DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			FORM APPR	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938	6-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	(
		345263	B. WING		R-C 01/05/201	9
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>
MACON V	ALLEY NURSING AND F	EHABILITATION CENTER		95 OLD MURPHY ROAD		
	l			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 CORR (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLI	LETION
F 000	INITIAL COMMENTS	i	F 000			
	Service Regulation, N Certification conducted the deficiency cited o	The Division of Health Aursing Home Licensure and ed an onsite revisit. While in the complaint investigation ected effective 12/07/18 the compliance.				
	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE	
	cally Signed				01/21/2	

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.

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			FOI	RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CO	TE SURVEY MPLETED
		345263	B. WING			R-C 1/05/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		1/05/2019
				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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00	2		
F 550 SS=D	Service Regulation, N Certification conducte some deficiencies citu investigation on 10/23 12/05/18 the facility re	3/18 were corrected effective emains out of compliance. cise of Rights	F 55(	5		2/4/19
	self-determination, an access to persons an	ght to a dignified existence, nd communication with and				
	with respect and dign resident in a manner promotes maintenance	and in an environment that ce or enhancement of his or ognizing each resident's lity must protect and				
	access to quality care severity of condition, must establish and m practices regarding tr	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.				
		right to exercise his or her f the facility and as a citizen				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE
Electroni	cally Signed					01/28/2019

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/13/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1. 7	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345263	B. WING		R-C 01/05/2019
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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 550	§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 facilit rights and to be supple exercise of his or her subpart. This REQUIREMENT by: Based on observatio and staff interviews th residents in a dignifie exposed resident, ent without obtaining perr enter and not verifying assistance for 3 of 6 s for dignity (Resident # The findings included 1. Resident #28 was 11/04/17 with diagnos major brain injury. Th Minimum Data Set (M 11/22/18 revealed Re cognitive impairment assistance with her an MDS also indicated R behaviors of rejecting On 01/05/19 at 3:56 F made from the hallwa her right side in her u the bottom half of her	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 ans, record reviews, resident the facility failed to treat d manner by not covering an tering resident rooms mission from the resident to g which resident required sampled residents reviewed #28, #15 and #6). : admitted to the facility on ses of seizure disorder and e most recent quarterly IDS) assessment dated sident #28 had severe and required extensive ctivities of daily living. The tesident #28 had no reare. PM an observation was by of Resident #28 lying on nmade bed sleeping with	F 550	F550 Resident Rights/Exercise of Rig How will corrective action be accomplished for those residents four be affected by the deficient practice? Resident #6 and #15 have no further concerns. Resident #28 was provided privacy up observation by the facility staff. Staff member identified during survey resident #15 is no longer is employed How will facility identify other resident having potential to be affected by the same deficient practice? Residents residing in the facility were interviewed regarding resident rights. Measures to be put into place or syste changes made to ensure that the defi practice will not recur? Licensed and non-licensed facility sta	nd to bon by s emic cient

Facility ID: 923019

If continuation sheet Page 2 of 40

					OMB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
			A. BUILDING		R-C
		345263	B. WING		01/05/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/00/2013
				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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE COMPLETIC
F 550	Continued From page	e 2	F 55	0	
		bove her waist and a brief		were re-educated by 2/4/2019 re	eaarding
	that was visible from			the F550 Resident Rights/Exerc	
		-		Rights specific to treating reside	nts in a
		dent #28 from the hallway		dignified manner; maintaining th	
		at 4:00 PM, at 4:07 PM, at		by ensured they are covered, kn	•
		and at 4:20 PM revealed		and asking to enter residents roo	
	she was lying in bed uncovered and expos			the corporate clinical nurse cons and the Staff Development Direct	
		ident's exposed legs and her		Education included hands on sc	
	brief were observed f			and interactive training sessions	
	-	on 01/05/19 from 4:00 PM to		How the facility plans to monitor	
		nembers and one resident		performance to make sure that s	solutions
	-	ss by Resident #28's opened /ing in her bed uncovered		are sustained?	
	-	rso and brief exposed. The		The Department Managers and/	or
		who passed by the resident's		designee began monitoring resid	
		e to cover the resident to		on 1/21/2019 with a Compliance	
	protect her from being	g exposed to others.		Monitoring Tool that includes ob	
				of resident privacy, knocking on	the
		PM observed the Corporate		resident doors, and maintaining	.
		urse (CQAN) knocked on		resident⊡s dignity by covering if	
		and entered the room. vith the CQAN on 01/05/19 at		Monitoring includes 10% of the of 3x/week times 4 weeks, then we	
		the pulled Resident #28's		weeks.	
		ise from the hallway she			
	observed that the res	-		Results of the monitoring tool wi	ll be
		-		brought to the stand-down meet	ing 5
		vith the Director of Nursing		times/weekly x 4 weeks, then we	-
	. ,	t 4:24 PM she stated she		weeks, the administrator will disc	
		look into each resident's		findings with the Manager and/o	r
	exposures. The DON	to monitor for issues like		Designee.	
		dent #28's privacy curtain to		Results of the audits will be pres	ented to
	prevent her from beir			the QAPI meeting monthly x3 m until a time determined by the Q	onths or
	During an interview w	vith Nurse Aide (NA) #5 on		members for sustained compliar	
	-	she stated on 01/05/19 she			
		#28 was lying in her bed		The Interdisciplinary Team Mem	bers are

Facility ID: 923019

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TI	IPI F	CONSTRUCTION	(X3) DATE	0. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,			· /	PLETED
						R	-C
		345263	B. WING			01/	05/2019
NAME OF P	ROVIDER OR SUPPLIER				TREET 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETIO DATE
F 550	Continued From page	e 3	F 5	50			
		red but she wanted to take			responsible for the Plan of Correction	and	
	-	e that she was using back to			the Administrator is responsible for		
	the dayroom before s	she provided care to A stated when she went			sustained compliance.		
		's room someone had			Date of Compliance 2/04/2019.		
	already closed her do						
	-	vith Nurse #7 on 01/05/19 at					
		he was not aware that					
		posed and uncovered while she would have expected the					
		f they were aware of it.					
	2. Resident #15 was	admitted to the facility on					
	-	ses which included diabetic					
		racts and blindness in both nt quarterly Minimum Data					
		ent dated 10/08/18 revealed					
	he was cognitively int						
	assistance with most and his vision was se	of his activities of daily living everely impaired.					
	On 01/02/19 at 5:50 I	PM Resident #15 was					
		oudly "get this d food out of					
		at me every time she comes					
	rush to Resident #15	member were observed to s room.					
	During an interview w						
		I he explained that he					
		the previous evening I not know her name) who					
	delivered his supper	tray to his room "just banged					
		and said here is your food."					
		the girl did not knock on his e into his room and that was					
		y that she had "done me that					
	way." The Resident of	continued to state the staff					
	came into his room a	II the time uninvited and it					

Facility ID: 923019

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CENTER	-	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA				FORM	0: 02/13/2019 1 APPROVED 0: 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	· ,			• •	LETED
		345263	B. WING				05/2019
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STAT	E, 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 CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 550	room was his home. On 01/05/19 at 12:18 conducted with the fa- one of the staff memb #15's room on the ever Scheduler stated Ress of Nursing (DON) (wh same time as she did when she came into h even knock on his doo Scheduler stated she person was that Reside During an interview w (DON) on 01/05/19 at staff member that Ress entered his room una 01/02/19 in a loud ma The DON stated she would knock on Reside resident's doors and w they entered a reside 3. Resident #6 was at 4/21/09. The quarter 10/08/18 revealed Re impairment and requin assistance for all active During an interview of 11:18 AM, Resident # headache and was of at 11:21 AM. While c Resident #6, Nurse A door and entered the	PM an interview was cility's "Scheduler" who was bers that went into Resident ening of 01/02/19. The ident #15 told the Director to went into the room at the ) that the girl was too loud his room and that she did not or before she entered. The did not know who the staff dent #15 referred to. With the Director of Nursing : 4:24 PM, she explained the sident #15 referred to who nnounced on the evening of inner was a new employee. expected that all employees dent #15's door and all wait for an invitation before nt's room. dmitted to the facility y Minimum Data Set dated sident #6 had mild cognitive red supervision to limited vities of daily living (ADL's). In 01/03/19 beginning at 6 stated she had a beerved to use her call light ontinuing the interview with ide (NA) #10 opened the room without knocking or	F 550				
	announcing her prese	ence and went directly to the #10 was overheard telling					

