review. The interventions esident's bed in the lowest		facility. How the facility will iden having the potential to b same deficient practice On 10/11/18 – 11/02/18 nurse, and corporate co 100% of nurse progress 60 days of all residents documented incidents/a	be affected by the , the DON, QI onsultant audited s notes for the past looking for any accidents. The
	with Nurse Aide (NA) started his shift and w rounds when he hear around 3:45 PM. He s and she was lying on arm underneath her a floor facing the bed. N was bleeding from sk	ed on 10/10/18 at 11:07 AM #1 revealed he had just vas doing his first set of d Resident #20 screaming stated he went to her room her right side with her right and her head lying on the NA #1 stated Resident #20 in tears to both sides of her bed was in the high position		audit revealed other inc relating to nursing staff care plan for falls. What measures will be systemic changes made deficient practice will no On 10/11/18, the QI nur 100% in-service with all (RNs), licensed practica	failing to follow the put into place or e to ensure the ot occur: se initiated a registered nurses

Facility ID: 923019

If continuation sheet Page 80 of 140

			a			). 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						С
		345263	B. WING		10/	23/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (	CODE	
		EHABILITATION CENTER		3195 OLD MURPHY ROAD		
	ALLET NORSING AND R	CENTER		FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 656	Continued From page	e 80	F 65	56		
	· · · · · · · · · · · · · · · · ·	I mats on the floor. NA #1	1 00	nursing assistants (NAs), a	and agency	
	stated he called a cod			staff. The DON must be no		
		lling out in pain. He stated		with injuries within 2 hours		
		urse #1 came into the room.		to discuss whether or not t		
		assessed the resident and		was followed and ensure a		
	then the 4 of them mo	oved Resident #20 back to		intervention is appropriate	-	
	bed using a sheet un	derneath her. NA #1 stated		On 10/19/18, the DON and		
	he did not ask and die	d not hear Nurse #1 ask		(SF) initiated multiple in-se	ervices for 100%	
	Resident #20 if she h	it her head on the floor but		of appropriate staff to inclu	ide registered	
	her head was laying o	on the floor when he found		nurses (RNs), licensed pra	actical nurses	
	her.			(LPNs), NAs, geriatric care		
				agency staff, housekeepin		
		ed on 10/10/18 at 12:05 PM		dietary, therapy, and depa		
		she helped NA #2 transfer		The in-services included e		
	Resident #20 from the			resident safety (as indicate		
		t change around 2:45 PM		plan). After 10/19/18, no f		
		o her hall. She stated she around 4:00 PM and went		staff, nursing agency staff, therapy staff will be allowe		
	•	m. She stated Resident #20		the in-services are comple		
		with her head on the floor		in-serviced with be added		
		as in the high position. NA		orientation, including agen		
		transfer Resident #20 back		contracted staff.		
		back to her hall. She further		On 10/19/18, the DON, QI	nurse and SF	
		was yelling out in pain		nurse began five day per v		
	before, during and aft			the nursing 24-hour report progress notes looking for	sheets and	
	An interview conducte	ed on 10/11/18 at 10:30 AM		orders, incident/accidents,		
		he had transferred Resident		safety measures added, to		
		the bed just before shift		the nursing staff, agency s	-	
		and he was at the nurse's		contracted therapy staff ar		
		ode green called. He stated		residents' care plans.	-	
		#20's room and she was		On 10/22/18, the administr	rator,	
	lying on the floor on h	ner right side with her right		department heads, and co	rporate facility	
		ath her and her head was		consultants began a proce		
		the bed in the high position.		cause analysis using "5-W		
		elling out in pain and was		interdisciplinary team (IDT		
		skin tears. NA #2 stated he		help ensure the residents'	-	
	-	#1 and NA #3 transfer		appropriate, updated, and	•	
	Resident #20 back to	bed and then left the room.		followed by the facility staf	<ol> <li>agency staff.</li> </ol>	

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		MEDICAID SERVICES		LE CONSTRUCTION		<u>NO. 0938-03</u> TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	MPLETED	
			B. WING			с	
		345263			1	10/23/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		0/20/2010	
				3195 OLD MURPHY ROAD			
MACON V	MACON VALLEY NURSING AND REHABILITATION CENTER			FRANKLIN, NC 28734			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION		(X5) COMPLETIO	
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE	
F 656	Continued From page	e 81	F 65	6			
		ed on 10/11/18 at 1:39 PM		and contracted therapy staff.			
	with Nurse #1 reveale Resident #20's room	ed she was called to by a code green and when		How the facility plans to mon	itor its		
		Resident #20 was lying on		performance to make sure so			
		head on the ground. She		sustained (include dates whe			
		ember what position the bed		action will be competed).			
	was in. Nurse #1 stat	ed Resident #20 was yelling					
	out in pain while she	assessed her but she had		On 10/19/18, the administrate	or initiated		
		of all extremities and		multiple audit tools which will	be		
		urse #1 stated Resident		completed by the department			
		arty (RP) came in during the		(DON, QI nurse, SF, social w	-		
		ike the resident had broken		manager, activities, activity d			
	-	n and wanted her sent out to		weekend manager-on-duty).			
	-	ed she told the RP they		will include supervision obser			
		lone at the facility and it		utilizing the Administrative Ro			
		n going to the hospital and		ensure residents are free of a			
		ng it that way. Nurse #1		hazards, have adequate supe			
		ember calling the on-call		safe devices to use which are	e all part of		
		the on-coming nurse had		the residents' care plans. On 10/26/18, the administrate	rhagan		
		reviewing her nurse's notes			•		
	she stated, "I guess I	order for the x-ray of her		working with the QIO to improve leadership and management			
		I she would not have told the		guidance on how to make ch			
		20 was on Coumadin after		improve the facility's nursing			
		because she wouldn't have		staff, and contracted therapy			
		t, she would have started		implementation of resident ca			
		pnitored her condition. Nurse		including fall care plans.	- 1		
		start neuro checks but		Beginning 10/19/18, the DON	I, and QI		
	reported off to the on-	-coming nurse about the fall.		nurse will present the in-serv			
		ave NA #1 obtain vital signs.		supervision observations, and			
	Nurse #1 further state	ed she was Resident #20's		to the IDT and monthly QI co			
		the 7:00 AM to 7:00 PM		(6) six months. The IDT and			
		was alert, and talking during		committee will help ensure th	-		
	the morning of 09/23/			following residents' care plan	-		
		as at her bedside most of		on care plans for falls. The a			
	-	ind 10:00 AM she was on		and/or DON will present the o	-		
		20's room and the NA yelled		monthly QI committee recom			
	Environ Nicona dia accor	lained when she got to the		to the quarterly QAPI commit	too for	1	

Facility ID: 923019

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/30/2018 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345263	B. WING			C 10/23/2018	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3195 OLD MURPHY ROAD FRANKLIN, NC 28734				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	room and assessed F stopped breathing. SI code status and she v initiate CPR. Review of the Incider and dated 09/22/18 6 #20 had multiple skin cleaned and treated. swollen and Respons broken and wanted th emergency room. The didn't feel her arm/sh she had range of mot pain while moving. Th An order for an x-ray technician and was d facility. Review of the physici 4:00 PM an order was Nurse #1 and signed of right shoulder to ru Review of the x-ray ri 09/22/18 revealed the acute fracture or dislo Two attempts were un Nurse #2 via phone of 10/12/18 at 8:40 AM. Review of the nurse's 12:45 PM written by I #20's RP had been a breakfast. The NA we	Resident #20 she had he stated she checked her was a DNR so she didn't at note written by Nurse #1 c:44 PM revealed Resident tears and they were The right shoulder was sible Party (RP) felt it was ne resident to go to the e note revealed Nurse #1 oulder was broken because tion and was using it, not in ne Physician was contacted. was called into the one at 6:00 PM in the an order's dated 09/22/18 at s written for Resident #20 by by the Physician for an x-ray ale out injury from a fall. aght shoulder results dated ere was no evidence of an ocation. hsuccessful to interview on 10/11/18 at 2:00 PM and	F	656	additional recommendations for monitoring and continued compliance	·	

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345263	B. WING		C 10/23/2018	
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
		REHABILITATION CENTER		3195 OLD MURPHY ROAD		
				FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO	
F 656	Continued From page	e 83	F 65	6		
		evealed Nurse #1 stated at				
		ent #20's RP walked up to				
		dent #20's oxygen wasn't ated when she got to the				
		as lying in bed without her				
	oxygen on and she p	icked up the oxygen tubing				
		and then to the RP's ear to				
		ing. The note revealed she would send Resident				
		y room for evaluation but she				
		esident #20 was a Do Not				
	Resuscitate (DNR) a	-				
	Resuscitation (CPR)	was not initiated.				
	An interview conduct	ed on 10/11/18 at 3:04 PM				
		ursing revealed it was her				
F 677	-	o follow the care plan. or Dependent Residents	F 67	7	12/5/18	
SS=D	CFR(s): 483.24(a)(2)				12/3/16	
	§483.24(a)(2) A resic	lent who is unable to carry				
		living receives the necessary				
		good nutrition, grooming, and				
	personal and oral hyg	is not met as evidenced				
	by:					
		ns, record review, and staff		F677		
	-	r failed to provide care to gernails were clean and oral		The plan of correcting the specific		
	care was completed	•		deficiency		
	dependent residents	reviewed for activities of				
	daily living skills. (Re	esident #1).		The position of Macon Valley Nursing	and	
	The findings included	ŀ		Rehabilitation center regarding the process that lead to this deficiency-the	<u>,</u>	
				facility failed to provide care to ensure		
		nitted to the facility on		hands and fingernails were clean and	oral	
		ses included Parkinson's		care was completed- was staff failure	to	
	Disease unstable an	gina, convulsions, major		follow established procedure.		

Event ID: J78Q11

Facility ID: 923019

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				LE CONSTRUCTION		NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	ATE SURVEY OMPLETED
			A. DOILDING			С
		345263	B. WING			10/23/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI		
				3195 OLD MURPHY ROAD		
MACON	ALLET NURSING AND P	REHABILITATION CENTER		FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 677	Continued From page	e 84	F 67			
1 0//			FO	7		
	disease and dysphag	anxiety, and chronic kidney na.		On 10/9/18 at 9:57 AM, Resid	ent #1 was	
		gra.		observed with dark smears or		
	The resident care gui	ide initiated on 07/09/18,		forefinger and his left thumbna		
		for care guidance, included		debris.		
		8, to provide mouth care		On 10/9/18, The NA cleaned		
	after meals.			#1 was provided hand and na	il care	
	The educionics Minim	Num Data Cat data d 07/10/10		immediately by staff.		
		num Data Set dated 07/16/18 rely impaired cognitive		10/19/18, the director of nursin quality improvement nurse (Q		
		tensive assistance with most		manager, and staff facilitator (		
		gs skills including hygiene		monitoring of 10 residents for	, <b>.</b>	
	and bathing. He was			of the residents daily for four v		
	behaviors.	Ū.		weekly for four weeks, then m months.		
	The Activity of daily li	ving Care Area Assessment		On 11/7/18, activities director	(AD), skilled	
		d Resident #1 needed staff		rehabilitation services, and the		
	assistance and he wa	as working with therapy.		administrative nursing team in weekly nail care program. The		
	The care plan for hyg	giene initiated on 07/17/18		program includes 1.) The activ		
	l i	to be neat, clean and odor		includes nail care during game		
		aintain good oral hygiene.		therapy department initiated n		
		luded to provide constant		an occupational treatment reg	imen for	
		sical assistance, i.e. comb		fine motor skills.	0/ in convice	
	oral/dental supplies.	de assistance with set up of		On 11/7/18, SF initiated a 100 with all licensed nurses, nursi		
				assistants (NA s) and Agency	0	
	The care plan for bat	hing initiated 07/16/18 had		include expected daily care or		
		e neat, clean and odor free.		(activities of daily living) must		
	-	lude for staff to ensure hair		to All residents routinely and a	•	
		are manicured on bathing		include bathing or showers, m		
	day.			and nail care. No licensed nur		
	Dovious of the nen	modical abort revealed a		nursing assistant (NA), or Age	-	
		medical chart revealed a Plan dated 07/24/18. The		be allowed to work after 11/19 in-service completed. This in-service		
	-	to "please provide oral care		be added to the orientation pro-		
	after all meals."	to picase provide oral care		new licensed nurses and NAs staff.		
	On 10/00/19 at 0:57	AM, Resident #1 was		On 11/8/18, the DON, QI, unit	managor	

Facility ID: 923019

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TATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345263	B. WING		C 10/23/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10/20/2010
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET
F 677	Continued From page	9 85	F 677		
	observed with dark sr and his left thumb nai On 10/09/18 at 11:05	nears on his right forefinger il had dark debris under it. PM, Nurse Aide #4 stated uth care on Resident #1.		and SF completed a 100% audit of r and oral care on the residents. The resulted in several residents were in of nail and/or oral care.	audit
	thumb nail. Both han then moved him and meal without any han had soiled hands and when observed on 10	soiled fingers and a dirty ds had food debris. NA #4 set him up with the noon d washing. Resident #1 still debris under his thumb nail		The DON, SF and/or QI nurse will tr and trend the results and re-train an initiate counseling for nursing staff a indicated. The DON will hare share the results audits with the QI committee monthl months then quarterly thereafter. The monthly QI committee will revie results of the resident care audit too months. The DON and/or QI nurse w	d/or is of ly for 3 w the I for 3
	interview that she had on Resident #1 this d not do hand care and hands. She stated th scheduled and workin care completed.	d not done any mouth care ate. She also stated she did did not notice dirty nails or ere was not enough staff ng to get all the necessary		review the results of the resident can audit tool for determine the need for and/or frequency of continued monit and make recommendations. The administrator and/or DON will prese findings of the monthly QI committee the quarterly executive QAPI commit	re toring nt the e to
	at 6:33 PM revealed s mouth care to be com	ector of Nursing on 10/10/18 she expected hand and upleted. She stated she I this morning needed		for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible implementing this plan of correction.	f le for
F 684 SS=J	Quality of Care CFR(s): 483.25		F 684		12/5/18
	applies to all treatment facility residents. Bas	are ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure			