Facility ID: 923019

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 02/13/2019 MAPPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		345263	B. WING			R-C 1/ <b>05/2019</b>
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIF		1/00/2013
			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 PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE	(X5) COMPLETION DATE
F 550	Resident #6's roomm get another NA to hel back. NA #10 exited to or acknowledging F returned to the room to to the call light station off. Resident #6 then call light for herself nd During an interview of #10 stated she had be that Resident #6's roo so she entered the ro roommate's bed. NA room assuming the lig roommate. NA #10 a protocol was to knock but she just forgot to o During an interview of housekeeper stated s the hallway for Reside NA that assistance wa housekeeper stated s person needed help b that information. During an interview of Resident #6 stated th room without knocking stated it irritated her t time to knock on the o room. She also state call light, but when sh medication. Resident does use her call light it's for her roommate	ate that she was going to p her and she would be right the room without speaking Resident #6. NA #10 with a second NA and went on the wall and turned it stated she had used the ot her roommate. In 01/03/19 at 11:31 AM, NA een told by a housekeeper ommate needed assistance, om and went directly to the #10 stated she entered the ght was for Resident #6's Iso stated the proper a on the door before entering do it. In 01/03/19 at 11:45 AM, the she had seen the light on in ent #6's room and told the as needed in that room. The she did not specify which because she did not know In 01/05/19 at 9:27 AM, e NA's often entered her g. Resident #6 further hat the NA's did not take the door before they entered her d she hardly ever used her re did it was usually for pain t #6 further stated when she t the staff usually assume because her roommate throughout the day to	F 550			

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	): 02/13/201 / APPROVEI ). 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345263	B. WING		R-C 01/05/2019	
	ROVIDER OR SUPPLIER ALLEY NURSING AND R	EHABILITATION 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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 550	Continued From page	9 6	F 55	50		
{F 561} SS=D	Director of Nursing (E was for all staff to know resident's room and w invitation to enter and resident needs assist resident's room. Self-Determination CFR(s): 483.10(f)(1)- §483.10(f) Self-detern The resident has the promote and facilitate through support of resident has the set of the set o	vait for a response or an a all staff should verify which ance when entering a (3)(8) mination. right to and the facility must e resident self-determination sident choice, including but ts specified in paragraphs (f) s section. ident has a right to choose (including sleeping and care and providers of health ent with his or her interests, an of care and other of this part. ident has a right to make s of his or her life in the cant to the resident. ident has a right to interact community and participate in both inside and outside the	{F 56	1}		2/4/19

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/13/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345263	B. WING		R-C 01/05/2019
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	01/00/2010
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER	3'	195 OLD MURPHY ROAD	
			F	RANKLIN, NC 28734	1
(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 CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
{F 561}	Continued From page	e 7	{F 561}		
	facility.				
		is not met as evidenced			
	by:				
		n, record reviews, staff and e facility failed to honor the		561 Self-Determination	
		vater at bedside for 1 of 4		How will corrective action be	
	sampled residents rev			accomplished for those residents fou	nd to
	(Resident #21).			be affected by the deficient practice?	
	The findings included	:		Resident #21 was provided fresh ice water upon notification.	
		mitted to the facility on			
		ses which included chronic		How will facility identify other residen	
		y disease (COPD). The Minimum Data Set (MDS)		having potential to be affected by the same deficient practice?	
		/30/18 revealed Resident		same dencient practice :	
		on and required supervision		Facility residents were observed to e	nsure
		ities of daily living. The MDS		they had fresh ice water and/or fluids	
	also indicated Reside	nt #21 received oxygen.		their bedside as ordered; services provided accordingly.	
	On 01/05/19 at 3:23 F	PM during an interview with			
	Resident #21 she sta			Measures to be put into place or syst	emic
		to treat her COPD and the		changes made to ensure that the def	icient
		ntinuous oxygen, her mouth		practice will not recur?	
		ad requested ice water be		Lippopod and unlippopod staff	
		Resident #21 explained that les (GCA's) were supposed		Licensed and unlicensed staff were re-educated by 2/4/2019 regarding Factorian states the states of	561
		but she ended up having to		Self-Determination, specific to provid	
		ost every day because it was		water at resident s bedside by the	
	not being done and th			corporate nurse consultants and the	Staff
	course." Resident #2	1 stated that eairler in the		Development Director. New hires will	
	-	urse Aide (NA) #4 to get her		receive the education during their	
		use there were no GCA's on		orientation to the facility. Education	
	her hall today.			included hands on scenarios and interactive training sessions.	
	Interview with NA #4	on 01/05/19 at 3:51 PM			
		21 had asked him to get her		How the facility plans to monitor its	
		efore dinner. The NA stated		performance to make sure that solution	ons
	her water pitcher was	approximately 1/4 full with		are sustained?	

STATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>`</b> ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345263	B. WING		R-C 01/05/2019		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
MACON	ALLEY NURSING AND R	REHABILITATION CENTER	3195 OLD MURPHY ROAD FRANKLIN, NC 28734				
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIO		
{F 561}	water and there was ice left in her water pi he was assigned to fl work on 01/05/19 at 2 the ice water had bee hall or not. An interview conducted 4:00 PM revealed she hall on the 7-3 shift a pass out ice water to they got behind in the completing their tasks GCAs usually passed did not have a GCA of Interview with NA #6 stated the GCAs usua they did not have a GCA of NA admitted Residen water" but they could because they got ber could not get to it. Th informed the nurse th able to pass out ice water Observation of the Da Shift 01/05/19 revealed (GCAs) were schedu Interview with the Dir 01/05/19 at 4:24 PM responsibility of the G water and it should be the shift. The DON ep there were no GCAs was the NAs response	maybe two pieces of melted itcher. The NA explained that oat halls when he came into 11:00 AM and did not know if en passed on Resident #21's ed with NA #5 on 01/05/19 at e worked on Resident #21's nd admitted they did not all of the residents because eir work and ended up is late. The NA stated the d out the ice water, but they on the hall that day. on 01/05/19 at 4:07 PM ally passed out ice water but GCA on the hall today. The t #21 was "big on having ice not pass out the ice water hind on the hall tasks and e NA stated she should have hat they were not going to be vater. ally Assignment Sheet 7-3 ed no Geriatric Care Aides led. ector of Nursing (DON) on	{F 561	<ul> <li>The Department Managers and/or designee began monitoring on 1/2 monitoring 10% of the resident cerlice Water at bedside and within resident to stard-down meeting 52 weeks.</li> <li>Results of the monitoring tool will be brought to stand-down meeting 52 weeks, then weekly x8 weeks. It of the on-going audits will be present the QAPI meeting x3 months or unitime determined by the QAPI memory for sustained compliance.</li> <li>The Interdisciplinary Team Member responsible for the Plan of Correct the Administrator is responsible for sustained compliance.</li> <li>Date of Compliance 2/04/2019</li> </ul>	1/2019 Isus for ach, k8 De k/weekly Results ented to til a lbers rs are ion and		

If continuation sheet Page 9 of 40

	-	ID HUMAN SERVICES MEDICAID SERVICES			FC	TED: 02/13/201 DRM APPROVE <u>NO. 0938-039</u>	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY DMPLETED R-C	
		345263	B. WING _			ਲ-੮ 01/05/2019	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, 3195 OLD MURPHY ROA FRANKLIN, NC 28734	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 561} {F 607} SS=D	the oncoming shift. Develop/Implement A CFR(s): 483.12(b)(1) §483.12(b) The facilit implement written pol §483.12(b)(1) Prohibi neglect, and exploitat misappropriation of re §483.12(b)(2) Establi to investigate any suc §483.12(b)(2) Establi to investigate any suc §483.12(b)(3) Include paragraph §483.95, This REQUIREMENT by: Based on record revi facility failed to opera procedures in the are allegation of abuse w immediately report th staff abuse during can resulted in a delay in an allegation of abuse residents reviewed for (Resident #18). Findings included: A review of the facility Misappropriation of R dated 01/2009 with a revealed in part: The	et done they should inform abuse/Neglect Policies -(3) y must develop and licies and procedures that: at and prevent abuse, ion of residents and esident property, sh policies and procedures ch allegations, and e training as required at - is not met as evidenced iews and staff interviews the tionalize abuse policies and a of staff reporting of an hen staff did not e resident's allegations of re to the administrator which the facility's investigation of e for 1 of 3 sampled r abuse and neglect / Abuse, Neglect, or lesident Property Policy revised date of 03/10/17	{F 5 {F 6	F607 Develop/Ir Policies How will correctiv accomplished for be affected by th Resident #18 rec evaluation and w the allegation. How will facility ic having potential is same deficient pi Facility residents	r those residents found to e deficient practice? ceived a head-to-toe skin vas interviewed regarding dentify other residents to be affected by the ractice? were interviewed by the garding any allegations	2/4/19	

Facility ID: 923019

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		NO. 0938-03 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	MPLETED
			A. BOILDING			R-C
		345263	B. WING			)1/05/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
				3195 OLD MURPHY ROAD		
MACON V	ALLEY NURSING AND R	REHABILITATION CENTER		FRANKLIN, NC 28734		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLETIO DATE
{F 607}	Continued From page	e 10	{F 607	3		
	misappropriation of p	roperty. Any employee who		Measures to be put into place	ce or systemic	
		s that abuse, neglect,		changes made to ensure the		
	exploitation, or misap	propriation of property has		practice will not recur?		
		ately report the alleged				
	incident to their super	rvisor, who will immediately		Licensed and unlicensed sta	aff were	
		the Administrator. Failure to		re-educated regarding		
	report any concern re	<b>U</b>		Development/Implementation		
	exploitation, abuse, o			Abuse/Neglect Policies spec		
		disciplinary action and		to reporting allegations of al		
	possible termination of			the abuse coordinator, proc		
		onsible to ensure that		reporting, and timeframes re		
	-	neglect, exploitation, or		corporate nurse consultants		
		roperty and injuries of		Development Coordinator. E		
	unknown origin are in	ivestigated.		included hands on scenario		
	Desident #40 mes ed			interactive training sessions		
		mitted to the facility on		will be completed by 2/04/20		
		ses which included heart		members will not be allowed		
	failure, peripheral vas			without receiving the educat reporting for their shift. New		
	and dementia.	abetes, respiratory failure		receive the education during		
	anu uementia.			orientation to the facility.	y inen	
	A review of a care pla	an dated 06/10/18 revealed a		onentation to the facility.		
		Resident #18 had acts		How the facility plans to mo	nitor its	
		propriate behavior and was		performance to make sure t		
		treatment and the goals		are sustained?		
		sident #18 would receive				
		es and preferences. The		Department managers and/	or designee	
	interventions were lis			will monitor abuse prevention		
	behaviors to Nurse a			notification utilizing a compl		
		<b>,</b>		monitoring tool. The monitor		
	A review of the quarter	erly Minimum Data Set		includes interview questions		
		8 revealed Resident #18 was		staff regarding abuse preve		
		in cognition for daily decision		reporting. On 1/21/2019 the		
		so revealed Resident #18		began and will continue 3x/v		
		ssistance for bed mobility,		weeks, then weekly for 8 we		
		pileting and hygiene and no		-		
		ehaviors were indicated.		Results of the monitoring to	ol will be	
				brought to the stand down n		
	A	24 Hour Report indicated the		5x/weeks times 4 weeks, ar		

Facility ID: 923019

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/13/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345263	B. WING		R-C 01/05/2019
	ROVIDER OR SUPPLIER	EHABILITATION 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
{F 607}	to Resident #18 on 12 section labeled Allega "Resident allegation of Details of Physical or revealed a handwritte change in affect." and the Administrator and A review of a handwrit which was included w the initial 24 hour rep Resident #18 made a 12/07/18 about NAs a them and "they were me." The statement f witnessed Resident # medication pass and mean or to kick Resid PM. The statement a went into Resident #1 5:45 AM to check his complaints. An attempt to contact 10:45 AM was unsucce A review of a handwrit Aide (NA) #7 with no included in a folder w dated 12/07/18 revea #18's room and no or resident. An attempt to contact AM was unsuccessfu	e of an incident which related 2/07/18 at 11:45 PM. A ation Details revealed of abuse." A section labeled Mental Injury/Harm en statement "No harm or d the report was signed by d dated 12/10/18. Atten statement by Nurse #10 vith documents in a file with ort dated 12/07/18, revealed accusations to Nurse #10 on and stated he was hurt by being mean" and "kicked further revealed Nurse #10 et 8 from the hallway during did not observe NAs to be dent #18 on 12/07/18 at 8:30 also revealed Nurse #10 et 8 from on 12/08/18 at blood sugar and he had no et Nurse #10 on 01/05/19 at cessful. Atten statement by Nurse date or time but was ith the initial 24 hour report led she went in Resident he "kicked" or hit the et NA #7 on 01/05/19 at 10:48 l. Atten statement by NA #8	{F 607}	times 8 weeks. Results of the audits will be present the QAPI meeting x3 months or untime determined by the QAPI mem for sustained compliance. The Interdisciplinary Team Member responsible for the Plan of Correcting the Administrator is responsible for sustained compliance. Date of Compliance 2/04/2019.	til a bers rs are on and

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 02/13/2019 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			R-C / <b>05/2019</b>
NAME OF PI	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 SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
{F 607}	dated 12/07/17 revea and did not kick Resid During a telephone in AM, NA #8 explained facility for a couple of abuse and neglect tra by the Director of Nur aware she was suppor abuse to the Nurse im she did not recall deta Resident #18 had acc and kicked him but sh the hallway when it ha stated she had writter had been asked to wr A review of the docum there was no stateme Resident #18 as part regarding his allegatio During an interview of Resident #18 stated a him in the past but he did not recall if he rep had not seen the NA i he did not recall the d 12/07/18. A review of a facsimile revealed the initial 24	th the initial 24 hour report led she worked on 12/07/18 dent #18. terview on 01/05/19 at 11:02 she had only worked at the months and had received ining during her orientation sing. She stated she was used to report allegations of mediately. She explained ails of the incident when cused NAs of being mean the did recall a Nurse was in ad happened and NA #8 in a statement because she ite one.	{F 607}			
	12/10/18. A review of a 5 Workin	by the Administrator on ng Day Report with fax 2/16/18 at 4:30 PM in a				

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		IO. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	IPLETED	
						R-C	
		345263	B. WING			1/05/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
				3195 OLD MURPHY ROAD			
MACON	ALLEY NURSING AND	REHABILITATION CENTER		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 (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
{F 607}	Continued From non	- 10	(5.00				
{F 007}	1 0		{F 607	}			
		nal Allegation Details					
		18 alleged abuse from a staff lent care. The report further					
		ff were in the room helping					
		id no witnesses saw any					
		ection labeled Witness					
		Nurse #10 was listed as a					
	witness.						
	-	on 01/05/19 at 5:53 PM, the					
		ned she was the Abuse					
		lained it was reported to her					
		onday 12/10/18 that Resident					
		uring care and he reported and had kicked him.She					
		eived the report she started					
		d gathered information and					
		ion. She explained she filed					
		ecause it had not been					
	· ·	e agency within 24 hours					
	after Resident #18 a	lleged staff had abused him.					
	She further stated st	aff should have reported an					
		on the day it happened on					
		ned Nurse #10 did not follow					
		ocedures to report allegations					
		#10 who was employed by a					
		nger worked at the facility. r expectation staff should					
		cident as an allegation of					
	-	ened so an investigation could					
		ght away. She further stated					
		nd procedures were very					
	regulatory and were						
		ained she felt the facility staff					
		r job of reporting allegations					
		t and they needed to put					
	training at a level that						
		d practice in their daily					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/13/ FORM APPRC OMB NO. 0938-0	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING		
		345263	B. WING		R-C 01/05/2019	
	Rovider or Supplier ALLEY NURSING AND R	EHABILITATION CENTER	3	TREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLE	
{F 609} SS=D	Reporting of Alleged CFR(s): 483.12(c)(1)		{F 609}		2/4/19	
	§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:					
	involving abuse, negl mistreatment, includin source and misappro	that all alleged violations ect, exploitation or ng injuries of unknown priation of resident property, itely, but not later than 2				
	hours after the allegat that cause the allegat serious bodily injury, the events that cause	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				
	the administrator of the officials (including to adult protective service for jurisdiction in long accordance with State	ne facility and to other the State Survey Agency and ces where state law provides -term care facilities) in e law through established				
	designated represent	administrator or his or her ative and to other officials in				
	Survey Agency, within incident, and if the all appropriate corrective	e law, including to the State n 5 working days of the eged violation is verified e action must be taken. is not met as evidenced				
	Based on record rev	iews and staff interviews the an allegation of abuse to		F609 Reporting of Alleged Violation	ns	
	the state agency with reported an allegation	in 24 hours when a resident n of staff abuse during care wiewed for abuse and		How will corrective action be accomplished for those residents for be affected by the deficient practice		
		J).		Resident #18 received a head to to	e skin	

Facility ID: 923019

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	· · · ·	ATE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		Ċ	OMPLETED	
						R-C	
		345263	B. WING			01/05/2019	
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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
{F 609}	Continued From page	<u>)</u> 15	{F 609	n			
[. 000]	Findings included:	, 10	1 008	evaluation and was intervi	ewed recording		
				the allegation.	eweu regarunny		
	Resident #18 was ad	mitted to the facility on					
		ses which included heart		How will facility identify oth	ner residents		
	failure, peripheral vas			having potential to be affe	cted by the		
		abetes, respiratory failure		same deficient practice?			
	and dementia.			Facility residents were inte	ruiowed by the		
	A review of the quarte	erly Minimum Data Set		Facility residents were inte facility Social Worker rega			
		B revealed Resident #18 was		allegations of staff mistrea			
		in cognition for daily decision					
	making. The MDS als	so revealed Resident #18		Measures to be put into pl	ace or systemic		
		sistance for bed mobility,		changes made to ensure t	hat the deficient		
	transfers, dressing, to	oileting and hygiene.		practice will not recur?			
	A review of an initial 2	24 Hour Report revealed the		The Administrator or Desig	nee will		
		of an incident which related		submitting the Initial Allega			
	to Resident #18 on 12	2/07/18 at 11:45 PM. A		Health Care Personnel.			
	section labeled Allega						
	-	of abuse." A section labeled		Licensed and unlicensed s			
	Details of Physical or			re-educated by 2/04/2019	• •		
	change in affect."	n statement "No harm or		Reporting allegations of Al within the required timefra	-		
	change in alleet.			members that have not co			
	A review of a handwri	tten statement by Nurse #10		education by 2/4/2019 will	•		
		vith documents in a file with		before able to work their n			
		ort dated 12/07/18, revealed		shift. Newly hired staff will			
		ccusations to Nurse #10 on		education during their facil			
		and stated he was hurt by		Education included hands			
		being mean" and "kicked further revealed Nurse #10		and interactive training see	5510115.		
		18 from the hallway during					
		did not observe NAs to be		How the facility plans to m	onitor its		
		lent #18 on 12/07/18 at 8:30		performance to make sure	that solutions		
		llso revealed Nurse #10		are sustained?			
		8's room on 12/08/18 at		The Administrates and D	oton of Nursham		
		blood sugar and he had no		The Administrator and Dire will audit each other regard	-		
	complaints.			submission of allegations			