Facility ID: 923019

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	S FOR MEDICARE &		<i></i>			10.0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · · ·	TE SURVEY MPLETED
			A. BUILDING	3		С
		345263	B. WING		1	0/23/2018
AME OF PF	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COL		0/20/2010
				3195 OLD MURPHY ROAD		
	ALLEY NURSING AND R	REHABILITATION CENTER		FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 684	Continued From page	- 9 <u>6</u>				
F 004	Continued From page		F 68	34		
		e treatment and care in				
		essional standards of nensive person-centered				
	care plan, and the res	•				
		is not met as evidenced				
	by:					
		iew, staff, Physician and		F 684		
		erviews, the facility failed to				
		checks per the facility's		How corrective action will be		
		ter a fall from the bed to the		accomplished for those resid	ents found to	
		nmunicate to the physician		have been affected by the de		
		an unwitnessed fall and was		practice		
		his affected one of three		P		
		viewed for assessment		On 9/12/18, Nurse #3 rechec	ked Resident	
	-	isode. The failure of the		#2's blood glucose with a res		
		ident #20's neurological		Nurse #3 contacted the nurse		
		s protocol and communicate		The nurse practitioner gave a	•	
		om the bed to the floor and		to Nurse #3 for Resident # 2		
		he physician resulted in the		emergency room. Resident #		
	high likelihood of seri			transferred to the hospital err		
	(Resident #20).			room by emergency medical		
	· ,			evaluation of elevated blood	glucose.	
	Immediate Jeopardy	began on 09/22/18 for				
		the facility failed to perform		On 10/11/18 - 10/19/18, the c	director of	
		per the facility's neurological		nursing (DON) and corporate		
	0	the bed to the floor and		reviewed Resident #20's prog	gress notes	
	failed to communicate	e to the physician that the		and care plan, witness staten		
		tnessed fall and was on a		incident report during the pos		
		liate Jeopardy was removed		investigation. The review rev		
		e facility implemented a		care plan for having the bed		
	credible allegation of			position was not followed imr		
	-	remains out of compliance at		prior to Resident #20's fall fro		
	•	everity level D (no actual		Resident #20 no longer resid	es at the	
		al for more than minimal		facility.		
		ediate jeopardy) to complete				
		and ensure monitoring		How the facility will identify of		
	systems in place are	effective.		having the potential to be affe	ected by the	

Facility ID: 923019

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ATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	. ,	E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM	IPLETED
						С
		345263	B. WING		1	0/23/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
		REHABILITATION CENTER		3195 OLD MURPHY ROAD		
				FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO DATE
F 684	Continued From pag	e 87	F 68	4		
	staff, and Nurse Prac	ctitioner interviews the facility		On 10/19/18, the DON	and unit manager	
		nsulin per physician order's		reviewed all current res	•	
		sident to be sent out to the		ensure no other doses		
	-	ketoacidosis (DKA), a		last 30 days. The review		
	-	of diabetes, for 1 of 3		occurrences where the		
		vith insulin dependent		insulin was not docume	•	
	diabetes (Resident #	-2).		physician's orders. On manager contacted the		
	Immediate Jeonardy	began on 09/11/18 for		regarding undocumente		
i		lurse #4 did not administer		The physician gave no		
		's order which resulted in		Multiple nurses failed to		
	Resident #2 develop			insulin as ordered or fai		
	Jeopardy was remov	ed on 10/22/18 when the		administration of insulir	n as ordered on	
	facility implemented	a credible allegation of		multiple residents, throu	ughout the facility	
		removal. The facility		at multiple times during	-	
		liance at a lower scope and		medication errors occur		
		actual harm with the potential		nurses' failure to follow	the medication	
		al harm that is not immediate		administration policy.	and unit managar	
		e employee education and /stems in place are effective.		On 10/19/18, the DON audited to ensure all res		
				have the insulin availab		
	The findings included	<b>d</b> :		All residents had insulir match order.	•	
	1. Review of the Ne	uro Checks Guide located at				
	each nurse's station	revealed neuro checks		On 10/11/18 – 11/02/18	, the DON, QI	
		llows: every thirty minutes		nurse, and corporate co		
		ur for 4 hours and every shift		100% of nurse progress	-	
	for 3 days once initia	ted.		60 days of all residents	• •	
	Decident #00			documented incidents/		
		Imitted to the facility on		audit revealed other inc		
		ses included hip fracture essure, atrial fibrillation,		relating to nursing staff care plan for falls.	railing to follow the	
	peripheral vascular of					
	obstructive pulmonal					
	Review of the admis	sion nursing assessment		What measures will be	nut into place or	
		aled Resident #20 was alert		systemic changes made		
	to person, place and			deficient practice will no		

Facility ID: 923019

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	11/30/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE S COMPLE	
		345263	B. WING		C 10/2	3/2018
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE		
MACON	ALLEY NURSING AND R	REHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Resident #20 was at injury, multiple risk fa deconditioning, incon and impaired mobility #20 to be free of falls injury through the ney included having the re- position. Review of the On-Ca Revision Date of 03/0 station revealed the fo on-call provider: Plea information ready bef current medications, condition, have a des symptoms associated synopsis, relevant pa report. Review of the physici revealed: On 09/17/1 thinner, 5 milligrams of fibrillation. An interview conducted with Nurse Aide (NA) started his shift and w rounds when he hear around 3:45 PM. He sand she was lying on arm underneath her a floor facing the bed. I was bleeding from sk body. He stated the l	an dated 09/18/18 revealed risk for falls/actual falls, ctors related to tinence, impaired balance 7. The goal was for Resident , and not sustain serious kt review. The interventions esident's bed in the lowest II Provider sheet with a 05/15 located at each nurse's ollowing when calling an se have the following fore calling which included if reporting a change in scription of the signs and d with the change, a brief st history, and incident an orders for Resident #20 8 Coumadin, a blood (mg) once a day for atrial ed on 10/10/18 at 11:07 AM #1 revealed he had just vas doing his first set of d Resident #20 screaming stated he went to her room her right side with her right and her head lying on the NA #1 stated Resident #20 in tears to both sides of her bed was in the high position I mats on the floor. NA #1	F 68		nurse ents on kly x 12 ilable for s audit will audit tool. se, SF, nurse ents on ompleted 2 weeks to ed as umented on se, SF, viewing all al resident edication is hission. This he insulin vill be 12 weeks. ated a ered nurses es (LPNs), agency ed of all falls the incident care plan new	

Facility ID: 923019

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		MEDICAID SERVICES			OMB NO. 0938	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	ſ
	CONTRACTION		A. BUILDING			
		245262	D. WINC		С	
		345263	B. WING		10/23/201	8
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER				
	1			RANKLIN, NC 28734		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU		(5) LETIC
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)		TE
F 684	Continued From page	e 89	F 684			
	NA #2, NA #3, and N	urse #1 came into the room.		dietary, therapy, and department h	eads.	
		1 assessed the resident and		The in-services included education		
	then the 4 of them me	oved Resident #20 back to		resident safety (as indicated in the	care	
	bed using a sheet un	derneath her. NA #1 stated		plan). After 10/19/18, no facility nu		
		d not hear Nurse #1 ask		staff, nursing agency staff, or contr		
		it her head on the floor but		therapy staff will be allowed to work		
		on the floor when he found		the in-services are completed. The		
	her.			in-service will be added to new stat	ff	
	A			orientation, including agency and		
		ed on 10/10/18 at 12:05 PM		contracted staff.		
	Resident #20 from th	she helped NA #2 transfer		On 10/19/18, the DON, QI nurse an nurse began five day per week rev		
		ft change around 2:45 PM		the nursing 24-hour report sheets a		
		o her hall. She stated she		progress notes looking for any new		
		around 4:00 PM and went		orders, incident/accidents, and/or r		
	-	om. She stated Resident #20		safety measures added, to help en		
		with her head on the floor		the nursing staff, agency staff, and		
		as in the high position. NA		contracted therapy staff are following		
	#3 stated she helped	transfer Resident #20 back		residents' care plans.	-	
	to bed and then went	back to her hall. She further		On 10/22/18, the administrator,		
	stated Resident #20	was yelling out in pain		department heads, and corporate f	-	
	before, during and af	ter the transfer.		consultants began a process of roc		
				cause analysis using "5-Whys", du	-	
		ed on 10/11/18 at 10:30 AM		interdisciplinary team (IDT) meeting	-	
		he had transferred Resident		help ensure the residents' care plat		
		the bed just before shift and he was at the nurse's		appropriate, updated, and are bein followed by the facility staff, agence		
		ode green called. He stated		and contracted therapy staff.	y stall,	
		#20's room and she was				
		her right side with her right				
		ath her and her head was		How the facility plans to monitor its		
		the bed in the high position.		performance to make sure solution		
		elling out in pain and was		sustained		
		skin tears. NA #2 stated he				
		#1 and NA #3 transfer		Beginning 10/20/18, the DON will p	present	
	Resident #20 back to	bed and then left the room.		the Insulin Audit Tool results to the		
				interdisciplinary team (IDT) weekly		
		ed on 10/11/18 at 1:39 PM		review. This review will include ens	•	
	with Nurse #1 revealed	ed she was called to		insulin was administered as ordere	d and	

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		O. 0938-03 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COM	PLETED
		345263	B WING			С
	ROVIDER OR SUPPLIER	545205		STREET ADDRESS, CITY, STATE, ZIP CO		/23/2018
NAME OF F	ROVIDER OR SUPPLIER			3195 OLD MURPHY ROAD	JDE	
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 684	Continued From page	90	F 68	34		
		by a code green and when		insulin is available for admir	nistration	
		Resident #20 was lying on		Presentation of the insulin a		
		head on the ground. She		IDT will serve as a second v		
		ember what position the bed				
		ed Resident #20 was yelling		Beginning 10/22/18, the DC		
		assessed her but she had		the Insulin Referral Audit too		
		of all extremities and urse #1 stated Resident		weekly to the daily IDT for review will ensure potential		
		arty (RP) came in during the		with a need for insulin have		
		ike the resident had broken		medication available upon a		
	her right shoulder/arn	n and wanted her sent out to		Presentation of the tool to the		
	-	ed she told the RP they		serve as a second verification	on to ensure	
	-	lone at the facility and it		resident well-being is being		
	-	n going to the hospital and		it relates to insulin administr	ration.	
	-	ng it that way. Nurse #1 ember calling the on-call		The daily IDT's role in this F	Posidont	
		the on-coming nurse had		Well-Being plan of correctio		
		reviewing her nurse's notes		implementation, monitoring,		
	she stated, "I guess I	5		the interventions are effective		
		order for the x-ray of her		also makes recommendatio		
		I she would not have told the		revisions as needed. The	•	
		20 was on Coumadin after		review findings will be broug		
		because she wouldn't have t. she would have started		quarterly quality assurance performance improvement (		
		nitored her condition. Nurse		meeting for additional review		
		start neuro checks but		recommendations.		
	reported off to the on-	-coming nurse about the fall.				
	She stated she did ha	ave NA #1 obtain vital signs.				
		nt note dated 09/22/18 6:44				
		t #20 had multiple skin tears				
		ed and treated. The right				
		and Responsible Party n and wanted the resident to				
		room. The note revealed				
		er arm/shoulder was broken				
		ge of motion and was using				
	it, not in pain while m	oving. The Physician was				
	contacted An order f	or an x-ray was called into				1

Facility ID: 923019

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	
AND FLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDI	NG _			C
		345263	B. WING				23/2018
NAME OF PI	ROVIDER OR SUPPLIER		•	ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	facility. Review of the physici 4:00 PM an order was Nurse #1 and signed of right shoulder to ru Review of the x-ray ri 09/22/18 revealed the acute fracture or dislo Review of the nurse's following: 09/22/18 6:48 PM Ne Vital Signs - 4:30 PM Ne Vital Signs - 4:30 PM (B/P), 139 Pulse (P), Oxygen saturation (O P-100, R-20, Tempera (O2), 5:30 PM - 140/8 6:00 PM - 150/80 B/P 94% O2, 6:30 PM - 14 Temp, 95% O2. Level PM alert/conscious (a -a/c, 6:00 PM a/c, 6:3 4:30 PM Pupils Equal 5:00 PM -PERL, 5:30 -PERL, 6:30 PM -PEF =, 5:00 PM =, 5:30 PM Further interview with 1:39 PM revealed she on 09/23/18 on the 7: the resident was alert morning of 09/23/18.	as done at 6:00 PM in the an order's dated 09/22/18 at s written for Resident #20 by by the Physician for an x-ray le out injury from a fall. ght shoulder results dated ere was no evidence of an ocation.	F	684			
	assessed Resident #2	-					

Facility ID: 923019

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345263	B. WING				C 23/2018
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER			3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	CPR. Two attempts were un Nurse #2 via phone of 10/12/18 at 8:40 AM. An interview conducted with the facility Physic recall being called ab 09/22/18. He stated if resident having an un Coumadin he would h out to the hospital for tomography, a scan t out a bleed. An interview conducted with the Director of N expectation for nurse that a resident's fall w witnessed and what n She further stated shu be completed per fac Review of the nurse's 12:45 PM written by N #20's RP had been an breakfast. The NA we vital signs and called	DNR so she didn't initiate hsuccessful to interview n 10/11/18 at 2:00 PM and ed on 10/11/18 at 3:57 PM cian revealed he did not out Resident #20's fall on the had been called about a witnessed fall was on have expected her to be sent evaluation and a Computed to see inside the body, to rule ed on 10/11/18 at 3:04 PM ursing revealed it was her ts to report to the physician was unwitnessed or nedications they were on. te expected neuro checks to	F	684			
	breathing. The note re RP she would send R	evaluation but she stopped 20 was a Do Not nd Cardio Pulmonary					

Facility ID: 923019

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	-	D HUMAN SERVICES				FORM	): 11/30/2018 I APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION		(X3) DATE COMP	LETED
		345263	B. WING		_	( 10/:	C 23/2018
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		195 OLD MURPHY ROAD RANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Review of the Death ( and signed by the Me cause of death for Re complications of a hip An interview conducted with the Medical Exar contacted by the fune Resident #20 had a fa accident before her do Medical Examiner had stated the facility Phy death on the death ce a hip fracture. The ME hospital and nursing h #20 but was unaware on 09/22/18. He state unwitnessed fall and t blood thinner he may differently but it was a cause of death compl because that was the facility to begin with. On 10/11/18 at 3:49 F and the Corporate Co Immediate Jeopardy. On 10/12/18 the facilit credible allegation of removal that included 1. How corrective a for those residents for by the deficient practif On 9/22/18 at approxit #20 was on the floor n	Certificate dated 09/23/18 dical Examiner revealed the sident #20 was from o fracture. ed on 10/12/18 at 12:09 PM miner (ME) revealed he was ral home due to the fact all which was considered an eath which meant the d to be called. The ME sician had put the cause of ertificate for complications of E stated he reviewed the nome records for Resident she had an unwitnessed fall d had he known about the the fact that she was on a have looked at the case acceptable to leave the iccations from a hip fracture reason she was in the PM the Director of Nursing onsultant were notified of ty provided an acceptable Immediate Jeopardy : ction will be accomplished und to have been affected	F 684				