Facility ID: 923019

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	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	, ,		COMPLETED
		345263	B. WING	R-C 01/05/2019	
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	TATEMENT OF DEFICIENCIES DY 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 COMPLETIC
{F 609}	Continued From page	e 16	{F 609	n l	
. ,		t Nurse #10 on 01/05/19 at	(	Health Care Personnel Registry.	
	Aide (NA) #7 with no included with docume hour report dated 12/ Resident #18's room the resident. An attempt to contact AM was unsuccessful A review of a handwr with no date or time B documents in a file w dated 12/07/17 revea and did not kick Resi During an interview of #8 explained she had for a couple of month and neglect training of Director of Nursing. she was supposed to to the Nurse immedia not recall details of th #18 had accused NA him but she recalled when it had happene the Nurse was. A review of the docum statement or interview part of the facility's in allegation of staff abu	ritten statement by NA #8 but was included with vith the initial 24 hour report aled she worked on 12/07/18 ident #18. on 01/05/19 at 11:02 AM, NA d only worked at the facility hs and had received abuse during her orientation by the She stated she was aware o report allegations of abuse ately. She explained she did he incident when Resident as of being mean and kicked a Nurse was in the hallway ed but did not remember who ments revealed there was no w notes with Resident #18 as investigation regarding his use.		The Department Managers and/o designee will monitor Abuse Preve and notification with targeted ques specific to reporting requirements of the compliance monitoring tool. The monitoring tool includes staff interv questions regarding reporting of allegations initiated 1/21/2019, to in 2 staff members 3x weekly x 4 weat then weekly x 8 weeks. The Interdisciplinary Team Member responsible for the Plan of Correct the Administrator is responsible for sustained compliance. Date of Compliance 2/04/2019	tions utilizing ve view nclude eks, ers are ion and
	-	on 01/03/19 at 10:48 AM a NA had been rough with			

		D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 02/13/2019 M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		345263	B. WING			R-C / <b>05/2019</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		103/2013
				3195 OLD MURPHY ROAD		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
TAG {F 609}	Continued From page him in the past but he did not recall if he rep had not seen the NA i he did not recall the d 12/07/18. A review of a facsimile revealed the initial 24 submitted to the state PM and the report wa Administrator on 12/1 A review of a 5 Workin confirmation date 12/7 section labeled Origin revealed Resident #17 member during reside revealed several staff with resident care and abuse. During an interview of Administrator explained Monday 12/10/18 that staff had been mean a stated when she rece 12/10/18 she started a started an investigatio realized an initial 24 h	e 17 did not recall her name and orted it to anyone but he n a while. He further stated etails of the incident on e (fax) confirmation report hour initial report was agency on 12/10/18 at 8:43 s signed by the 0/18. mg Day Report with fax 16/18 at 4:30 PM in a al Allegation Details 8 alleged abuse from a staff ent care. The report further were in the room helping a no witnesses saw any h 01/05/19 at 5:53 PM, the ed she received a report on c Resident #18 had reported and had kicked him. She ived the report on Monday	TAG	DEFICIENCY)	PRIATE	
	the initial 24 hour report informed to cover the she had questioned s stated Resident #18 h and they did not think further stated staff she allegation of abuse or 12/07/18 and the 24 h	ort the day she was facility. She explained when taff about the incident they had behaviors during care to report it as abuse. She				

Facility ID: 923019

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/13/201 FORM APPROVEI OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		345263	B. WING		R-C 01/05/2019
NAME OF PI	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP COD	
MACON V	ALLEY NURSING AND R	EHABILITATION 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 PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION APPROPRIATE DATE
{F 609} {F 656} SS=D	facility policy and proo of abuse to the Admir was employed by a s worked at the facility. expectation staff shou incident as an allegat happened so the initia been faxed within 24 Develop/Implement C CFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The fac implement a compreh care plan for each res resident rights set for §483.10(c)(3), that in objectives and timefra medical, nursing, and needs that are identif assessment. The con describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that a under §483.20, include treatment under §483.2 (iii) Any specialized s rehabilitative services provide as a result of recommendations. If	Nurse #10 did not follow cedures to report allegations histrator and Nurse #10 who taffing agency no longer She stated it was her uld have reported the ion of abuse when it al 24 hour report could have hours of the incident. Comprehensive Care Plan ensive Care Plans cility must develop and hensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's I mental and psychosocial ied in the comprehensive nprehensive care plan must Q- are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 8.10(c)(6). ervices or specialized a the nursing facility will PASARR a facility disagrees with the RR, it must indicate its	{F 609}		2/4/19

Facility ID: 923019

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/13/ FORM APPRC OMB NO. 0938-0	OVED
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED R-C	
		345263	B. WING		01/05/2019	)
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
MACON V	ALLEY NURSING AND R	REHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLE	TION
{F 656}	resident's representa (A) The resident's god desired outcomes. (B) The resident's pre- future discharge. Fac whether the resident's community was asse- local contact agencie entities, for this purper (C) Discharge plans i plan, as appropriate, requirements set forth section. This REQUIREMENT by: Based on observation and staff interviews, t and implement a care 3 residents (Resident care plan for 1 of 4 re- reviewed for comprete The findings included 1. Resident #17 was 10/06/18 with diagnos glaucoma and macula admission Minimum I 10/13/18 indicated Re- vision and had correct further indicated Re- simpairment and requi with most activities of Review of the admission	h the resident and the tive(s)- als for admission and eference and potential for illities must document s desire to return to the ssed and any referrals to s and/or other appropriate ose. In the comprehensive care in accordance with the h in paragraph (c) of this is not met as evidenced in, record review, resident the facility failed to develop e plan for vision care for 1 of t #17) and failed to follow the esidents (Resident #14) hensive care plans. I: admitted to the facility on ses including cataracts, ar degeneration. The Data Set (MDS) dated esident #17 had impaired otive lenses. The MDS ident #17 had mild cognitive ired extensive assistance f daily living.	{F 656	F656 Develop/Implement Con Care Plans How will corrective action be accomplished for those reside be affected by the deficient pr Resident #14 care plan was u no longer requires Intake and IDT Members reviewed reside plan and determined he did no monitoring intake and output. Resident #17 care plan was u reflect her glasses. How will facility identify other thaving potential to be affected same deficient practice?	ents found to ractice? updated and Output. The ent #14 care ot warrant updated to residents d by the	
	wore eye glasses and	tion revealed the resident d had a diagnosis of a urther indicated a care plan		The facility consultant reviewed days of Comprehensive Assess included were 11 residents ide	ssments;	

Facility ID: 923019

If continuation sheet Page 20 of 40

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLETED
		345263	B. WING		R-C
NAME OF PI	ROVIDER OR SUPPLIER	040200		STREET ADDRESS, CITY, STATE, ZI	P CODE 01/05/2019
				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 / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLETI TO THE APPROPRIATE DATE
{F 656}	Continued From page	e 20	{F 656	33	
(,	10	begin addressing vision	1 000	triggered for the Visual C	CAA, 2 of the 11
	concerns for Residen			assessments reviewed r	
				according to the RAI Ma	nual. Care plans
		care plans revealed no care d to address vision for		were updated according	ly.
	Resident #17.			Measures to be put into	
				changes made to ensure	e that the deficient
		Physician's admission (H&P) revealed Resident		practice will not recur?	
		isual acuity and visual field		The Interdisciplinary Tea	m Members that
		revealed Resident #17		contribute to the MDS as	
	stated she "needed e	yeglasses to see."		re-educated by the Corp	orate AVP of
				Clinical Quality and Reir	
		n on 01/03/19 at 11:14 AM,		1/18/19 and 1/22/19 reg	
		served sitting in her room		documentation and care	
	l C	Resident #17 was unable to ad been wearing her glasses		on the comprehensive a include development and	
		ble to see out of them.		of the care plan for visio the care plans as develo	n care following
	During an interview o	n 01/03/19 at 1:11 PM,			r
	Nurse Assistant (NA)	#11 revealed Resident #17		How the facility plans to	monitor its
	had glasses and wore			performance to make su are sustained?	ire that solutions
		n 01/03/19 at 4:28 PM, the iewed the admission MDS		The Interdiscipliners Tes	m Momboro
		t #17 and stated there		The Interdisciplinary Tea and/or designee will mor	
	should have been a c			condition and/or concerr	
		ewed all previously written		change of condition aud	-
		nt #17 to verify if a care plan		care plan revision, and in	
		d resolved but did validate		interventions to maintain	
	no care plan had bee	n created for vision		highest practical, physic	
	problems.			psychosocial well-being.	
	-	n 01/03/19 at 4:35 PM, MDS		will be monitored throug indicated by care plan re	
	Coordinator #2 stated				
		she would go ahead and		Results of the audit tool	
		IDS Coordinator #2 verified AA for Resident #17 but		in stand down meeting 5 weeks, then weekly time	-
		a care plan was not written,		Results of the on-going a	

Event ID: J78Q12

Facility ID: 923019

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		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 02/13/2019 M APPROVED D. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
		345263	B. WING			₹-C / <b>05/2019</b>	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3195 OLD MURPHY ROAD FRANKLIN, NC 28734		01/03/2013	
(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)	OULD BE	(X5) COMPLETION DATE	
{F 656}	During an interview of Director of Nursing (E expectations were for comprehensive, up to resident in his or her 2. Resident #14 was 06/13/15 with a recer hospitalization on 09/ The admission Minim 09/28/18 indicated Re cognitive deficits and activities of daily livin revealed Resident #1 catheter due to Benig (BPH) as well as urin admission Care Area urinary incontinence a urinary catheter and with toileting. Review of the admiss Resident #14 had an elimination with indwe infection - urinary rete the care plan indicate clean, dry and free fro and to be free of urin the interventions was of shift observe and r Review of urinary out days revealed five ins greater time when uri recorded. These day	et an accidental oversight. on 01/05/19 at 1:17 PM, the DON) stated her r care plans to be o date, and reflect the current state. admitted to the facility on nt readmission after a /21/18. num Data Set (MDS) dated esident #14 had mild required assistance with all g. The MDS further 14 had an indwelling urinary gn Prostatic Hypertrophy te retention. Review of the Assessment (CAA) for indicated Resident #14 had d required staff assistance sion care plan revealed "altered pattern of urinary elling cath (foley) at risk for ention, BPH." Goals listed on ed for Resident #14 to be om odor or skin breakdown ary tract infections. One of a "empty drainage bag at end record output." tput for the most recent 30 stances of 12 hours or inary output was not	{F 650	<ul> <li>presented to the QAPI meeting x3 or until a time determined by the 0 members for sustained compliance.</li> <li>The Interdisciplinary Team Membrresponsible for the Plan of Correct the Administrator is responsible for sustained compliance.</li> <li>Date of Compliance 2/04/2019.</li> </ul>	QAPI ce. ers are ction and		

Facility ID: 923019

If continuation sheet Page 22 of 40

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		345263	B. WING				-C 05/2019
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET 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 656}	Continued From page	22	{F 6	56}			
	Resident #14 was obdining room while sitticatheter was observed catheter and tubing were catheter of Nursing (E output sheets for Residays. The DON states the NA's to document urinary output was for During an interview of Nurse Assistant (NA) a catheter that had to shift unless it seemed empty it a second time also stated that she in document his output of sure. NA #6 further seemptying his catheter the site of the site of the second terms of	n 01/03/19 at 6:09 PM, the DON) reviewed the urinary ident #14 for the past 30 ed her expectation was for t on each shift what the total r Resident #14. n 01/04/19 at 1:39 PM, #6 stated Resident #14 had be emptied at least once a d overly full and you might e during the shift. NA #6					
	#3 stated Resident #7 stayed in a privacy ba catheter tubing. NA # the catheter bag when and then checks it ag shift. NA #3 stated he to document the urine but it was possible it h During an interview o	n 01/04/19 at 2:02 PM, NA					
	#12 stated Resident #	#14 had a catheter and of 800-1000 cc's per shift.					

Facility ID: 923019

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	S FOR MEDICARE &				MB NO. 0938-039	
	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION (	X3) DATE SURVEY COMPLETED	
			A. BOILDING		R-C	
		345263	B. WING		01/05/2019	
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
		REHABILITATION CENTER	:	195 OLD MURPHY ROAD		
			1	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 BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLETION DATE	
{F 656}	Continued From page	e 23	{F 656}			
	shift and documented #12 also stated he m	ptied his catheter bag every d what the output was. NA ay have emptied the bag iment Resident #14's output,				
{F 677} SS=D	Coordinator #2 stated information put into the the kardex (system N care needs) but some in. MDS Coordinator that was listed on the for the NA's to "obset end of each shift nor bag was to be emptie ADL Care Provided fr	he care plan flowed over to IA's use to view resident e of it had to be manually put #2 stated the information e care guide had not reflected rve and record output" at the did it indicate the catheter ed at the end of each shift. for Dependent Residents	{F 677}		2/4/19	
	out activities of daily services to maintain personal and oral hy This REQUIREMEN by: Based on observation and staff interviews, fingernail care and ke	is not met as evidenced on, record review, resident the facility failed to provide eep the fingernails clean for		F677 ADL Care Provided for Dependen Residents	t	
	of daily living (Reside			How will corrective action be accomplished for those residents found be affected by the deficient practice?	to	
	05/11/18 with diagno	: admitted to the facility ses which included diabetes		Resident #5 and #18 were provided nail care by the facility staff.		
	and heart failure.			How will facility identify other residents having potential to be affected by the		

Event ID: J78Q12

Facility ID: 923019

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CENTERS FOR MEDICARE & MEI	IUMAN SERVICES			PRINTED: 02/13/2019 FORM APPROVED OMB NO. 0938-0391
	) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345263	B. WING		R-C 01/05/2019
NAME OF PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	·
MACON VALLEY NURSING AND REHABILITATION CENTER			3195 OLD MURPHY ROAD FRANKLIN, NC 28734	
PREFIX (EACH DEFICIENCY MU	IENT OF DEFICIENCIES IST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
that were directed toward lookback period. During an observation or Resident #18 was observ fingernails on both hands each fingernail. During an observation or Resident #18 was observ fingernails on both hands each fingernail. During an observation or Resident #18 was observ fingernails on both hands each fingernail. During an observation or Resident #18 was observ fingernail.	ent #18 had cognitive ensive to total assistance y Living (ADL's). The dent #18 had no rejection revealed no rejection of e some behavioral issues d others during the 01/02/19 at 5:47 PM, yed to have long s with brown debris under 01/03/19 at 10:48 AM, yed to have long s with brown debris under 01/04/19 at 5:53 PM, yed to have long s with brown debris under 01/05/19 at 2:57 PM, yed to have long s with brown debris under 01/05/19 at 2:57 PM, yed to have long s with brown debris under 01/05/19 at 2:57 PM, yed to have long s with brown debris under 01/05/19 at 2:57 PM, yed to have long s with brown debris under	{F 677	<ul> <li>On 1/8/19 The Treatment Nurse completed 100% observation of dependent residents for nail care a provided accordingly. Care Plans w updated to reflect resident intervent based on resident preferences and requirements.</li> <li>Measures to be put into place or sy changes made to ensure that the d practice will not recur?</li> <li>Nursing Staff were re-educated by 2/4/2019 regarding F677 ADL Care Dependent Residents by the corpo clinical nurses and staff developme coordinator. Education included ha scenarios and interactive training sessions including fingernail care a cleanliness of fingernails.</li> <li>How the facility plans to monitor its performance to make sure that solutare sustained?</li> <li>The Department Managers and/or designee will monitor ADL Care del specifically related to fingernail care acleanliness of fingernails for 10% of current census 3x a week x4 weeks weekly times 8 weeks utilizing the compliance Monitoring Tool.</li> <li>Results of the monitoring tool will b brought to stand-down meeting 5 ti weekly times for 4 weeks, then week 8 weeks. Results of the on-going and staff the on-going and th</li></ul>	vere tions care vstemic leficient e for rate ent nds on and utions livery e and f the s, then e mes ekly for

Facility ID: 923019

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			PLETED
		345263	B. WING		R-C	
NAME OF P	ROVIDER OR SUPPLIER	040200		STREET ADDRESS, CITY, STATE, ZIP CODE	01	/05/2019
			3			
MACON V		REHABILITATION CENTER	1	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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
{F 677}	Continued From page	e 25	{F 677}			
	stated his nails were too long and they were dirty, and he could no longer care for them because of his arthritis. NA #13 proceeded to clean the fingernails of Resident #18 and stated she would report to her nurse that his fingernails needed to The Interdisciplinary Team Memb		bers are			
	#9 revealed he had o	5/19 at 3:44 PM with Nurse nly given Resident #18		responsible for the Plan of Correct the Administrator is responsible sustained compliance.		
	-	ince there was a Certified A) on the unit and he had not s were long and dirty.		Date of Compliance 2/04/2019.		
	revealed he gave Re completed 2 capillary checks and he did no #6 also stated he pro did not notice Reside	5/19 at 4:17 PM with CMA #6 sident #18 his oral meds and blood glucose (CBG) of notice his fingernails. CMA bably got task oriented and nt #18's fingernails, but he fingernails when he gives be of care.				
	Director of Nursing (I expectations were du should observe a res	5/19 at 3:59 PM with the DON) revealed her Iring delivery of care a nurse ident's fingernails and needed when the resident is				
	02/18/13 with diagno peripheral vascular d most recent quarterly assessment dated 11 had severe cognitive	isease and dementia. The Minimum Data Set (MDS) /16/18 revealed Resident #5 impairment and required with personal hygiene. The				