Facility ID: 923019

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FO	ED: 11/30/2018 RM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED
		345263	B. WING		-   1	C 0/23/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	· · · · · · · · · · · · · · · · · · ·	
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	floor, and demonstratinursing assistant call resident's fall in the re On 9/22/18 at approxidirected the nursing as Resident #20's vital spressure 143/86, pulsitympanic temperature saturation 95%. On 9/22/18, Nurse #1 assistants assisted R On 9/22/18 at approxitreatment nurse note: (5) skin tears on Resiright forearm, right km foot second toe. After treatments, the treatment (5) individual flow she conditions in the elect the assessment tab. On 9/22/18 at approxinoted Resident #20's The nurse notified the physician gave an or shoulder. Nurse #1 of that the resident had notify the physician the Coumadin. On 9/22/18 at approximeted for 9/22/18 at approximately 7:00 pm, 5:30 pm, 6:10 mm, 5:30 pm, 6:10 mm, 5:30 pm, 6:10 mm, 5:00 pm, 5:30 pm, 6:10 mm, Singer approximately 7:00 pm, 5:00 pm,	ted signs of pain. The ed a code to announce the esident's room. imately 3:55 pm, Nurse #1 assistant to take vital signs. igns post fall were blood se 88, respirations 20, e 97.8 F, and oxygen I and three nursing esident #20 to the bed. imately 4:00 pm, the d, cleaned, and dressed five ident #20: right upper arm, nee/leg, right lower leg, left er completing the skin tear nent nurse completed five eets of non-ulcer skin tronic health record under imately 4:00 pm, Nurse #1 right shoulder was swollen. e physician and the der for an x-ray of the right did not notify the physician a fall and Nurse #1 did not nat Resident #20 was taking imately 4:30 pm the Nurse cal checks on Resident #20. e #1 completed five (5) on Resident #20: 4:30 pm, 00 pm, and 6:30pm. Nurse eurological checks in onic health record under type: neurological	F 64		)EFICIENCY)	

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 11/30/201 RM APPROVE O. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		TE SURVEY IPLETED
		345263	B. WING		10	C D/23/2018
NAME OF PI	ROVIDER OR SUPPLIER	•	:	STREET ADDRESS, CITY, STATE, ZIP CO	DE	
		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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
F 684	any neurological chec On 9/23/18 at approx documented a skilled neurological: alert an rate and rhythm, tach pulse present, respira wounds with dressing On 9/23/18 at approx completed a discharg #20's electronic healt included: the assigne unable to attain vital s unable to attain vital s contacted 911. Resid bedside. Resident #20 approximately 12:45 On 10/11/18, the DOD regarding resident ind assessments, neurolo unobserved falls, doo report, and reporting the physician, nurse p On 10/11/18, the DOD regarding resident ind assessments, neurolo unobserved falls, doo report, and reporting the physician, nurse p On 10/11/18, the DOD regarding resident ind assessments, neurolo unobserved falls, doo report, and reporting the physician, nurse p 2. How the facility v	urse #2 did not document cks. imately 1:48 am, Nurse #2 post-acute note stating d oriented, cardiac: regular nycardic at times, peripheral atory rate clear, several gs intact, clean, and dry. imately 12:45 pm, Nurse #1 ge summary in Resident h record. The summary d nursing assistant was signs, the Nurse #1 was signs. The Nurse #1 dent #20's husband was at 20 was a Do Not Resuscitate 0 was pronounced dead at pm. N re-educated Nurse #1 cident/accidents, post-fall ogical checks for all sumentation, shift change all relevant information to practitioner, and DON. N re-educated Nurse #2 cident/accidents, post-fall ogical checks for all sumentation, shift change all relevant information to practitioner, and DON. N re-educated Nurse #2 cident/accidents, post-fall ogical checks for all sumentation, shift change all relevant information to practitioner, and DON.	F 684			
	deficient practice: On 10/11/18, the qua audited 100% of resid	o be affected by the same lity improvement (QI) nurse dent current medication s (MARs) to identify all t orders to receive				

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		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 11/30/2018 ORM APPROVED NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	IPLE CONSTRU		(X3)	DATE SURVEY COMPLETED
		345263	B. WING				10/23/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADD	DRESS, CITY, STATE, ZIP CO	DE	10.20.20.10
MACON V	ALLEY NURSING AND R	REHABILITATION CENTER			IURPHY ROAD I, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO ROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 684	with Coumadin listed On 10/11/18, the dire performed an audit or receiving Coumadin. any Coumadin reside past 60 days. The au- resident currently taki within the past 60 day 3. What measures systemic changes ma- practice will not recur On 10/11/18, the QI minitiated a re-education NAs, and contracted re-education covered especially for those re- medication that has biphysician must be ca- including Nurse #1 ar instructed to use the ensure the nurse pro- relevant information f document relevant information	t identified one (1) resident on the MAR. ctor of nursing (DON) n 100% of residents The audit was to identify ent having a fall within the udit identified zero/no ing Coumadin who had a fall ys. will be put into place or ade to ensure the deficient c: nurse and staff facilitator on for all RNs, LPNs, MAs, therapy personnel. The : In the event of any/all falls, esidents receiving blood thinning properties, the lled right away. Nurses, nd Nurse #2, are being PCC E-Interact form to vides the physician with all formation on the 24 hour bourt relevant information to urse regarding all falls. the facility's policy on ent is on Coumadin. Nurses o start neuro-checks and iro-check guidelines which of performing the ensed registered nurses and	F	.84			

Facility ID: 923019

If continuation sheet Page 97 of 140

		ID HUMAN SERVICES					RINTED: 11 FORMAPI MB NO. 09	PROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345263	B. WING				C 10/23/2	018
NAME OF P	ROVIDER OR SUPPLIER	•	<b>I</b>	STR	EET ADDRESS, CITY, STATE, ZIP COD	)E		-
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER			5 OLD MURPHY ROAD ANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE		(X5) MPLETION DATE
F 684	due to an injury post- to the facility the neur re-started at the appr be notified within two to ensure proper inter re-education was cor staff working; no RN, therapy personnel wi including Nurse #1 ar re-education is comp added to the new sta LPNs, MAs, NAs, and personnel. On 10/11/18, the QI r for all RNs and LPNs, in #2, to enter all neurol electronic medical ren neurological observations documents are availar physician, nurse prace The in-service was co staff working; no RN work until the re-educ including Nurse #1 ar re-education is added for all RNs and LPNs On 10/11/18, the DOI inter-disciplinary team all falls, to include res blood-thinning proper verifying that an asse immediately post-fall, practitioner was notifi information provided. was notified, if the res blood-thinning proper	fall and the resident returns rological checks must be opriate time. The DON must hours of all falls with injuries rventions are in place. The npleted on 10/11/18 with all LPN, MA, NA, or contracted Il be allowed to work, nd Nurse #2, until the leted. The re-education is ff orientation for all RNs, d contracted therapy nurse initiated a re-education be contracted therapy nurse initiated a re-educatio	F	684				

If continuation sheet Page 98 of 140

		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 11/30/2018 ORM APPROVED 3 NO. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		345263	B. WING _				C 10/23/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
		EHABILITATION CENTER		319	95 OLD MURPHY ROAD		
	ALLET NORSING AND IN			FR	ANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684	Continued From page	98	F6	684			
	4. How the facility p performance to make sustained (include da will be completed)						
		he DON and/or QI nurse will port sheets for all falls.					
	staff facilitator will rev progress notes. Begi report sheet review fi with the 24 hour PCC findings to ensure all assessments and rep practitioner which inc with blood-thinning pr Coumadin. These re	the DON, QI nurse, and/or riew the 24 hour PCC inning 10/11/18, the 24 hour ndings will be reconciled progress note review falls have documented ports to physician/nurse lude current medications roperties including views and reconciliations will les each week for a period of					
	director notified the d performance improve daily QAPI team's rol includes implementat the interventions are also making recommeneeded. The daily C brought to the next qu additional review and Beginning 10/11/18, t responsible for implet corrective measures sustained.	he administrator will be menting and monitoring to ensure solutions are credible allegation of IJ					

Facility ID: 923019

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345263	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER		<b>I</b>	3	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER			3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	99	F	684	1		
	demonstrated they had of using the PCC E-Ir nurses provided the p information after falls, neuro checks, DON n to on-coming nurse, a	taff were interviewed and ad been trained on the topics interact forms to ensure obysician with all relevant , when and how to perform iotification, reporting of falls and documenting on the 24 mmediate jeopardy was /11/18.					
	(MAR) for September revealed on 09/11/18 units of scheduled reg and an additional 2 un	tion Administration Record 2018 for Resident #2 Resident #2 was given 6 gular insulin at 12:00 PM nits of sliding scale insulin capillary blood glucose					
	revealed Resident #2 physician ordered ins at 5:00 PM and 10 un sliding scale insulin c CBG of 206 that requ	nber 2018 MAR further did not receive his ulin's of 6 units on 09/11/18 its at 9:00 PM and his overage at 4:30 PM for a ired 2 units of coverage and f 240 that required 2 units of					
	further revealed Resident physician ordered 6 ut 09/12/18 at 8:00 AM.	e September 2018 MAR dent #2 received the inits of regular insulin on Resident #2 also received 6 isulin on 09/12/18 at 7:30					

Facility ID: 923019

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345263	B. WING				C 23/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER			195 OLD MURPHY ROAD RANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	AM to cover a CBG o Review of the Blood for 09/11/18 for Resid following readings: 09/11/18 1:00 PM 09/11/18 4:12 PM 09/11/18 8:50 PM Per physician order a of 206, Resident #2 s regular insulin on 09/ Per physician order a of 240, Resident #2 s regular insulin on 09/ An interview with Nur PM revealed she gav regular insulin on 09/ included the 6 units o and 6 units of regular CBG reading "HI". Nu recheck of Resident # read "HI". Nurse #3 r the facility and she ex ordered him transferm possible DKA. Nurse not recheck the gluco she did not try anothe results. An interview with Nur	f "HI". Glucose Monitoring Sheet lent #2 revealed the A CBG 236 A CBG 206 A CBG 240 Ind based on CBG reading hould have received 2 units 11/18 at 4:30 PM. Ind based on CBG reading hould have received 2 units 11/18 at 4:30 PM. Ind based on CBG reading hould have received 2 units 11/18 at 3:30 PM. Ise #3 on 10/09/18 at 1:00 e Resident #2 12 units of 12/18 at 7:30 AM. This f regular scheduled insulin insulin for SSI coverage of Irse #3 further revealed the #2's CBG at 9:30 AM still hotified the NP, who was at tamined the resident and ed to the hospital for #3 further revealed she did meter when it read HI and er glucometer to verify test Ise #4 on 10/10/18 at 9:06	F	584			
	physician ordered ins PM and 09/11/18 at 5 PM. She further state	not give Resident #2 his ulin's on 09/11/18 at 4:30 :00 PM or 09/11/18 at 8:30 d she did not give Resident scheduled for 09/11/18 at					

Facility ID: 923019

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	-	D HUMAN SERVICES				FORM	): 11/30/2018 I APPROVED
	DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE COMP	LETED
		345263	B. WING			( 10/2	C 23/2018
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE		
MACON VA	LLEY NURSING AND R	EHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ED TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
	insulin and just did no An interview with Nurs AM revealed she obta administered to Resid 09/12/18 from house s Review of the nurse n PM revealed the CBG The nurse gave Resid insulin per physician a was rechecked at 9:30 note further revealed I and not feeling well ar Practitioner (NP) who Resident #2 to the em evaluation of possible Review of the Nurse F note dated 9/12/18 ind seen on 09/12/18 afte The progress note ind developed nausea and clammy and anxious. NP to transfer the resid department for possible An interview with the I revealed she was una received his insulin's t sent to the hospital. F revealed her expectat to contact the on-call p not available. An interview with Nurs AM revealed she did r	she did not look for the t give it. Se #3 on 10/10/18 at 9:30 ined the regular insulin ent #2 on 09/11/18 and stock in the emergency box. otes dated 09/12/18 at 2:05 t taken at 7:30 AM read "HI". lent #2 12 units of regular admission orders. The CBG D AM which read "HI". The Resident #2 was vomiting nd was seen by the Nurse wrote an order for transfer tergency department for DKA. Practitioner (NP) progress dicated Resident #2 was r a CBG reading was 'HI'. iicated Resident #2 had also d vomiting and he was An order was given by the dent to the emergency	F 684				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345263	B. WING				C 23/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>.                                    </u>	
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER			195 OLD MURPHY ROAD RANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	had not received his i not contact the on-cal the unavailability of in stated she did not cal insulin or look for the box which contains en During an interview w 10/09/18 at 4:05 PM s facility staff to contact medications. She furt staff to check for the of emergency box and to missing medications. Review of the hospita #2 was admitted to th unit for DKA on 09/12 admission to the hospita from the morning of 0 discharged on 09/14/ On 10/18/18 at 8:30 A and the Administrator Jeopardy via telephor 1. How corrective acti those residents found the deficient practice: On 9/11/18 at approxi #2 was admitted to M Rehabilitation center for diagnosis including 1.	nsulin. She stated she did II physician to notify them of isulin. Nurse #4 further I the pharmacy to obtain the insulin in the emergency mergency medications. With Director of Nursing on she stated she expected the t the physician for all missing her stated she expected ordered medications in the o contact pharmacy for II records revealed Resident te hospital intensive care 2/18. Blood sugar on bital was 485. Resident #2 ip which he was weaned 19/13/18. He was 18. AM the Director of Nursing twere notified of Immediate ne.	F	584			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345263	B. WING				C 23/2018
NAME OF PI	ROVIDER OR SUPPLIER	1	<b>I</b>	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER			3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 684	to Resident #2 two ur subcutaneously, as o a blood glucose level On 9/11/18 at 12 noo Resident #2 six units subcutaneously, as o On 9/11/18 at 4:12 pr Resident #2's blood g blood glucose reading On 9/11/18, the media (MAR) documentation #2 received 2 units of glucose level of 206, On 9/11/18 5:00 pm, 1 not show that Resided dose of 6 units of Reg physician. On 9/11/18 at 8:50 pm Resident #2's blood g blood glucose reading On 9/11/18 at 8:50 pm did not show that Resided of Regular insulin for 240, as ordered by ph On 9/11/18 at 9:00 pm	g of 236. Im, Nurse #3 administered hits of Regular insulin rdered by the physician, for of 236. In, Nurse #3 administered to of Regular insulin rdered by the physician. In, Nurse #4 checked glucose; Resident #2 had a g of 206. Cation administration record In did not show that Resident F Regular insulin for blood as ordered by physician. Ithe MAR documentation did Int #2 received a scheduled gular insulin, as ordered by In, Nurse #4 checked glucose; Resident #2 had a g of 240. In, the MAR documentation sident #2 received two units a blood glucose reading of hysician. In, the MAR documentation sident #2 received 10 units	F	684			
	of Levemir, as ordere						