Facility ID: 923019

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	0: 02/13/2019 1 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345263	B. WING _					-C 05/2019
NAME OF P	ROVIDER OR SUPPLIER	•		STF	REET ADDRESS, CITY, STATE, ZIP CODE	-		
MACON V	ALLEY NURSING AND R	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 PREFIX TAG	(	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
{F 677}	hygiene and would be on a daily basis. Inter would provide intermi and guidance and wo the portions of the tas attempt. Observation of Resid PM revealed he was brown debris under th hands. Subsequent observat 01/02/19 at 6:43 PM, 01/03/19 at 5:00 PM, 01/04/19 at 1:00 PM revealed the fingerna continued to be uncle underneath them. Interview with Bather revealed Resident #5 which included nail ca Resident #5 was not was cooperative to hi cleaned. Interview with Nursing 01/04/19 at 10:46 AM bathed twice a week during his baths and Interview with NA #3 revealed he had work day and he had not c fingernails. At this tim	on 12/17/18 indicated assistance with personal e neat, clean and odor free cventions included the staff ittent supervision with cues ould discuss with Resident #5 sk that he would be willing to ent #5 on 01/02/19 at 3:21 sitting in the hallway with he fingernails on both of his tions of Resident #5 on 01/03/19 at 2:14 PM, 01/04/19 at 9:33 AM, and 01/04/19 2:50 PM ils on both of his hands ean with brown debris #1 on 01/03/19 at 12:08 PM 6 was bathed twice a week are. The Bather stated one to refuse his bath and is nails being trimmed and g Assistant (NA) #3 on 1 revealed Resident #5 was and received nail care daily as needed. on 01/04/19 at 2:50 PM ked on Resident #5's hall all	{F 67	77}				

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FO	ED: 02/13/2019 RM APPROVEI NO. 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DA CO	TE SURVEY MPLETED
		345263	B. WING			R-C 1/05/2019
	ROVIDER OR SUPPLIER ALLEY NURSING AND F	REHABILITATION CENTER	3.	TREET ADDRESS, CITY, STATE, ZIP COI 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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
{F 677} {F 690} SS=D	me clean his nails". Interview with Nurse revealed she expected to be trimmed and clean his fingernails particul shift. At this time, Nur condition of Resident was in the process of Nurse #8 stated "I wo cleaned". During an interview w (DON) on 01/05/19 a expected Resident #8 Bowel/Bladder Income CFR(s): 483.25(e)(1) §483.25(e) Incontinent §483.25(e)(1) The factor resident who is contin admission receives s maintain continence of condition is or become not possible to mainta §483.25(e)(2)For a re- incontinence, based of comprehensive assess ensure that- (i) A resident who ent (ii) A resident who ent (ii) A resident who ent	aderneath all of his the "I will see if he will let #8 on 01/04/19 at 2:56 PM ed Resident #5's fingernails eaned on his bath days and larly needed cleaned every rse #8 observed the #5's fingernails while NA #3 i cleaning his fingernails. build say they needed to be with the Director of Nursing t 4:24 PM she stated she 5's nails to be kept clean. tinence, Catheter, UTI -(3) nce. cility must ensure that hent of bladder and bowel on ervices and assistance to unless his or her clinical tes such that continence is ain. esident with urinary on the resident's ssment, the facility must ters the facility without an not catheterized unless the dition demonstrates that	{F 677}			2/4/19

Facility ID: 923019

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/13/2019 FORM APPROVED OMB NO. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345263	B. WING		R-C 01/05/2019
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	
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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
{F 690}	Continued From page	e 28 val of the catheter as soon	{F 690	5}	
	as possible unless the	e resident's clinical condition theterization is necessary;			
	receives appropriate prevent urinary tract i	incontinent of bladder treatment and services to infections and to restore			
	continence to the exte	-			
	§483.25(e)(3) For a r incontinence, based of				
		ssment, the facility must			
		t who is incontinent of bowel			
		treatment and services to			
	restore as much norn possible.	nal bowel function as			
	This REQUIREMENT	is not met as evidenced			
	by: Based on record rev	iew, observations, resident,		F690 Bowel/Bladder Incontin	ence
	staff and physician in	terviews, the facility failed to for an indwelling urinary		Catheter, UTI	
		n and to assess the resident		How will corrective action be	
	•	val of the catheter for 1 of 3 or urinary catheters (Resident		accomplished for those reside be affected by the deficient pr	
	The findings included	:		Resident #12'⊡s catheter was discontinued.	3
		ginally admitted to the facility noses that included diabetes		How will facility identify other having potential to be affected	
				same deficient practice?	
	hospital did not have	rge summary from the a diagnosis for urinary r diagnosis for the urinary		On 1/8/19 the RN Consultant 100% audit of residents with validate appropriate diagnosis	catheters to
	catheter.			indwelling foley catheters, and rationale for use.	
	Review of physician's revealed no order for	s orders upon admission an indwelling urinary		Measures to be put into place	e or systemic

Facility ID: 923019

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TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION		NO. 0938-03 ATE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		) íco	MPLETED	
						R-C	
345263		345263	B. WING			01/05/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	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	(EACH CORRECTIVE CROSS-REFERENCED	I OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO DATE	
{F 690}	Continued From page	29	{F 690	3			
. ,	catheter.		(1 000	changes made to ensur	e that the deficient		
				practice will not recur?			
	Review of the care pla	an for Resident #12 dated					
		an altered pattern of urinary		The Director of Nursing	and/or designee		
	elimination with indwe	elling catheter and 2) at risk		will monitor new orders	-		
	for infection due to ur	inary retention.		1/21/2019 for catheters			
	<b>.</b>			audit tool upon admissi			
		an's History and Physical		indwelling urinary cathe			
	present for the use of	B revealed no diagnoses		reviewed for appropriate	-		
	-	irther revealed the following		discontinuance. The res			
		f both bowel and bladder,"		will be reviewed with the			
	-	urination), and "frequency		physician if an appropri	-		
		A second follow-up visit		not available.	0		
	dated 11/19/18 revea	led "patient is continent of					
	both bowel and bladd			Results of the auditing f			
	"frequency and urgen	-		reviewed in stand down	•		
	11/16/18 and 11/19/18 for genitourinary was	8 the physical examination deferred.		weekly times 4 weeks, 8 weeks.	then weekly times		
		Minimum Data Set (MDS)		How the facility plans to	o monitor its		
		led Resident #12 had some and had been admitted from		performance to make sale are sustained?	ure that solutions		
		idwelling urinary catheter.					
		Area Assessment (CAA)		Results of the audits to	ol will be presented		
		2 took medications that		to the QAPI meeting x3	-		
		ence but gave no specific		time determined by the			
	information to addres	s the catheter or		for sustained compliance			
		itoring for the catheter's use					
		. The 14-day MDS dated		The Director of Nursing			
		d the resident had some		the Plan of Correction a			
		along with an indwelling		Administrator is response	sidle for sustained		
		es of diabetes and renal		compliance.			
		ted diagnoses were listed.		Plan of Correction 2/04	/2019.		
	Review of nurse's not	es dated 11/28/18 revealed			2010.		
		iagnosis of urinary retention					
	and continued to have						

Facility ID: 923019

If continuation sheet Page 30 of 40

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345263	B. WING			R-C 01/05/2019	
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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 690}	revealed a urinalysis i was positive for a Urin Review of the physici 12/10/18 revealed Re catheter secondary to Review of nurse's not the catheter was in pl drainage. Review of nurse's not revealed no assess monitoring to assess removal prior to 01/02 During an interview w 01/02/19 at 5:47 PM, and right indicating "n why he had a urinary tubing were observed sitting in a pink basin bag underneath his b Review of nurse's not a late entry note to dis to monitor for urinatio nurse's note dated 01 had occurred yet, the and oral fluids were b Review of nurse's not Resident #12 was inc note from skin wound revealed Resident #1	results dated 12/10/18 had indicated Resident #12 hary Tract Infection (UTI). an's progress note dated sident #12 had a urinary ourinary retention. es dated 01/02/19 revealed ace with clear yellow es and assessments ent had been completed or the need for catheter 2/19. ith Resident #12 on he shook his head to the left o" when asked if he knew catheter. The catheter and d uring this interview to be wrapped in a clear plastic ed. es dated 01/03/19 revealed scontinue the catheter and n and residual. A second /03/19 revealed no voiding bladder was non-distended eing pushed. es dated 01/04/19 revealed ontinent of urine. A second treatment dated 01/04/19 2 was voiding freely.	{F 6	90}			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 02/13/2019 // APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	_		LETED
		345263	B. WING				-C 05/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S		-	
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	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 690}	admission MDS and v diagnosis listed for the catheter but wanted to file to verify if there way During a second inter Coordinator on 01/05, she was must have of have a diagnosis for a the assessment. She recognized it she wou diagnosis from the ph During an interview w 01/05/19 at 12:45 PM stated Resident #12 of a urinary catheter. Th a resident has a urina be a diagnosis and if the catheter. The phy could be removed if e with the resident within scenario and 4 weeks circumstances. Tech of urinary retention ac however he stated off cracks when a reside to setting and he often pieces and in this cas catheter fell through the During an interview w (DON) on 01/05/19 at expectations were for physician upon a reside facility if there was not	verified there was no e use of Resident #12's o look back at his admission as a diagnosis present. view with the MDS /19 at 12:09 PM, she stated verlooked that he did not a catheter when she put it in e further stated if she had uld have requested a hysician. with the physician on 1, he reviewed his notes and did not have a diagnosis for he physician further stated if ary catheter there needs to not, they need to remove sician also stated a catheter everything was going well in 2 weeks in a best-case is if there were extenuating nically there was a diagnosis coording to the physician, ten things fall through the nt is transferred from setting n had to try to pick up the se the diagnosis for the he cracks. with the Director of Nursing t 2:57 PM, she revealed her the nurse to notify the dent's admission to the o diagnosis for an indwelling a diagnosis for the catheter	{F 690	}			

Facility ID: 923019

If continuation sheet Page 32 of 40

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/13/2019 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345263	B. WING		R-C 01/05/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
		REHABILITATION CENTER		3195 OLD MURPHY ROAD	
			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 OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
{F 725}	Continued From page	a 32	{F 725]		
{F 725}			{F 725] {F 725]		2/4/19
{F 725} SS=E	CFR(s): 483.35(a)(1)		{[723]	} }	2/4/19
00-2					
	§483.35(a) Sufficient				
		e sufficient nursing staff with			
		etencies 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			
	and considering the r	-			
		lity's resident population in			
	accordance with the fat §483.70(e).	facility assessment required			
	§483.35(a)(1) The fac	cility must provide services			
		of each of the following			
		a 24-hour basis to provide			
	resident care plans:	sidents in accordance with			
	· ·	ed under paragraph (e) of			
	this section, licensed				
		sonnel, including but not			
	limited to nurse aides	3.			
	§483.35(a)(2) Except				
		section, the facility must			
		nurse to serve as a charge			
	nurse on each tour of	-			
		is not met as evidenced			
	by: Based on observatio	ns, record reviews and staff,		F725 Sufficient Nursing Staff	
		an interviews the facility failed			
		ursing staffing to perform		How will corrective action be	
	assessment and take	e vital signs, to provide		accomplished for those resident(s)	
		vide ice water at the bedside		to be affected by the deficient pract	ice?
	for 4 of 11 sampled re	esidents reviewed for vision of activities of daily		Resident #2 remains in the facility a	and
		ision of activities of daily			

Facility ID: 923019

If continuation sheet Page 33 of 40

STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	ΓIPLE	CONSTRUCTION	(X3) DAT	O. 0938-039
and plan of	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			IPLETED
		345263	B. WING			1	R-C 1/ <b>05/2019</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0	1/05/2019
				31	195 OLD MURPHY ROAD		
MACON V	ALLEY NURSING AND R	REHABILITATION CENTER		F	RANKLIN, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
{F 725}	Continued From page	a 33	F 7	251			
[1 / 20]		lependent residents and	<u></u> {Γ /	25}	remains stable.		
	choices (Residents #	•			Resident #5 and #18 were provided na	il	
		2, #21, #10 and #3).			care by the facility staff.		
	This citation is crosse	ed reference to:			Resident #21 was provided fresh ice		
					water upon notification.		
	1a. F-0695: Based or	n observations, record					
	reviews and resident,	, Physician and staff			How will facility identify other residents		
	interviews the facility				having potential to be affected by the		
		al signs for a resident who			same deficient practice?		
		was sent to the hospital with					
		or 1 of 4 residents reviewed			Residents who are dependent were		
	for respiratory care (F	Resident #2).			audited regarding care and services, interventions provided accordingly.		
	An interview with Nur	rse Aide (NA) #9 conducted			interventions provided accordingly.		
		PM revealed she observed			Measures to be put into place or system	mic	
		hard time breathing and the			changes made to ensure that the defic		
	-	she could not breathe. The			practice will not recur?		
	NA stated she inform	ed the Nurse about Resident					
	#2 having difficulty br	eathing but did not go back			A Wage Analysis was completed; as a		
		erwards because she had			result wage adjustments were made,		
		to take care of and did not			implementation of a sign-on bonus and	1	
	have time.				recruitment bonus to facilitate staff		
	b E 0677: A stivition	of Doily Living Skiller Deced			recruitment in all departments.		
		of Daily Living Skills: Based d review, resident and staff			The Administrator and the Director of		
		/ failed to provide fingernail			Nursing will meet staffing patterns and		
	-	gernails clean for 2 of 5			shift assignments for appropriate		
	-	reviewed for activities of			coverage weekly and prior to the week	end	
	daily living (Resident				based on needs in conjunction with		
					on-boarding process. Director of Nursi	ng	
	c. F-0561: Self Deter				will ensure adequate staffing is provide	ed	
		eviews, staff and resident			daily for performance of assessments		
		failed to honor the choice of			including vital signs, provision of nail ca		
		edside for 1 of 4 sampled			and provision of ice water at the bedsic	je.	
	residents reviewed to	or choices (Resident #21).			How the facility plans to monitor its		
	An interview with Bat	her #1 on 01/03/19 at 12:08			How the facility plans to monitor its performance to make sure that solutior	ne	
		ere days when she was			are sustained?	10	
		ork with just herself and					

Facility ID: 923019

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED	
					R-C	
		345263	B. WING		01/05/2019	
NAME OF PROVIDER OR SUPPLIER MACON VALLEY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE			
			3195 OLD MURPHY ROAD			
				FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	(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)	ULD BE COMPLE	
{F 725}	Continued From page	e 34	{F 725	}		
( )		s newly hired. The Bather	(1720	Results of the monitoring tool whi	ch	
	explained that made			include ADL Care, Call Light resp		
		as often as needed because		time, and passing water at the be		
	-	was not familiar with the		will be brought to stand-down me		
		ot work on their own as she		5x/week times 4 weeks, then wee	-	
		ited some resident care		times 8 weeks for discussion with		
		oviding incontinent care and off because there was not		Members and to the monthly QAF meeting. Results of the audits will		
		I of the resident care done,		presented to the QAPI meeting x		
		on to the oncoming shift		or until a time determined by the		
	what resident care wa	-		members for sustained compliance		
		vith Bather #2 on 01/03/19 at		The Director of Nursing is respon-	sible for	
		the facility had hired a lot of		the Plan of Correction and the	untraine d	
		ich was a good thing but gned to a hall with only a new		Administrator is responsible for su compliance.	ustained	
		de it difficult to provide all of				
		are needs in a timely manner		Date of Compliance 2/04/2019.		
		f member doesn't know the				
		es. The Bather stated when				
		as assigned to work by				
		hat she had to provide the				
		needs and what resident et done she passed on to the				
		stated she knew for a fact				
		n knew how hard it was to				
	work with only a new	hire and be expected to get				
	all of the resident car	e tasks done.				
	-	vith Nurse #3 on 01/03/19 at				
		was difficult for the aides				
		facility aide and an agency gh as they needed to be with				
	providing resident ca					
		nd feeding the residents but				
		as much as she could with				
	answering the call lig	hts in order to free the aides				
	up to be able to provi	de meere resident sere				

Facility ID: 923019

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/13/2019 FORM APPROVED OMB NO. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345263	B. WING		R-C 01/05/2019
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	•
MACON V	MACON VALLEY NURSING AND 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 C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE COMPLETION THE APPROPRIATE DATE
{F 725}	Continued From page During an interview w	e 35 vith Nursing Assistant (NA)	{F 72	25}	
	difficult at times to co that the residents req	46 AM he explained it was mplete the daily care needs juired when he worked the d aide because he was			
	resident's basic activi stated when he was u	ities of daily living. The aide unable to complete the tasks undone on to the oncoming			
	4:07 PM she stated to Gray/300 hall with a r behind with their hall NA stated they had to lights, and try to prov they could but could of with their tasks. The intentions to pass out	t ice water but was unable to I to go to the other hall to			
	9:55 AM she explained employee that was git orientation on first sh work the following se herself. The aide statt not her ideal orientatic choice to work the hat she did the best she	ift then was expected to cond shift on a hall by red that although that was on she felt that she had no all by herself. The aide stated could to provide the needs considering how little			
	the "Scheduler" she e the facility's current s	PM during an interview with explained she was aware of taffing situation and ge of 80 percent of agency			