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG _			PLETED
		345263	B. WING				C / <b>23/2018</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	23/2010
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		3.	195 OLD MURPHY ROAD		
				F	RANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From page	e 104	F	684			
	#2's blood glucose; R glucose result of "HI".	esident #2 had a blood					
		n, Nurse #3 administered Isulin subcutaneously to by the physician.					
		n, Nurse #3 administered sulin subcutaneously to red by the physician.					
		n, Nurse #3 rechecked Jlucose with a result of "HI".					
	ensured Resident #2' the nurse practitioner reading remaining "H of Regular insulin for Nurse #3 administerir	ately 9:30 am, Nurse #3 s well-being by: contacting of the blood glucose I", administration of 6 units the initial "HI" reading, and ng the scheduled 6 units of neduled by the physician's					
		e practitioner gave a verbal Resident # 2 to be sent to					
	hospital emergency re	# 2 was transferred to the oom by emergency medical n of elevated blood glucose.					
	deficient practice that well-being was the nu established policy in o the medication is not cart.	obtaining medications when available on the medication					
	On 10/19/18, the DOI	N, quality improvement (QI)					

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM	D: 11/30/2018 APPROVED D: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345263	B. WING				( 10/	C 23/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER			195 OLD MURPHY ROAD RANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 684	needs, and treating re- respect was reviewed agency and contracte staff, agency, or contr work until the in-servic was educated on 10/2 added to new staff ori and contracted staff. Beginning 10/19/18 to practice, all licensed r staff, will be in-service medication. Insulin m physician orders, inclu- when the medication is medication cart or in t no staff, agency, or co allowed to work until to Nurse # 4 was educat in-service with be add including agency and 2. How the facility will having the potential to deficient practice: On 10/19/18, the DO reviewed all current re no other doses were of The review identified 3	ator (SF) initiated the noting a Resident's ervice included the g physicians' orders, informed if unable to orders, attending to resident esidents with dignity and with all staff, including d staff. After 10/19/18, no acted staff will be allowed to ce is completed. Nurse # 4 22/18. The in-service will be entation, including agency ed on administering fust be administered per uding obtaining medications is not available on the he facility. After 10/19/18, ontracted staff will be he in-service is completed. ted on 10/22/18. The led to new staff orientation, contracted staff. identify other residents o be affected by the same N and unit manager esidents on insulin to ensure omitted in the last 30 days. 28 occurrences where the lin was not documented	F	684				

Facility ID: 923019

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/30/2018 MAPPROVED D. 0938-0391	
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		PLETED	
		345263	B. WING			C 10/23/2018		
NAME OF PI	ROVIDER OR SUPPLIER	l	<b>I</b>	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER			195 OLD MURPHY ROAD			
				F	RANKLIN, NC 28734		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 684		manager contacted the	F	684				
	On 10/22/18 the unit manager contacted the physician regarding undocumented doses of insulin. The physician gave no new orders. Multiple nurses failed to either administer insulin as ordered or failed to document administration of insulin as ordered on multiple residents, throughout the facility at multiple times during the							
	multiple nurses' failur administration policy.							
	to ensure all resident	N and Unit Manager audited s on insulin have the insulin y. All Residents had Insulin der.						
	3. What measures wi systemic changes ma practice will not recur	ade to ensure the deficient						
	auditing 100% of resi times weekly x 12 we available for administ	N, QI nurse, SF, licensed nurse began dents on insulin once daily 5 eks to ensure insulin is ration as ordered. This audit n the insulin audit tool.						
	auditing audit 100% o	licensed nurse began of residents on insulin. The leted once daily 5 times ensure insulin was red. This audit will be						
	administrator began r ensure if a potential r	N, QI nurse, SF, and/or eviewing all referrals to esident would be on insulin available prior to resident						

Facility ID: 923019

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/30/2018 MAPPROVED O. 0938-0391	
STATEMENT (	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345263	B. WING				C / <b>23/2018</b>	
NAME OF P	ROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE			
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER			195 OLD MURPHY ROAD FRANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 684	insulin referral audit to completed on each ref 4. How the facility plat performance to make sustained (include dat will be completed) Beginning 10/20/18, to Insulin Audit Tool resu- team (IDT) weekly for include ensuring insu- ordered and insulin is Presentation of the in- will serve as a second Beginning 10/22/18, present the Insulin Ref weekly to the daily ID ensure potential adm insulin have the medi- admission. Presentat serve as a second ver well-being is being m- insulin administration The daily IDT's role in- plan of correction incl monitoring, and ensu- effective. The IDT als for revisions as needer findings will be broug quality assurance and (QAPI) meeting for ad- recommendations. Co-	will be documented on the ool. This audit will be eferral for 12 weeks. Ins to monitor its a sure solutions are tes when corrective action the DON will present the ults to the interdisciplinary r review. This review will lin was administered as a available for administration. sulin audit tool to the IDT d verification. the social worker (SW) will eferral Audit tool results T for review. This review will issions with a need for cation available upon ion of the tool to the IDT will wification to ensure resident aintained as it relates to this Resident Well-Being fudes implementation, ring the interventions are so makes recommendations ed. The daily IDT review th to the next quarterly d performance improvement dditional review and on 10/22/18, the the QAPI committee of the a error IJ and the facility's	F	684				

Facility ID: 923019

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	S FOR MEDICARE &			CONSTRUCTION		M APPROVE 0. 0938-039
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED C
		345263	B. WING		10	/23/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		TREET ADDRESS, CITY, STATE, ZIP CO	DE	
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER		195 OLD MURPHY ROAD RANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 684	Continued From page committee's role in th		F 684			
	responsible for imple corrective measures sustained.	the administrator will be menting and monitoring to ensure solutions are				
	Macon Valley alleges as of 10/22/18.	compliance of removal of IJ				
	demonstrated they ha of medication administ pharmacy for medica physician if medication	taff were interviewed and ad been trained on the topics stration, and how to call the tions, and to notify the ons weren't available. was removed effective				
F 689 SS=D	Free of Accident Haz CFR(s): 483.25(d)(1)	ards/Supervision/Devices (2)	F 689			12/5/18
	supervision and assis accidents. This REQUIREMENT	esident receives adequate stance devices to prevent is not met as evidenced				
	facility failed to place	iew and staff interviews the a bed in the low position		F 689		
	position for Resident	II from the bed in high #20 causing the need for a kin tears (Resident #20).		How corrective action will be accomplished for those resic have been affected by the de practice	lents found to	
	The findings included	1:		On 10/11/18 - 10/19/18, the		

Event ID: J78Q11

Facility ID: 923019

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		MEDICAID SERVICES			OMB NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345263	B. WING		C 10/23/2018	
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
				95 OLD MURPHY ROAD		
WACON V	ALLET NURSING AND R	EHABILITATION CENTER		FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE COMPLETI	
F 689	Continued From page	e 109	F 689			
1 009	Resident #20 was ad 09/17/18 with diagnos repair, high blood pre peripheral vascular di obstructive pulmonar Review of the admiss	mitted to the facility on ses included hip fracture ssure, atrial fibrillation, isease, and chronic y disease. sion nursing assessment led Resident #20 was alert	F 685	nursing (DON) and quality improv (QI) nurse audited Resident #20's progress notes and interviewed flu nurses and nursing assistants (N/ regarding Resident #20's acciden Resident #20 no longer resides at facility.	s nursing oor As) t.	
	Resident #20 was at injury, multiple risk fa deconditioning, incon and impaired mobility #20 to be free of falls injury through the nex	an dated 09/18/18 revealed risk for falls/actual falls, ctors related to tinence, impaired balance 7. The goal was for Resident , and not sustain serious kt review. The interventions esident's bed in the lowest		How the facility will identify other in having the potential to be affected same deficient practice On 10/11/18 – 10/19/18, the DON nurse audited 100% of nurse prog notes for all residents looking for a documented incidents/accidents. audit revealed no other incidents accidents that had not been previ- identified and corrective action tal	I by the and QI gress any The ously	
	and dated 09/22/18 6 #20 had multiple skin cleaned and treated. swollen and Respons broken and wanted th emergency room. The didn't feel her arm/shi she had range of mot pain while moving. Th An order for an x-ray technician and was d facility. Review of the 09/22/18 at 4:00 PM a Resident #20 by Nurs	The right shoulder was sible Party (RP) felt it was ne resident to go to the e note revealed Nurse #1 oulder was broken because tion and was using it, not in ne Physician was contacted.		What measures will be put into pla systemic changes made to ensure deficient practice will not occur: On 10/11/18, the QI nurse initiated 100% in-service with all registered (RNs), licensed practical nurses ( nursing assistants (NAs), geriatric assistants (GCAs) and agency sta in-service included the nurse mus the physician immediately of resid with unwitnessed falls that are on medications with blood thinning properties. Neurological checks m started and the nurse must follow	ace or e the d a d nurses LPNs), c care aff. The t notify lents	

Facility ID: 923019

STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	, <i>,</i>	PLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
AND PLAN OF	UURREUTUN	IDENTIFICATION NUMBER:	A. BUILDING	3	C
		345263	B. WING		10/23/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	
MACON V	ALLEY NURSING AND R	REHABILITATION CENTER		3195 OLD MURPHY ROAD	
				FRANKLIN, NC 28734	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COMPLETI O THE APPROPRIATE DATE
F 689	Continued From page	e 110	F 68	39	
		ere was no evidence of an	1.00	the resident is sent to the	ER for
	acute fracture or dislo			evaluation and treatment	
				the neurological checks	
		ed on 10/10/18 at 11:07 AM		when the resident return	
		#1 revealed he had just		the appropriate time. The	
		vas doing his first set of		notified of all falls with in residents on blood thinne	
		d Resident #20 screaming stated he went to her room		of the incident to ensure	-
		her right side with her right		appropriate.	
		and her head lying on the			
	floor facing the bed. I	NA #1 stated Resident #20		On 10/11/18 – 10/15/18,	the corporate
	-	in tears to both sides of her		nurse consultants mento	
	-	new what fall precautions		administrator, DON, QI n	
		dents from the Resident		where to find and access	•
		dent #20's care indicated the lowest position and it		policies, procedures, and checklists. The corporat	
		on when he found Resident		consultants also assisted	
	#20 on the floor.			in-services to include fall and neurological check of	s investigations
		ed on 10/10/18 at 12:05 PM			
		she helped NA #2 transfer		On 10/19/18, the DON a	
	Resident #20 from the			(SF) initiated multiple in-	
		ft change around 2:45 PM o her hall. She stated she		of appropriate staff to inc nurses (RNs), licensed p	-
		around 4:00 PM and went		(LPNs), NAs, geriatric ca	
	•	m. She stated Resident #20		agency staff, housekeep	
		with her head on the floor		dietary, therapy, and dep	
		as in the high position.		The in-services included	education on
				resident safety to preven	
		ed on 10/11/18 at 10:30 AM		neurological checks after	
		he had transferred Resident the bed just before shift		10/19/18, no facility nurs agency staff, or contracted	
		and he was at the nurse's		will be allowed to work u	
	÷	ode green called. He stated		are completed. On 10/1	
		#20's room and she was		in-service was added to	
		ner right side with her right ath her and her head was		orientation, including age contracted staff.	ency and
	lying on the floor with	the bed in the high position. Resident #20's should have		On 10/19/18, the DON, 0	I nurse and SF

Facility ID: 923019

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		O. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	· /		. ,	IPLETED
			A. BOILDING			С
		345263	B. WING		1	0/23/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
				3195 OLD MURPHY ROAD		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE
F 689	Continued From page	e 111	F 68	9		
		on per the Resident Care	1 00	nurse began five day per	r week reviews of	
		he high position when he		the nursing 24-hour repo		
	entered Resident #20			for any new medication of		
				incident/accidents, notific		
	An interview conducted	ed on 10/11/18 at 1:39 PM		to the physician/nurse pr	ractitioner (NP) in	
	with Nurse #1 revealed			the progress notes, new	-	
		by a code green and when		added, and neurological	checks after a	
		Resident #20 was lying on		fall.		
		head on the ground. She				
		ember what position the bed		On 10/22/18, the adminis		
		ed Resident #20 was yelling assessed her but she had		department heads, and c consultants began a proc		
		of all extremities and		cause analysis using "5-"		
		urse #1 stated Resident		interdisciplinary team (ID		
	-	arty (RP) came in during the		root cause analysis was		
		ike the resident had broken		why the facility failed pla		
		n and wanted her sent out to		low position which result		
	the hospital. She stat	ed she told the RP they		the bed in high position f	for Resident #20	
	could have an x-ray o	lone at the facility and it		causing the need for a sl	houlder x-ray and	
	-	n going to the hospital and		skin tears. The root cau		
	-	ng it that way. Nurse #1		there was a lack of comr		
		ember calling the on-call		between the nursing staf		
		the on-coming nurse had		nursing department rega		
		reviewing her nurse's notes		#20's safety needs; beds		
	she stated, "I guess I			the appropriate height po	osition for the	
	shoulder."	order for the x-ray of her		resident.		
		nt note written by Nurse #1				
		:44 PM revealed Resident		How the facility plans to		
	#20 had multiple skin	-		performance to make su		
		The right shoulder was ible Party (RP) felt it was		sustained (include dates action will be competed)		
		he resident to go to the		action will be competed)		
		e note revealed Nurse #1		On 10/19/18, the adminis	strator initiated	
		oulder was broken because		multiple audit tools which		
		ion and was using it, not in		completed by the depart		
	-	ne Physician was contacted.		(DON, QI nurse, SF, soc		
	An order for an x-ray		1			1

Facility ID: 923019

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MUI TIPI	E CONSTRUCTION		<u>NO. 0938-03</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · ·	MPLETED
						С
		345263	B. WING		1	0/23/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
		REHABILITATION CENTER		3195 OLD MURPHY ROAD		
				FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 689	Continued From page	e 112	F 68	9		
	facility. Review of the 09/22/18 at 4:00 PM Resident #20 by Nurs Physician for an x-ray injury from a fall. Review of the x-ray ri 09/22/18 revealed the acute fracture or dislo Further interview with 1:39 PM revealed she on 09/23/18 on the 7: she had no complaint An interview conducte with the Director of N expectation for staff to in place for residents bed should have bee she was in bed unles and then after providi	one at 6:00 PM in the physician order's dated an order was written for se #1 and signed by the y of right shoulder to rule out aght shoulder results dated ere was no evidence of an ocation. In Nurse #1 on 10/11/18 at e was Resident #20's nurse to AM to 7:00 PM shift and ts of shoulder pain that day. ed on 10/11/18 at 3:04 PM ursing revealed it was her o follow fall preventions put . She stated Resident #20's n in the low position when s staff were providing care ing care the bed should be obsition to prevent injuries		weekend manager-on-duty). T will include supervision observa- utilizing the Administrative Rou- ensure residents are free of ac hazards, have adequate super safe devices to use. On 10/19/18, the administrator nurse, SF, vice president of op and/or corporate consultant be reviews of the audit tool results six months to validate the facili provided each resident with su and devices to prevent inciden accidents. The administrator, I president, and/or corporate cor initial the bottom right corner or tools with the date as validation On-going mentoring with the ac and administrative team will co be provided by the vice preside operations and/or corporate co team at a minimum of at least of On 10/20/18 and 10/22/18, the president of operations contact Quality Improvement Organiza and requested mentoring assiss monitoring recommendations. mentoring will also be provided administrator and administrative the QIO beginning 10/26/18 du facility visit.	ations inds tool to icident vision and , DON, QI erations gan s weekly for ty has pervision ts and DON, vice nsultant will f the audit n of review. dministrator intinue to ent of insultant monthly.	
				On 10/26/18, the administrator working with the QIO to improv leadership and management a guidance on how changes lead make to implement a safe, haz	ve effective nd seek dership can	

Event ID: J78Q11

Facility ID: 923019

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			0.00		OMB NO. 0938	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	Y
					С	
		345263	B. WING		10/23/201	18
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMP	X5) PLETIOI ATE
F 689	Continued From page	e 113	F 689			
F 690 SS=D	CFR(s): 483.25(e)(1)- §483.25(e) Incontiner §483.25(e)(1) The fac resident who is contin admission receives so maintain continence u condition is or becom not possible to mainta §483.25(e)(2)For a re- incontinence, based of comprehensive assess ensure that-	-(3) nce. cility must ensure that nent of bladder and bowel on ervices and assistance to unless his or her clinical les such that continence is ain. esident with urinary on the resident's assment, the facility must ers the facility without an	F 690	Beginning 10/19/18, the administra DON, and QI nurse will present the in-service/mentoring comments, supervision observations, and aud to the IDT and monthly QI commit six months. The IDT and QI commit will review incident investigation fil ensure there is adequate supervis safety measures are in place, bed proper position, devices are safe, neurological check documentation completed. The administrator and DON will present the daily IDT and monthly QI committee recommend to the quarterly QAPI committee for additional recommendations for monitoring and continued complia The QAPI committee will continue consulting with the QIO until subst compliance is achieved.	e lit trends tee for nittee es to ion, s are in and is l/or d dations or nce.	18

Facility ID: 923019

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	): 11/30/2018 1 APPROVEE ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION		LETED
		345263	B. WING _			( 10/:	23/2018
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER			95 OLD MURPHY ROAD		
				FI	RANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 690	Continued From page	e 114	F	590			
		dition demonstrates that		550			
	catheterization was n						
		iters the facility with an					
		r subsequently receives one					
		val of the catheter as soon					
		e resident's clinical condition theterization is necessary;					
	and						
	. ,	incontinent of bladder					
		treatment and services to infections and to restore					
	continence to the ext						
	§483.25(e)(3) For a r						
	incontinence, based						
		ssment, the facility must					
		t who is incontinent of bowel treatment and services to					
		nal bowel function as					
	This REQUIREMEN	Γ is not met as evidenced					
	by: Based on observation	ons, record review, and staff			F690		
		failed to ensure a resident's					
	-	was not in contact with the			How corrective action will be		
	floor (Resident #14).				accomplished for those residents found	d to	
					have been affected by the deficient		
	The findings included	1:			practice		
	Posidont #14 was ad	mitted to the facility on			On 10/09/18, Nurse #3 had Resident #15's urinary catheter bag changed an	d	
		Imitted to the facility on ecently on 09/21/18 with			re-hung on the wheelchair so there was		
		uded: dementia without			privacy cover and the catheter bag was		
		ion, coronary artery disease,			not in contact with the floor.	-	
	urinary retention, and				On 10/09/18, the director of nursing		
	hyperplasia with lowe	er urinary tract symptoms.			(DON) re-educated NA #5 regarding		
					maintaining dignity of residents in relation		
		num Data Set (MDS) dated			to privacy covers on urinary catheter ba	-	
	09/28/18 revealed the				and the urinary catheter bags not being	g in	
	moderately cognitive	ly impaired. He was coded			contact with the floor.		

Facility ID: 923019

			PRINTED: 11/30/2018 FORM APPROVED OMB NO. 0938-0391
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		(X3) DATE SURVEY COMPLETED
345263	B. WING		C 10/23/2018
		STREET ADDRESS, CITY, STATE, ZIP COD	Ε
REHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734	
NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION APPROPRIATE DATE
<ul> <li>ive assistance with most ing skills (ADL) including further revealed Resident #14 atheter during the reference</li> <li>Resident #14 on 10/09/18 at resident sitting in wheelchair with urinary catheter bag was elchair just below arm rest.</li> <li>5 on 10/09/18 at 7:55 am placed urinary bags under the</li> <li>de on 10/09/18 at 8:57 am of resident's room revealed his guing the floor.</li> <li>de on 10/09/18 at 11:10 am of facility front hallway revealed a hanging under his wheelchair bor.</li> <li>de on 10/09/18 at 12:03 pm of g therapy room revealed his nging under his wheelchair bor.</li> <li>de on 10/09/18 at 12:42pm of facility dining room revealed a hanging under his wheelchair bor.</li> </ul>	F 69	<ul> <li>How the facility will identify of having the potential to be affer same deficient practice</li> <li>On 10/09/18, the quality impranurse and DON audited urinat bags to ensure they were not with the floor. The audit reverissues related to urinary cather contact with the floor.</li> <li>What measures will be put infision of the deficient practice will not practice will not practice a 100% re-education registered nurses (LPNs), NAs agency staff titled "Foley Cathere-education instructs staff " bags and/or tubing must remation for all new RNs, Li and all nursing agency staff.</li> <li>11/28/18, no RN, LPN, NA, or is allowed to work until the incompleted.</li> <li>Beginning 11/28/18, the DON SF, unit manager, activities d social worker, administrator, results of the admir rounds is being documented for the admir rounds is being documented</li></ul>	ected by the ovement (QI) iny catheter in contact aled no other eter bags in to place or nsure that recur r (SF) of nsed , and all neter". The .all catheter ain off the revention completed w employee PNs, NAs, After r agency staff -service is I, QI nurse, irector, manager on nt began ure urinary act with the nistrative the 100%
	IDENTIFICATION NUMBER:	& MEDICAID SERVICES       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTI A. BUILDIN         345263       B. WING	& MEDICAID SERVICES         (x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (x2) MULTIPLE CONSTRUCTION A BUILDING         345263       STREET ADDRESS, CITY, STATE, ZIP COL 3195 OLD MURPH YROAD FRANKLIN, NC 23734         D REHABILITATION CENTER       STREET ADDRESS, CITY, STATE, ZIP COL 3195 OLD MURPH YROAD FRANKLIN, NC 23734         STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)         sige 115       F 690         ive assistance with most ing skills (ADL) including further revealed Resident #14 atheter during the reference       F 690         Resident #14 on 10/09/18 at resident sitting in wheelchair with uninary catheler bag was elchair just below arm rest.       F 690         65 on 10/09/18 at 7:55 am y placed urinary bags under the gging the floor.       What measures will be put in systemic changes made to er the deficient practice will not.         de on 10/09/18 at 12:03 pm of g deany under his word.       On 11/6/18, the staff facilitato initiated a 100% re-education registered nurses (LPNs), NAs agency staff titled "Foley Catl re-education instructs staff "

Facility ID: 923019

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		ND HUMAN SERVICES MEDICAID SERVICES			FOI	ED: 11/30/201 RM APPROVE IO. 0938-039
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION		TE SURVEY MPLETED
		345263	B. WING		1	C 0/23/2018
	ROVIDER OR SUPPLIER Alley Nursing and F	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 690	#3 stated with the uri be lying on the groun Nurse #3 repositione the ground. An interview with the on 10/09/18 at 4:05 p	ed with the urinary catheter bag should not g on the ground or dragging the ground. #3 repositioned bag so it would not drag on und. rview with the Director of Nursing (DON) 09/18 at 4:05 pm revealed urinary catheter hould be positioned so they don't drag or		will be / for four nes eight or one		
F 725	Sufficient Nursing St		F 72	performance to make sure that are sustained Beginning 11/28/18, the QI nurs review the results of the audits monthly QI committee for four ( to identify trends, corrective act to determine the need for and/o frequency of continued monitor maintain compliance. The QI n present trends and QI committee recommendations to the quartee assurance and performance im (QAPI) Committee for further recommendations and oversigh	se will with the 4) months tions, and or ing to iurse will ee rly quality provement	12/5/18
SS=E	CFR(s): 483.35(a)(1) §483.35(a) Sufficient The facility must have the appropriate comp provide nursing and resident safety and a practicable physical, well-being of each re resident assessment and considering the re	(2) Staff. e sufficient nursing staff with betencies and skills sets to related services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by s and individual plans of care				

Facility ID: 923019

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	-	ND HUMAN SERVICES MEDICAID SERVICES			FORM	D: 11/30/2018 APPROVED ). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		LETED
		345263	B. WING			C 23/2018
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP COD	E	
		REHABILITATION CENTER		3195 OLD MURPHY ROAD		
				FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 725	Continued From page	e 117	F 72	5		
1 720						
	at §483.70(e).	facility assessment required				
	§483.35(a)(1) The fa	cility must provide services				
	•	s of each of the following				
	types of personnel or	n a 24-hour basis to provide				
	-	sidents in accordance with				
	resident care plans:					
		ed under paragraph (e) of				
	this section, licensed	sonnel, including but not				
	limited to nurse aides	-				
	§483.35(a)(2) Except	t when waived under				
		section, the facility must				
	•	nurse to serve as a charge				
	nurse on each tour of	2				
		Γ is not met as evidenced				
	by: Based on observation	ons, record reviews, family		F 725 – Sufficient Staffing		
		nterviews, the facility failed to				
		ffing and scheduling to meet		The plan of correcting the spe	cific	
	-	, nail and hand care, and/or		deficiency	-	
	keeping water access	sible for 7 of 7 sampled		The position of Macon Valley	Nursing and	
	residents reviewed for	or these areas. (Residents		Rehabilitation center regardin	g the	
	#1, #5, #10, #13, #16	6, #19 and #21)		process that lead to this defici		
	<b></b>			facility failed to provide sufficie	-	
	The findings included	1:		staff and scheduling to meet t		
	This tog is proposed re	oforrad to:		showering, nail and hand care keeping water accessible. (Re		
	This tag is crossed re			#5, #10, #13, #16, #19 and #2		
	1 E558 Accommod	ation of Needs: Based on		The procedure for implementi	,	
		review and family and staff		acceptable plan of correction	•	
		failed to maintain fluids		specific deficiency cited		
	•	of 15 sampled residents.		On 10/16/18, the facility signe	d a contract	
	(Residents #1, #4, ar	nd #13).		with a staffing agency to provi nursing staffing.	de sufficient	
	An interview with Nur	rse Aide (NA) #4 on 10/10/18		On 10/16/18, the facility bega	n offering a	
		that sometimes when the		sign on bonus for certified nur		

Facility ID: 923019

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TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURV	38-03 EY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	j	COMPLETED	
					С	
		345263	B. WING	·····	10/23/20	)18
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		3195 OLD MURPHY ROAD		
				FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE COM THE APPROPRIATE	(X5) /IPLETIO DATE
F 725	Continued From page	e 118	F 72	5		
		nts bring the residents back		assistants, licensed pract	ical nurses. and	
		ning room, they failed to		registered nurses.		
	ensure the fluids are	in their reach. She stated		On 10/16/18, the facility p	oosted a hiring ad	
	•	n staff to keep up with all the		in the local newspaper to		
	residents' needs.			sufficient nursing staffing		
	Intonyiow with the Dire	actor of Nursing (DON) on		On 11/7/18, the facility be assistant (NA) classes at		
		ector of Nursing (DON) on revealed some days there		Community College. The		
		. The DON stated the facility		sponsored seven student	-	
	used geriatric care as			On 11/15/18, the facility s		
	-	hands on care as they were		additional contract with a	-	
	not nurse aides. She	confirmed that 10/09/18		to provide sufficient nursi	ng staffing.	
	there was not enough	n staff scheduled.		By 11/19/18, the facility a in-service the director of r		
	2. F561: Choices for			on providing adequate sta	affing for the	
		it, family and staff interviews		facility.		
		he facility failed to honor the		The monitoring procedure		
	choices of 7 of 7 sam	baths as often as they		the plan of correction is e specific deficiency cited r		
		s #1, #5, #10, #13, #16, #19		and/or in compliance with		
	and #21).			requirements		
	,			The DON, staff facilitator	(SF), and/or	
	On 10/09/18 at 9:01 A	AM, Nurse Aide (NA) #4		quality improvement (QI)		
	-	orked the hall alone and was		daily staffing for 8 weeks		
	-	are completed. She did		tool will be documented of	on the Adequate	
		hing the underarms and		staffing Monitoring Tool.	•	
		g residents up but was		The monthly QI committe results of the Adequate S		
	-	hs/showers. She stated that tration about the care not		Monitoring tool monthly for		
	being completed.			identification of trends, ac		
				to determine the need for		
	Interview with NA #3	on 10/10/18 at 9:54 AM		frequency of continued m	onitoring, and	
	revealed that there is			make recommendations f	5	
		o she does her best to wash		continued compliance. Th		
		n the shower. She further		and/or DON will present t		
		en lots of complaints about		recommendations of the		
	showers being misse	u.		committee to the quarterl		
		0/18 at 10:48 AM, that when		and oversight.		

Facility ID: 923019

If continuation sheet Page 119 of 140

		MEDICAID SERVICES			OMB NO. 0938-	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345263	B. WING		C 10/23/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/20/2010	
MACON V	ALLEY NURSING AND R	REHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLE	
F 725	Continued From page	e 119	F 72	5		
	he floated between th assignment and so he hall, then moved to a then moved to the ne he was to be availabl	ne halls, he had actually no e spent one hour on one nother hall for an hour and ext hall for an hour. He stated e to assist as needed. ector of Nursing (DON) on		The title of the person responsible implementing the acceptable plan correction. The Director of Nursing is respon implementing the acceptable plan correction.	of sible for	
	was not enough staff completed. She state complaints from famil showers not being co that 10/09/18 there w scheduled. She state 10/09/18 at he was re	ed she has received a lot of lies and residents about ompleted. She confirmed vas not enough staff ed NA #1 was a floater on esponsible for assisting with ind to give showers. DON the				
	observations, record the facility failed to pr and fingernails were completed for 1 of 7 s	Daily Living Skills: Based on review, and staff interviews, rovide care to ensure hands clean and oral care was sampled residents reviewed iving skills. (Resident #1).				
	stated during intervier mouth care on Reside stated she did not do notice dirty nails or ha	PM, Nurse Aide (NA) #4 w that she had not done any ent #1 this date. She also hand care and did not ands. She stated there was eduled and working to get all ompleted.				
	10/10/18 at 6:33 PM and mouth care to be noticed his thumb nai attention. She further	ector of Nursing (DON) on revealed she expected hand e completed. She stated she il this morning needed stated there were some nough staff. She confirmed				

Facility ID: 923019

If continuation sheet Page 120 of 140

TATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345263	B. WING			C 10/23/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL			
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER		3195 OLD MURPHY ROAD			
				FRANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 725			F 72	5			
	that 10/09/18 there w scheduled.	-					
F 760 SS=J	Residents are Free o CFR(s): 483.45(f)(2)	f Significant Med Errors	F 76	0		12/5/18	
	medication errors. This REQUIREMENT by: Based on observations staff, and Nurse Prace failed to administer pro- medication to keep re- medication errors in a professional standard residents reviewed for (Resident #2). Immediate Jeopardy Nurse #4 did not administration physician's order white developing DKA. Imministrations or der white monitoring by the displayer of the displayer monitoring systems in the findings included Resident #2 was administrations of the displayer of the di	began on 09/11/18 when ninister insulin per ch resulted in Resident #2 nediate Jeopardy was 8 when the facility ole allegation of Immediate he facility remains out of er scope and severity level D the potential for more than not immediate jeopardy) to education and ensure in place are effective.		F 760 - Significant Medication How corrective action will be accomplished for those reside have been affected by the de practice On the morning of 9/12/18, F experienced at FSBS reading resident received two doses Regular Insulin; however the FSBS reading would not drop Resident #2 was sent to the room, where the resident wa with diabetic ketoacidosis, ar an insulin drip to lower his ble On 10/17/18, the director of r (DON) interviewed Nurse #4 Resident #2, for date of servi which revealed Nurse #4 did insulin because it was unava How the facility will identify o having the potential to be affe same deficient practice On 10/19/18, the DON and u	ents found to eficient Resident #2 g of "HI." The of 6 units of resident's o below "HI." emergency s admitted nd placed on ood sugar. nursing assigned to ice 09/11/18, not give the ilable.		

Event ID: J78Q11

Facility ID: 923019

If continuation sheet Page 121 of 140

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/30/2018 MAPPROVED D: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345263	B. WING				C 23/2018
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
		EHABILITATION CENTER		31	95 OLD MURPHY ROAD		
	ALLET NORSING AND R			FF	RANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 760	Continued From page	e 121	F7	60			
	Record review of the Record (MAR) for Se #2 revealed on 09/11. units of scheduled reg and an additional 2 un (SSI) for coverage of (CBG) reading of 236 Review of the Septen revealed Resident #2 physician ordered ins at 5:00 PM and 9:00 f insulin coverage at 4: required 2 units of co CBG of 240 that required Review of the Blood 0 for 09/11/18 for Resid following readings: 09/11/18 1:00 PM 09/11/18 4:12 PM 09/11/18 8:50 PM Per physician order a of 206, Resident #2 s regular insulin on 09/	Medication Administration ptember 2018 for Resident /18 Resident #2 was given 6 gular insulin at 12:00 PM nits of sliding scale insulin capillary blood glucose 5. hber 2018 MAR further did not receive his ulin's of 6 units on 09/11/18 PM and his sliding scale 30 PM for a CBG of 206 that verage and 8:30 PM for a ired 2 units of coverage. Glucose Monitoring Sheet lent #2 revealed the A CBG 236 A CBG 240 nd based on CBG reading hould have received 2 units 11/18 at 4:30 PM. nd based on CBG reading hould have received 2 units			reviewed the medication availability of facility residents receiving insulin to ensure insulin was available. This rev compared each resident's current insu- orders with the medication administrat record (MAR) and the insulin available the medication carts. No concerns we identified, all residents with an order for insulin had insulin available. On 10/19/18, the DON and unit manage reviewed all current residents on insul ensure no other doses were omitted in last 30 days. The review identified 28 occurrences where the administration insulin was not documented according physician's orders. On 10/22/18 the un manager contact the physician regard undocumented doses of insulin. The physician gave no new orders. Multip nurses failed to either administer insul as ordered or failed to document administration of insulin as ordered on multiple residents, throughout the facil at multiple times during the day. The medication errors occurred due to mul nurses' failure to follow the medication administration policy.	iew ilin ion e in ere or ger in to of to nit ing le in ity tiple or	
	PM revealed she gav regular insulin on 09/ included the 6 units o and 6 units of regular	se #3 on 10/09/18 at 1:00 e Resident #2 12 units of 12/18 at 7:30 AM. This f regular scheduled insulin insulin for SSI coverage of urse #3 further revealed the			On 10/19/18, the DON, QI nurse and a facilitator (SF) began education with a licensed nurses to include agency stat the importance of following insulin ord This education included: 1) the physic must be notified anytime the prescribe	ll ff on ers. ian	

Facility ID: 923019

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		MEDICAID SERVICES			OMB NO. 0938-0
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345263	B. WING		C 10/23/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734	
				,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETI THE APPROPRIATE DATE
F 760	Continued From page	e 122	F 76	50	
	<ul> <li>Continued From page 122</li> <li>recheck of Resident #2 CBG at 9:30 AM still read "HI". Nurse #3 notified the NP, who was at the facility and she examined the resident and ordered him transferred to the hospital for possible diabetic ketoacidosis (DKA).</li> <li>An interview with Nurse #4 on 10/10/18 at 9:06 AM revealed she did not give Resident #2 his regular insulin on 09/11/18 at 4:30 PM and 09/11/18 at 5:00 PM or 09/11/18 at 8:30 PM. Nurse #4 further stated she did not give Resident #2 his 10 units of Detemir insulin scheduled for 09/11/18 at 9:00 PM.</li> </ul>			insulin is not available to a ordered, 2) the contents of available for use if the me for the resident is not ava cannot be missed, the nur address immediately. On 11/26/18, the education completed with all registe (RNs) and licensed praction (LPNs). No was allowed education was completed	of the EDK are edication ordered ilable, 3) insulin rse must on was 100% red nurses cal nurses to work until the
	A follow up interview 9:30 AM revealed she administered to Resid	with Nurse #3 on 10/10/18 at e obtained the regular insulin dent #2 on 09/11/18 and		How the facility plans to n performance to make sure sustained	e solutions are
	A review of the Nurse note dated 9/12/18 in seen on 09/12/18 afte The progress note ind developed nausea ar clammy and anxious. NP to transfer the res department for possib			Beginning 10/19/18, the E SF, or unit manager will a resident receiving insulin insulin was available, give and if the MD was notified not administered as order will be completed five time (4)four weeks, then week then monthly for three mo results of the audit will be Insulin Audit Sheet. Any	udit each to ensure their en as ordered, d if insulin was red. This audit es weekly for ly for 8 weeks, onths. The recorded on the concerns
	revealed she was una received his insulin's sent to the hospital. F revealed her expecta to contact the on-call not available.	NP on 10/10/18 at 10:00 AM aware Resident #2 had not the evening before he was Further interview with the NP tion was for the facility nurse physician if the insulin was with Nurse #4 on 10/10/18 at		<ul> <li>identified by the auditor w corrective action taken by immediately. The complet reviewed at the daily inter (IDT) meeting for addition measures.</li> <li>The daily IDT's role in this correction includes impler monitoring, and ensuring</li> </ul>	the auditor and audits will be disciplinary team al corrective s plan of nentation,
	10:45 AM revealed sh	ne did not remember if she rd shift nurse that Resident		are effective. The IDT als recommendations for revi	o makes

Facility ID: 923019

TATEMENT C	F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DAT	E SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED	
		345263	B. WING			С	
	ROVIDER OR SUPPLIER	040200		STREET ADDRESS, CITY, STATE, ZIP CODE	1	0/23/2018	
0.002 01 11				3195 OLD MURPHY ROAD			
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		FRANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
F 760	Continued From page	123	F 76				
		is insulin. She stated she	170	needed. The daily IDT review	findings		
		-call physician to notify them		are brought to the quarterly qua	•		
		f insulin. Nurse #4 indicated		assurance and performance im	•		
	-	narmacy to obtain the insulin		(QAPI) meeting for additional re	eview and		
		in the emergency box which		recommendations.			
	contains emergency r	medications.		Beginning 10/19/18, the DON v responsible for implementing a			
	During an interview w	ith Director of Nursing on		monitoring corrective measures			
		she stated she expected the		solutions are sustained.			
		the physician for all missing					
		her revealed she expected					
		ordered medications in the					
	missing medications.	o contact pharmacy for					
	Review of the hospita	I records revealed Resident					
	-	e hospital intensive care					
	unit for DKA on 09/12	•					
		pital was 485. Resident #2					
	from the morning of 0	ip which he was weaned					
	discharged on 09/14/						
	On 10/18/18 at 8:30 A	AM the Director of Nursing					
	and the Administrator Jeopardy via telephor	were notified of Immediate ne.					
		ion will be accomplished for I to have been affected by					
	Resident #2 was adm	-					
		ary diagnosis of uncontrolled					
		hyperglycemia. Resident #2					
		6 units of Regular insulin of Detemir (Levemir) at					
		scale of Regular insulin					
	before meals and at b	-					

Facility ID: 923019

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345263	B. WING				C 23/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER			3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 760	On 9/11/18 at approxi #2's finger-stick blood Nurse #4 did not admi insulin, sliding scale ( physician. Nurse #4 did place for when medic #4 should have obtain emergency drug kit (E physician to give the treatment. Upon accor failed to identify the mi On 9/11/18 at approxi supper meal coverage units were not given. On 9/11/18 at approxi #2's FSBS was 240.2 were not given. On 9/11/18 9 pm, Res Levemir 10 units were On the morning of 9/1 experienced at FSBS resident received two Insulin; however the mi would not drop below to the emergency roo admitted with Diabetic on an insulin drip to lo On 10/17/18, the dire interviewed Nurse #4 for date of service 09/ Nurse #4 did not give unavailable.	imately 4:12 pm, Resident d sugar (FSBS) was 206. inister 2 units of Regular SS), as ordered by the did not follow the system ation is not available. Nurse hed insulin from the EDK) or contacted the physician opportunity to alter essing the EDK, Nurse #4 hedication. imately 5 pm, Resident #2's e dose of Regular Insulin 6 imately 8:50 pm, Resident 2 Units of SS Regular Insulin sident #2's bedtime dose of e not given. 12/18, Resident #2 reading of "HI." The doses of 6 units of Regular esident's FSBS reading "HI." Resident #2 was sent m, where the resident was c Ketoacidosis, and placed over his blood sugar.	F	760			

	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345263	B. WING				C / <b>23/2018</b>
NAME OF PI	ROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER			3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	deficient practice: On 10/19/18, the DOI reviewed the medicat residents receiving in available. This review current insulin orders administration record available in the medic were identified, all res- insulin had insulin ava On 10/19/18, the DO reviewed all current re- no other doses were of The review identified administration of insu according to physician On 10/22/18 the unit of physician regarding u insulin. The physician Multiple nurses failed as ordered or failed to insulin as ordered on throughout the facility day. The medication of multiple nurses' failur administration policy.	A and unit manager ion availability of all facility sulin to ensure insulin was v compared each resident's with the medication (MAR) and the insulin cation carts. No concerns sidents with an order for ailable. N and unit manager esidents on insulin to ensure omitted in the last 30 days. 28 occurrences where the lin was not documented n's orders. manager contact the ndocumented doses of n gave no new orders. to either administer insulin o document administration of multiple residents, at multiple times during the errors occurred due to e to follow the medication	F	760			
		de to ensure the deficient					
		N, QI nurse and staff education with all licensed ance of following insulin					

Facility ID: 923019

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345263	B. WING				
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER			3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 760	orders. This education must be notified anyti not available to admir contents of the EDK a medication ordered for available, 3) insulin ca must address immedi On 10/21/18, the educ with all registered nur practical nurses (LPN work until the education 4. How the facility pla performance to make sustained (include da will be completed) Beginning 10/19/18, t unit manager will aud insulin to ensure their given as ordered, and insulin was not admin audit will be complete recorded on the Insuli concerns identified by corrective action take immediately. The com reviewed at the daily meeting for additional The daily IDT's role in includes implementati ensuring the intervent also makes recomme needed. The daily ID brought to the next qu and performance imp	nn included: 1) the physician me the prescribed insulin is hister as ordered, 2) the are available for use if the or the resident is not annot be missed, the nurse ately. cation was 50% completed ses (RNs) and licensed s). No nurse is allowed to on is completed. ns to monitor its sure solutions are tes when corrective action he DON, QI nurse, SF, or it each resident receiving insulin was available and d if the MD was notified if istered as ordered. This d five times weekly and in Audit Sheet. Any v the auditor will have n by the auditor npleted audits will be interdisciplinary team (IDT) corrective measures.	F	760			

Facility ID: 923019

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 11/30/201 MAPPROVE D. 0938-039
TATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345263	B. WING			C / <b>23/2018</b>
NAME OF P	ROVIDER OR SUPPLIER	l	STI	REET ADDRESS, CITY, STATE, ZIP CO		
MACON V	ALLEY NURSING AND R	REHABILITATION CENTER		95 OLD MURPHY ROAD ANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 760 F 761 SS=D	10/22/18, the administ committee of the sign and the facility's plan QAPI committee's rol Beginning 10/19/18, the responsible for implet corrective measures of sustained. Macon Valley Nursing alleges compliance of 10/22/18. On 10/23/18 facility st demonstrated they had of medication administ pharmacy for medication Immediate jeopardy with 10/22/18. Label/Store Drugs an CFR(s): 483.45(g)(h) §483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the of applicable. §483.45(h) Storage of §483.45(h)(1) In according Federal laws, the faci- biologicals in locked of	strator notified the QAPI nificant medication error IJ of correction, including the e in the plan of correction. the administrator will be menting and monitoring to ensure solutions are g and Rehabilitation Center f removal of IJ, F 760, as of taff were interviewed and ad been trained on the topics stration, and how to call the tions, and to notify the ons weren't available. was removed effective ad Biologicals (1)(2) of Drugs and Biologicals is used in the facility must be e with currently accepted is, and include the y and cautionary	F 760			12/5/18

Facility ID: 923019

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				OMB N	O. 0938-039
OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345263	B. WING		10	C D/23/2018
ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
		3	195 OLD MURPHY ROAD		
ALLET NORSING AND R		F	RANKLIN, NC 28734		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE
Continued From page	e 128	F 761			
locked, permanently a storage of controlled the Comprehensive E Control Act of 1976 a abuse, except when t package drug distribu quantity stored is min be readily detected. This REQUIREMENT by: Based on observatio facility failed to secure medication rooms (ba	affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and nd other drugs subject to the facility uses single unit ition systems in which the imal and a missing dose can - is not met as evidenced ns and staff interviews, the e medications in 1 of 3 ack of 100 hall).		F761 The plan of correcting the specifi deficiency	с	
room near Room 129 open with a shelving stated "This door must times". Observations revealed it stored over insulin syringes and a a vial of pneumonia v tuberculin PPD (purifi solution. This was in construction, however off from access from 200 hall. On 10/10/18 at 9:02 A stated that the hallwa construction for a whit	was observed propped unit. A sign on the door st remain locked at all of the medication room er the counter medications, a medication refrigerator with vaccine and a vial of ted protein derivative) a hallway that was under r, the hall was not blocked the upper 100 hall or the		Rehabilitation center regarding the process that lead to this deficient to secure medications- was the se failure to follow policies for medic storage due to knowledge deficit. On 10/9/28 at 6:57 AM, Hall 100 medication room was propped op a shelving unit. On 11/8/18 the director of nurses manager, quality improvement nu- and staff facilitator (SF) audited 1 medication rooms to ensure all medications were in date and stor according to the medication stora policy. No negative findings were observed.	ne cy-failed taff cation oen with , unit urse (QI) 100% of age	
	ALLEY NURSING AND R SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page personnel to have ac §483.45(h)(2) The fac locked, permanently a storage of controlled the Comprehensive E Control Act of 1976 a abuse, except when the package drug distribut quantity stored is min be readily detected. This REQUIREMENT by: Based on observation facility failed to secure medication rooms (based) The findings included On 10/09/18 at 6:57 / room near Room 129 open with a shelving stated "This door must times". Observations revealed it stored over insulin syringes and a a vial of pneumonia v tuberculin PPD (purifi- solution. This was in construction, however off from access from 200 hall. On 10/10/18 at 9:02 / stated that the hallwar construction for a white	ALEY NURSING AND REHABILITATION CENTER ALEY NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 128 personnel to have access to the keys. \$483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Do 10/09/18 at 6:57 AM, the 100 hall medication room near Room 129 was observed propped open with a shelving unit. A sign on the door stated "This door must remain locked at all times". Observations of the medication room revealed it stored over the counter medications, insulin syringes and a medication refrigerator with a vial of pneumonia vaccine and a vial of tuberculin PPD (purified protein derivative) solution. This was in a hallway that was under construction, however, the hall was not blocked off from access from the upper 100 hall or the 200 hall.	A BUILDING- 345263       B. WING	A BUILDING           BUILDING           STREET ADDRESS, CITY, STATE, ZIP CODE           STR	NUMPLIER       STREET ADDRESS, CITY, STATE, ZP CODE       SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CRACE CORR

Facility ID: 923019

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DEPARTMENT OF HEALTH A				PRINTED: 11/30/2018 FORM APPROVED
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
	345263	B. WING		C 10/23/2018
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1
		:	3195 OLD MURPHY ROAD	
MACON VALLEY NURSING AND	REHABILITATION CENTER		FRANKLIN, NC 28734	
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 761 Continued From pag		F 764	Medication rooms cannot be left open Medication room doors must remain closed and locked at all times for all licensed nurses, and medication aides This in-service will be complete by 11/19/18. No licensed nurses or medication aides will be allowed to we after 11/19/18 until in-service complet This in-service will be included with orientation for all newly hired licensed nursing staff, and medication aides. The director of nursing, QI nurse, unit manager, and/or SF will audit all medication rooms five times per week (4) four weeks, then weekly for twenty weeks to ensure the rooms remain loo at all times. This audit will be docume on the medication storage audit tool. The monthly QI committee will review results of the medication storage audit tool monthly for 6 months for identifica of trends, actions taken, and to detern the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administra and/or DON will present the findings a recommendations of the monthly QI committee to the quarterly executive O committee for further recommendation and oversight. The Director of Nursing is responsible implementing the plan of correction.	s. prk ed. for sked nted the t tor ind QA is

Facility ID: 923019

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TATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345263	B. WING		1	C 0/23/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z			
				3195 OLD MURPHY ROAD			
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER		FRANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	X (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 835	Continued From page	e 130	F	335			
	enables it to use its r efficiently to attain or practicable physical, well-being of each re This REQUIREMEN	esources effectively and maintain the highest mental, and psychosocial					
	and Medical Examine record reviews the fa provide effective lead processes and policie that residents were p and free from abuse			F 835 Administration Macon Valley Nursing an Center was placed into I Jeopardy on October 19 1. How corrective action accomplished for those have been affected by the practice:	Immediate ), 2018. on will be residents found to		
	Resident #2 when Nu physician of the unav ordered insulin's which developing DKA. Im 09/22/18 for Residen to perform neurologic neurological guide af floor and failed to con that the resident had on a blood thinner. In Resident #3 on 10/1/ observed NA #8 forci #3 sit down on the to being soiled.	began on 09/11/18 for urse #4 did not notify the vailability of the physician ch resulted in Resident #2 mediate Jeopardy began on t # 20 when the facility failed cal checks per the facility's ter a fall from the bed to the mmunicate to the physician an unwitnessed fall and was nmediate jeopardy began for 18 when Nurse Aide (NA) #1 ibly trying to make Resident ilet and yelling at her for		<ul> <li>On 9/11/18, Nurse #4 fa physician s order by no insulin to Resident #2 as 9/12/18, Resident #2 s level continued to registe practitioner gave an order Resident #2 to the hosp of nursing (DON) failed to implement training and r processes to maintain R highest practicable physical control of the property inform the physical control of the property form the physical control of the property inform the physical control of the physical control control of the physical control con</li></ul>	at administering s prescribed. On blood glucose er as HI; the nurse er to send ital. The director to effectively monitoring tesident #2 s sical well-being. and Nurse #2 failed hecks and sician of Resident ion after a fall. tively implement		
	20 on 10/11/18 and 1 Resident # 3 when th	0/22/18 for Resident # 2 and he facility implemented a Immediate Jeopardy		training and supervision care was provided to att #20⊡s highest practicab	to ensure basic ain Resident		

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If continuation sheet Page 131 of 140

		ND HUMAN SERVICES MEDICAID SERVICES			FO	ED: 11/30/2018 RM APPROVED NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED
		345263	B. WING		1	C 0/23/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		0.20.20.10
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 835	The facility remains of scope and severity let the potential for more not immediate jeopar education and ensure place are effective. The findings included 1. This tag is cross re Based on staff intervi interview, and record notify the physician of medication which cau to the hospital with di serious complication residents reviewed for (Resident #2). The fat the physician resulted receiving the medicat admission to the hos Based on record revi facility failed to comm the resident had an u a blood thinner for or residents reviewed for failure of the facility to unwitnessed fall from thinner use to the phy likelihood of serious i #20). 2. This tag is cross re	<ul> <li>but of compliance at a lower evel D (no actual harm with a than minimal harm that is dy) to complete employee emonitoring systems in</li> <li>d:</li> <li>efferred to F 580:</li> <li>fews, Nurse Practitioner reviews, the facility failed to of the missing insulin used the resident to be sent labetic ketoacidosis (DKA), a of diabetes, for 1 of 3 or notification of change tilure of the facility to notify d in Resident #2 not tions he needed to prevent pital for DKA.</li> <li>ew, staff, and Physician, the nunicate to the physician that unwitnessed fall and was on the of three sampled or notification of change. The ocommunicate an the bed to the floor and blood ysician resulted in the high njury or death (Resident</li> </ul>	F 85	abused Resident #3 when resident to keep the resident the bathroom during incont #8 failed to follow the abus NA #8 did not intervene and report NA #1 □s abuse of a 10/11/18 upon notification of DON ensured Resident #3 initiated an abuse investiga completion of the investiga determined quality of life, q and resident abuse issues to staff not being properly the supervision, and staff burned On 10/11/18 - 10/19/18, the quality improvement (QI) may Resident #20□s and Resident #20]s well-being.	nt from leaving inent care. NA e policy when d immediately resident. On of abuse, the was safe and ation. Upon tion, the DON juality of care, occurred due rained lack of out. e DON and urse audited ent #2 s record (MAR) s, inspected the reviewed d effective to maintain lent #2 s al, mental, and he reviews and ation sing ncies in facility g on policies, notifying ication errors, g care which	
	facility failed to prote	ct a cognitively impaired andled roughly by a staff		2. How the facility will ide	entify other	

Facility ID: 923019

		MEDICAID SERVICES	(X2) MULT		CONSTRUCTION	(X3) DATE	). 0938-03 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	` '			COMPLETED	
							С
		345263	B. WING			10/	23/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		EHABILITATION CENTER		31	195 OLD MURPHY ROAD		
				F	RANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
F 835	Continued From page	e 132	F 8	35			
	-	sidents reviewed for abuse			residents having the potential to be		
	(Resident #3).			affected by the same deficient practice	:		
<ul> <li>Based on record review, resident, staff, and Nurse Practitioner interviews the facility failed to administer insulin per physician order's or contact physician which caused the resident to be sent out to the hospital with diabetic ketoacidosis (DKA), a serious complication of diabetes, for 1 of 3 residents reviewed with insulin dependent diabetes (Resident #2).</li> <li>3. This tag is cross referred to F607:</li> <li>Based on record review and staff interviews the facility failed to implement their abuse policy and procedures to protect the resident, report, and investigate an allegation of staff to resident abuse for 1 of 3 residents reviewed for abuse (Resident #3).</li> </ul>				On 10/19/18, the DON and staff facilita (SF) initiated multiple in-services for 10 of appropriate staff to include the Administrator, RNs, LPNs, nursing assistants, geriatric care assistants, agency staff, housekeeping, laundry, dietary, therapy, and department head regarding resident safety, neurological checks, abuse, neglect, and staff burn After 12/5/18, no staff, agency, or contracted staff will be allowed to work until the in-service is completed. The in-service with be added to new staff orientation, including agency and contracted staff.	s out.		
	4. This tag is cross re				On 10/19/18, the DON, QI nurse or SF nurse began five day per week reviews the nursing 24-hour report sheets for a	s of iny	
	Medical Examiner inter perform neurological neurological guide aff	ew, staff, Physician and erviews, the facility failed to checks per the facility's ter a fall from the bed to the nmunicate to the physician			new orders, notification of changes to physician/NP in the progress notes, hypo/hyperglycemic episodes, neurological checks, and abuse/negled		
	that the resident had on a blood thinner. Th sampled residents re- following an acute ep facility to assess Res status per the facility! an unwitnessed fall fr	an unwitnessed fall and was his affected one of three viewed for assessment isode. The failure of the ident #20's neurological s protocol and communicate om the bed to the floor and he physician resulted in the			On 10/19/18, the administrator initiated multiple audit tools which will be completed by the administrative department heads (DON, QI nurse, SF social worker, dietary, activities): the assistant dietary manager, activity director, and weekend manager-on-du will complete supervision observations	<del>.</del> , ty	
		he physician resulted in the			-	Ι,	

Facility ID: 923019

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		10. 0938-03 TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,	6	· · ·	COMPLETED	
						С	
		345263	B. WING		1	0/23/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
	ALLEY NURSING AND R	EHABILITATION CENTER		3195 OLD MURPHY ROAD			
				FRANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 835	Continued From page	e 133	F 83	35			
		ns, record review, resident,		ensure no abuse occurred.	QI nurse/unit		
		titioner interviews the facility		manager will complete five			
		sulin per physician order's		week the Insulin Audit Tool	•		
		ident to be sent out to the		diabetic residents are recei			
	hospital with diabetic	ketoacidosis (DKA), a		ordered by the physician a	nd medication		
	serious complication	of diabetes, for 1 of 3		is available.			
	residents reviewed wi	ith insulin dependent					
	diabetes (Resident #2	2).		On 10/22/18, the administra			
				department heads and corp			
	5. This tag is cross re	eferred to F 760:		consultants began meeting	-		
	Deceder sheeting			interdisciplinary team (IDT)	-		
		ns, record review, resident,		perform a root cause analy	-		
		titioner interviews, the facility hysician ordered insulin		5-Whys process. Commun evidenced by lack of inform			
		esidents free of significant		of access to needed resour			
		accordance with accepted		determined to be the root of			
		Is and principles for 1 of 3		the facility failed to have re	•		
	residents reviewed fo			processes in place to admi			
	(Resident #2).			nursing care and resident t			
	,			promote resident well-being			
	An interview conducte	ed on 10/23/18 at 11:45 AM			-		
	with the Director of N	ursing (DON) revealed she		3. What measures will be	e put into place		
	was new to the facility	y and had been the DON for		or systemic changes made	to ensure the		
		onths. She stated she felt		deficient practice will not or			
	like there was facility			On 10/11/18 🗆 10/15/18, th			
		ducation and that was the		nurse consultants mentore			
		failures that caused the		administrator, DON, QI nur			
	deficient practice.			where to find and access c	•		
		ed on 10/23/18 at 11:55 AM		policies, procedures, and a			
		r revealed there had been a		checklists. The corporate r consultants also assisted w			
	lack of communication			in-services to include: falls	•		
		ne physician. She stated		checks, blood glucose mor			
		be provided to make sure		administration, and abuse/			
	facility policies and pr			purpose was to instruct fac	-		
		could be kept safe and		provide basic nursing care	-		
	appropriate care prov	-		to residents in a manner w			
				well-being and respect.			
	On 10/11/18 at 3:49 F	PM the Director of Nursing		On 10/19/18, the DON, the	OL nurse and		

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S FOR MEDICARE &	MEDICAID SERVICES			OMB NC	0. 0938-039
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · /	SURVEY LETED
	0.45000			С	
	345263			- 10/23/2018 ATE, ZIP CODE	
ROVIDER OR SUPPLIER					
ALLEY NURSING AND R	EHABILITATION CENTER				
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETIO DATE
Continued From page	- 13 <u>4</u>	E 83	5		
and the Corporate Co Immediate Jeopardy 1 0/18/18 administratic immediate jeopardy for On 10/22/18 the facilic credible allegation of removal that included Macon Valley Nursing was placed into Imme 19, 2018. 1. How corrective a for those residents for by the deficient practic On 9/11/18, Nurse #4 physician's order by r Resident #2 as presc #2's blood glucose lee "HI"; the nurse practit Resident #1 to the hor nursing (DON) failed training and monitorir Resident #2's highest well-being. On 9/22/18, Nurse #1 initiate neurological c the physician of Resid condition after a fall.	onsultant were notified of for Resident # 20. On on was notified of additional or Resident # 2 and # 3. Ity provided an acceptable Immediate Jeopardy I: g and Rehabilitation Center ediate Jeopardy on October action will be accomplished und to have been affected ice: failed to follow the not administering insulin to ribed. On 9/12/18, Resident vel continued to register as ioner gave an order to send ospital. The director of to effectively implement of processes to maintain t practicable physical and Nurse #2 failed to hecks and properly inform dent #20's change in The DON failed to	F 83	<ul> <li>SF nurse initiated an education the DON □ s expectation for all registed nurses (RNs), and licensed praction glucose monitoring and insulin administration as ordered by the physician, checking the emerger kit (EDK) for a backup, and notified the physician/NP.</li> <li>On 10/19/18, the administrator, If nurse, SF, Vice President of Operation and/or corporate consultant will reand analyze the audit tool results for six months to validate the fact provided each resident with the reattain or maintain the highest practice, and/or corporate consultant with the reattain or maintain the highest practice, member of the bottom right corner of the tools with the date as validation of On-going mentoring with the administrative team will contain the bottom right corner of the provided by the Vice Presider Operations and/or consultant teaminimum of at least monthly.</li> <li>On 10/20/18 and 10/22/18, the Vice President of Operations contacted Quality Improvement Organization and requested mentoring assistation.</li> </ul>	ered tical is blood acy drug cation of DON, QI erations eview s weekly, ility has means to acticable ial DN, vice ultant will he audit of review. ninistrator inue to at of um at a vice ed the on (QIO) ince	
Resident #20's higher On 10/1/18, nursing a	st practicable well-being. assistant (NA) #1 abused		administrator and administrative the QIO beginning 10/26/18 durin facility visit.	team by ng a	
	ALLEY NURSING AND R SUMMARY ST. (EACH DEFICIENC REGULATORY OR I SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page and the Corporate Co Immediate Jeopardy 10/18/18 administratii immediate jeopardy f On 10/22/18 the facilit credible allegation of removal that included Macon Valley Nursing was placed into Imme 19, 2018. 1. How corrective a for those residents fo by the deficient practif On 9/11/18, Nurse #4 physician's order by r Resident #2 as presc #2's blood glucose le "HI"; the nurse practif Resident #1 to the ho nursing (DON) failed training and monitorir Resident #2's highest well-being. On 9/22/18, Nurse #4 initiate neurological c the physician of Resident ensure basic care wa Resident #20's highest On 10/1/18, nursing a Resident #3 when NA	CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         345263         ROVIDER OR SUPPLIER         ALLEY NURSING AND REHABILITATION CENTER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 134         and the Corporate Consultant were notified of Immediate Jeopardy for Resident # 20. On 10/18/18 administration was notified of additional immediate jeopardy for Resident # 2 and # 3.         On 10/22/18 the facility provided an acceptable credible allegation of Immediate Jeopardy removal that included:         Macon Valley Nursing and Rehabilitation Center was placed into Immediate Jeopardy on October 19, 2018.         1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice:         On 9/11/18, Nurse #4 failed to follow the physician's order by not administering insulin to Resident #2 as prescribed. On 9/12/18, Resident #2's blood glucose level continued to register as "HI"; the nurse practitioner gave an order to send Resident #1 to the hospital. The director of nursing (DON) failed to effectively implement training and monitoring processes to maintain Resident #2's highest practicable physical	DF DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPI A BUILDING         345263       B. WING         ROVIDER OR SUPPLIER       B. WING         ALLEY NURSING AND REHABILITATION CENTER       ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 134 and the Corporate Consultant were notified of Immediate Jeopardy for Resident # 20. On 10/18/18 administration was notified of additional immediate jeopardy for Resident # 2 and # 3.       F 83         On 10/22/18 the facility provided an acceptable credible allegation of Immediate Jeopardy removal that included:       F         Macon Valley Nursing and Rehabilitation Center was placed into Immediate Jeopardy on October 19, 2018.       In How corrective action will be accomplished for those residents found to have been affected by the deficient practice:       On 9/12/18, Resident #2's blood glucose level continued to register as "H"; the nurse practitioner gave an order to send Resident #2 as prescribed. On 9/12/18, Resident #2's blood glucose level continued to register as "H"; the nurse practicable physical well-being.         On 9/22/18, Nurse #1 and Nurse #2 failed to initiate neurological checks and properly inform the physician of Resident #2's change in condition after a fail. The DON failed to effectively implement training and supervision to ensure basic care was provided to attain Resident #20's highest practicable well-being.         On 10/118, nursing assistant (NA) #1 abused Resident #3 when NA #1 held the resident to	FERCIENCIES CORRECTION       (X1) PROVIDERSUPPLIERCLAN IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A BUILDING         345283       STREET ADDRESS, CITY, STATE, ZIP CODE         SWINDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         ALLEY NURSING AND REHABILITATION CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST DE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PROVIDER'S FLAN OF CORRECT (EACH ORRECTIVE ACTION SH REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 134 and the Corporate Consultant were notified of Immediate Jeopardy for Resident # 20. On 10/18/18 administration was notified of additional immediate Jeopardy for Resident # 20. On 10/18/18 administration was notified of additional immediate Jeopardy for Resident # 20. On 10/18/18 administration was notified of additional immediate Jeopardy for Resident # 20. On 10/18/18 administration was notified of additional immediate Jeopardy for Resident # 20. On 10/19/18, the facility provided an acceptable credible allegation of Immediate Jeopardy removal that included:       F 835         Macon Valley Nursing and Rehabilitation Center was placed into Immediate Jeopardy on October 19, 2018.       The administrator, I physician, Checking the emerger kit (EDK) for a backup, and notifi the physician's order by not administerior pare and physician, Incer of the other physician's order by not administerior to nurse, SF, Vice President On 10/12/18, Resident #2's blood glucose level continued to register as initial the bottom right corporate consultant the physician's order by not administerior to physicial, Intervention in the administrator, D provided by the Vice President On 10	prederocences connection         (x1) PROVIDERGUPUERCUA IDENTIFICATION NUMBER:         (x2) MULTIPLE CONSTRUCTION A BUILDING         (x3) MULTIPLE CONSTRUCTION BIS OLD MURPHY ROAD FRANKLIN, NC 23734           SUMMARY STATEMENT OF DEFICIENCES RECORDERING AND REHABILITATION CENTER         STRUES ADDRESS CONSTRUCTION MUST BE PRECEIPED BY YULL RECORDERICTS ACTION NUMBER         F 835           Continued From page 134 and the Corporate Consultant were notified of Immediate jeopardy for Resident # 20 and # 3.         F 835         SF nurse initiated an education to set the DON is expectation for all registered nurses (LPNs), and licensed practical nurses (LPNs). The expectation is blood glucose commolicing and insulin administration was notified of additional immediate jeopardy on October 19, 2018.         F 835           1         How corrective action will be accomplished for those resident found to have been affected by the deficient practice:         F 835           1         How corrective action will be accomplished for those resident #20 to highest practicable physical well-being.         F 835           1         How corrective action will be accomplished for those resident #20 to highest practicable phys

Facility ID: 923019

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION	OMB NO. 093 (X3) DATE SURV	
	CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING		
		245262	B. WING		С	
		345263	B. WING		10/23/20	<u>)18</u>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLA	N OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCEE	EACTION SHOULD BE COM	MPLÉTIC DATE
F 835	Continued From page	e 135	F 83	35		
		re. NA #8 failed to follow the		utilization of the cause	and effect 5 Whys	
		A #8 did not intervene and		Root Cause Analysis (	5	
	immediately report N	A #1's abuse of a resident.		to help the facility unco	·	
		tification of abuse, the DON		for showers not being	offered, incontinent	
		was safe and initiated an		care not provided, falls		
		Upon completion of the		checks, blood glucose	<b>U</b> ,	
		N determined quality of life,		administration, and ab	<b>.</b>	
	quality of care, and re	not being properly trained,		promote resident well- The IDT and the QI co	•	
	lack of supervision, a			provided information a		
				analysis tools to drill do		
	On 10/11/18 - 10/19/	18, the DON and quality		areas needing improve	-	
		rse audited Resident #20's		On 10/22/18, the admi		
		edication administration		working with the QIO to	-	
		irsing progress notes,		effective leadership an	-	
	inspected the emerge			seek guidance on how		
	-	al checks, and interviewed		leadership can make to	-	
		entified effective systems naintain Resident #20's and		healthy, and respectful the residents.	environment for	
	-	t practicable physical,				
		ocial well-being. The reviews		4. How the facility pla	ans to monitor its	
		communication breakdowns		performance to make s		
	within the nursing de			sustained (include date		
	deficiencies in facility	practices related to training		action will be competed	d).	
		physician orders, notifying		Beginning 10/11/18, th	-	
		, medication errors, and		communication in the f		
		ng care which neglected		communication during		
	Resident #20's, and I	Resident #2's well-being.		daily interdisciplinary te		
	2. How the facility v	will identify other residents		meetings, written educ reminders, and audit fo	-	
	-	o be affected by the same		facility provides resider		
	deficient practice:			medications as ordered		
				care, dignity and respe	C C	
	On 10/19/18, the DO	N and staff facilitator (SF)		to resident well-being.		
	initiated multiple in-se			QAPI committees will o		
		clude RNs, LPNs, nursing		the facility to identify of	-	
	-	are assistants, agency staff,		the failure to communion		
		ry, dietary, therapy, and		stemming from training	-	
	epartment heads re	garding resident safety,		nursing care, abuse/ne	egiect, or	

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						<u>). 0938-03</u>		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMF	SURVEY		
		345263	B. WING			C 1 <b>23/2018</b>		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		23/2010		
				3195 OLD MURPHY ROAD				
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		FRANKLIN, NC 28734				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	NOF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO DATE		
F 835	Continued From page	a 136	F 83	35				
		abuse, neglect, and staff	1.00	supervision issues.				
	burnout. After 10/19/1	18, no staff, agency, or		Beginning 10/19/18, the				
		e allowed to work until the		nurse will present the ir				
		ed. The in-service with be		comments, supervision				
		ientation, including agency		audit trends to the IDT	-			
	and contracted staff.			committee for six mont				
	On 10/10/18 the DOI	N, QI nurse or SF nurse		QI committee will focus residents□ well-being,	· •			
		eek reviews of the nursing		provision of medication				
	24-hour report sheets			neurological checks thr				
		s to the physician/NP in the		communication. The a				
		/hyperglycemic episodes,		DON will present the da	aily IDT and			
	neurological checks,			monthly QI committee r to the quarterly QAPI c	ecommendations			
	On 10/19/18. the adm	ninistrator initiated multiple		additional recommenda				
	audit tools which will			monitoring and continue				
		ment heads (DON, QI nurse,		The QAPI committee w	•			
	SF, social worker, die	etary, activities): the		consulting with the QIO	until substantial			
	assistant dietary man	ager, activity director, and		compliance is achieved				
	weekend manager-or			The administrator will b	-			
	supervision observati			implementing this plan				
		Is tool, the social worker will		ensure any issues of fa				
		rviews with interviewable		resident with dignity an				
	residents to ensure n	o abuse occurred. QI vill complete five times per		promote well-being will through additional root				
		t Tool to ensure diabetic		process correction, train				
		ig insulin as ordered by the		monitoring.	mig, and			
	physician and medica							
	On 10/22/18, the adm	ninistrator, other department						
		facility consultants began						
		terdisciplinary team (IDT)						
		root cause analysis using						
	the "5-Whys" process							
		information and lack of						
	access to needed res	root cause of why the facility						
		tes and processes in place						
	i aneu to nave resourt	200 and processes in place	1			1		

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FOR	D: 11/30/2018 MAPPROVED O. 0938-0391	
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345263	B. WING			C 10/23/2018		
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
	ALLEY NURSING AND R	EHABILITATION CENTER		-	3195 OLD MURPHY ROAD FRANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	I IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 835	Continued From page treatment to promote 3. What measures a practice will not occur On 10/11/18 - 10/15/7 consultants mentored nurse and SF on whe corporate policies, pro- checklists. The corpor assisted with drafting neurological checks, insulin administration purpose was to instru- basic nursing care an manner which promo On 10/19/18, the DOI nurse initiated an edu expectation for all reg licensed practical nur is blood glucose mon administration as ordic checking the emerger backup, and notificati On 10/19/18, the adm SF, Vice President of corporate consultant audit tool results wee validate the facility ha with the means to atta	e 137 resident well-being. will be put into place or ade to ensure the deficient ". I8, the corporate nurse I the administrator, DON, QI are to find and access locedures, and action brate nurse consultants also in-services to include: falls, blood glucose monitoring, , and abuse/neglect. The ict facility staff to provide id treatment to residents in a tes well-being and respect. N, the QI nurse, and SF incation to set the DON's pistered nurses (RNs), and ses (LPNs). The expectation itoring and insulin ered by the physician, ncy drug kit (EDK) for a on of the physician/NP.		835	DEFICIENCY)	PRIATE		
	president, and/or corp the bottom right corne date as validation of r with the administrator continue to be provide	porate consultant will initial er of the audit tools with the review. On-going mentoring and administrative team will ed by the Vice President of nsultant team at a minimum						

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	D: 11/30/2018 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		345263	B. WING			C 10/23/2018		-
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE			
	ALLEY NURSING AND R	EHABILITATION CENTER	3195 OLD MURPHY ROAD		5 OLD MURPHY ROAD			
				FR	ANKLIN, NC 28734			
(X4) ID     SUMMARY STATEMENT OF DEFICIENCIES       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL       TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFI TAG	x	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 835	the Vice President of Quality Improvement requested mentoring recommendations. Of be provided to the ad administrative team b 10/26/18 during a fac On 10/21/18, the corp provided information cause and effect (fish chart, and/or "5 Whys (RCA) will be used to real causes for showe incontinent care not p checks, blood glucos administration, and al resident well-being ar information and root-ou used by the IDT and to down to identify areas On 10/22/18, the adm with the QIO to impro- management and see changes leadership of safe, healthy, and res- residents. 4. How the facility p performance to make sustained (include da will be competed). Beginning 10/11/18, to communication during interdisciplinary team education, posted rer ensure the facility pro-	In 10/20/18 and 10/22/18, Operations contacted the Organization (QIO) and assistance monitoring in-going mentoring will also ministrator and by the QIO beginning ility visit. Dorate nurse consultant on how a utilization of the abone) diagram, Pareto 5" Root Cause Analysis help the facility uncover the ers not being offered, provided, falls, neurological e monitoring, insulin buse/neglect to promote nd respect. The provided cause analysis tools will be the QI committee to drill s needing improvement. ninistrator will begin working we effective leadership and ek guidance on how an make to implement a spectful environment for the plans to monitor its e sure solutions are tes when correction action the facility increased e form of: verbal g in-services and daily (IDT) meetings, written ninders, and audit forms to	F	335				

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	TEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION         PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING		CONSTRUCTION	(X3) DATE COMPI		
AND PLAN OF	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	A. BUILDING		
		345263	B. WING		C 10/23/201	
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	DDRESS, CITY, STATE, ZIP CODE	
MACON V	ALLEY NURSING AND R	REHABILITATION CENTER		95 OLD MURPHY ROAD RANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 835	dignity and respect al well-being. The IDT, will continue to monit factors causing the fa- related stemming from nursing care, abuse/r issues. Beginning 10/19/18, t present the in-service supervision observati IDT and monthly QI of The IDT and QI comr improving residents' y provision of medication neurological checks t communication. The will present the daily committee recommer QAPI committee for a for monitoring and co QAPI committee will of QIO until substantial The administrator will implementing this pla issues of failure to pro- addressed through ac process correction, tr	nd the means to resident QI and QAPI committees or the facility to identify other ailure to communicate issues m training, staffing, basic neglect, or supervision the DON, and QI nurse will e/mentoring comments, ions, and audit trends to the committee for six months. mittee will focus on well-being, including the on as ordered and hrough developing administrator and/or DON IDT and monthly QI ndations to the quarterly additional recommendations intinued compliance. The continue consulting with the compliance is achieved. I be responsible for in of correction to ensure any ovide a resident with dignity	F 835			
	demonstrated they have	taff were interviewed and ad been trained on QI. was removed effective				

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