Facility ID: 923019

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345263	B. WING		R-C 01/05/2019
AME OF PF	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-
IACON 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
{F 725}	Continued From page	e 36	{F 725}		
	Scheduler stated the new programs such a hire on bonuses, offe and had adjusted the staff.	orked at the facility. The facility had initiated several as offering both referral and ring shift differential pay, pay scale to hire new facility PM during an interview with			
{F 760} SS=D	the Director of Nursin because the facility we staffing on the last co- focus had been on ge facility. The DON star majority of the facility staff but that there was staff that remained at of them worked on fir and third shift to be so that made it difficult to orientation to the age hired facility staff. The get over one hurdle at was bringing staff into	ng (DON) she explained that vas cited for insufficient omplaint investigation her etting agency staff in the ted she was aware that the vas staffed with agency as a core of the long term the facility and the majority st shift which left second taffed with agency staff and o provide a sufficient ency staff and to the newly e DON stated she needed to at a time and the biggest one	{F 760}		2/4/19
	medication errors. This REQUIREMENT by:	ure that its- nts are free of any significant └ is not met as evidenced iew, staff, and physician		F760 Residents are Free of Significan	t
	interviews, the facility significant medication			Med Errors How will corrective action be	
	for 1 of 3 residents (F	-		accomplished for those resident(s) fou	

Event ID: J78Q12

Facility ID: 923019

If continuation sheet Page 37 of 40

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/13/2 FORM APPRO OMB NO. 0938-03	VED
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345263	B. WING		R-C 01/05/2019	
NAME OF PF	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COD		
	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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETI	
{F 760}	Continued From page	a 37	{F 760			
[1 7 00]	The findings included			Resident 18'⊡s Eliquis was a for his PM dose on the given		
	Resident #18 was rea	admitted to the facility on				
	embolism and thromb	ses which included acute posis of deep veins of upper		How will facility identify other having potential to be affected		
		vascular disease (PVD), coagulants and others.		same deficient practice?		
				Residents on anticoagulants		
		#18's most recent quarterly		to ensure administration occu	irred per	
		DS) dated 11/19/18 revealed lerately impaired for daily		orders.		
		an open lesion on his foot		Measures to be put into place	e or systemic	
	-	gs to his feet. The MDS also		changes made to ensure that	-	
		had received anticoagulants		practice will not recur?		
				Unit Managers and/or design		
		#18's care plan dated		responsible for reviewing app		
		e resident had a care plan		for the next day and notifying		
		ing related to anticoagulant as the resident would be free		physician to obtain orders for administering medications be	0	
	of signs/symptoms of	bleeding. The interventions inister medications as		appointments.		
	ordered by the physic			Measures to be put Into place changes made to ensure that		
	Review of Resident # physician orders reve	18's monthly January 2019 aled an order for the		practice will not recur?		
		5 milligram tablet of Eliquis		Licensed Nurses and Medica	tion Aides	
		dication) twice a day by		were re-educated by 2/4/2019	9 regarding	
	mouth.			Medication Administration/Sa	-	
		<b></b>		specifically related to anticoa	-	
	A review of Resident			anticoagulant administration to		
		d (MAR) for January of t, the resident had an order		physician orders. Education in hands on scenarios and intera		
	· · ·	ication in the morning:		training sessions.		
	Eliquis 5 milligram (m twice daily at 8:00 AN	ng) tablet - 1 tablet by mouth / and 8:00 PM.		The Director of Nursing and/o will monitor new medication o	orders,	
				medications available on cart	and	

Event ID: J78Q12

Facility ID: 923019

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			LE CONSTRUCTION		<u>3-039</u> ⁄
F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
				R-C	
	345263	B. WING		01/05/2019	9
ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
			3195 OLD MURPHY ROAD		
			FRANKLIN, NC 28734		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE COMPLI	LETIO
Continued From page	e 38	{F 760	)}		
			anticoagulants beginning 1/28/20		
			-		
			Tool.	0	
	-				
Medication Alde (CM)	A) #1.		•	Diutions	
An interview on 01/05	5/19 at 10:01 AM with CMA				
			Results of the monitoring tool will	be	
previous night shift.					
•				s for	
			sustained compliance.		
			The Director of Nursing is respon	sible for	
•			the Plan of Correction and the		
			-	ustained	
			compliance.		
			Date of Compliance 2/04/2010		
	5				
An interview on 01/05	5/19 at 7:53 PM with the				
have wanted Resider	nt #18 to have gone out of				
	CORRECTION ROVIDER OR SUPPLIER ALLEY NURSING AND F SUMMARY ST (EACH DEFICIENC REGULATORY OR I Continued From page physician appointmen leave the facility betw Review of the resident prior to leaving for his revealed the medicat the medication was c Medication Aide (CM. An interview on 01/08 #1 revealed she had Resident #18 becaus narcotics with the off she could not give an able to count with the previous night shift. A telephone interview with Nurse #6 who ha 01/04/19 revealed sh #18 his Eliquis becaus than her medication p Resident #18 left the Nurse #9 and CMA # his medications prior stated Resident #18 left the Nurse #9 and CMA # his medications prior stated Resident #18 left the Nurse #18 had left medications with Nur probably should have him prior to him leavin An interview on 01/08 Medical Director (MD have wanted Resider the facility to an appoint morning medications	CORRECTION 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 38 physician appointment and was scheduled to leave the facility between 7:00 AM and 7:30 AM. Review of the residents MAR revealed on 01/04/19 the resident had not received his Eliquis prior to leaving for his appointment. The MAR revealed the medication had not been given and the medication was circled by Certified Medication Aide (CMA) #1. An interview on 01/05/19 at 10:01 AM with CMA #1 revealed she had not given the Eliquis to Resident #18 because she had not counted narcotics with the off going nurse. CMA #1 stated she could not give any medications until she was able to count with the nurse that had worked the previous night shift. A telephone interview on 01/05/19 at 2:16 PM with Nurse #6 who had worked the night shift on 01/04/19 revealed she had not given Resident #18 his Eliquis because it was scheduled later than her medication pass. Nurse #6 stated Resident #18 left the facility at 7:00 AM and Nurse #9 and CMA #1 knew she had not given his medications prior to him leaving. Nurse #6 stated Resident #18 had an early breakfast before he left and had a bagged lunch to take with him to his appointment. Nurse #6 stated Resident #18 had left before she had counted medications with Nurse #9 or CMA #1 and she probably should have given his medications to him prior to him leaving the facility. An interview on 01/05/19 at 7:53 PM with the Medical Director (MD) revealed he would not have wanted Resident #18 to have gone out of the facility to an appointment without receiving his morning medications. The MD stated Resident	CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING         345263       B. WING	CORRECTION         IDENTIFICATION NUMBER:         A BUILDING           345263         B. WING           COURDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE 3195 OLD MURPHY ROAD FRANKLIN, NC 28734           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIDED BY FULL REQUILATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX           Continued From page 38 physician appointment and was scheduled to leave the facility between 7:00 AM and 7:30 AM. Review of the residents MAR revealed on 01/04/19 the resident had not received his Eliquis prior to leaving for his appointment. The MAR revealed the medication had not been given and the medication was circled by Certified Medication Aide (CMA) #1.         {F 760}           An interview on 01/05/19 at 10:01 AM with CMA #1 revealed she had not given the Eliquis to Resident #18 because she had not given the Eliquis to anacrolics with the off going nurse. CMA #1 stated she could not give any medications until she was able to count with the nurse that had worked the previous night shift.         Results of the monitoring tool will brought to stand-down meeting. Sec until detrimined by the CAPI members sustained compliance.           A telephone interview on 01/05/19 at 2:16 PM with Nurse #6 who had worked the right shift on 01/04/19 revealed she had not given the Sident #18 his Eliquis because it was scheduled later than her medication pass. Nurse #6 stated Resident #18 left the facility at 7:00 AM and Nurse #6 and CMA #1 have she fasted Resident #18 had an eary breakfast before he left and had a bagged lunch to take with him to his appointment. Nurse #6 stated Resident #18 had had begrow CMA #1 and she probably should have given his medications to him prior to him leaving. Nurse #6 stated Resident #18 h	CORRECTION     IDENTIFICATION NUMBER     A. BUILDING     COMPLETED     R-C       345263     B. WING     STREET ADDRESS, CITY, STATE, 2P CODE     31000000000000000000000000000000000000

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 02/13/2019 RM APPROVED IO. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		345263	B. WING			R-C 1/ <b>05/2019</b>
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP		1/00/2010
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 PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
{F 760}	Continued From page medication error" and medication due to the An interview on 01/05 Director of Nursing (D have expected Nurse #18 his medications p	· ·	{F 760}			

Facility ID: 923019

If continuation sheet Page 40 of 40

DEPART	MENT OF HEALTH AN	D HUMAN SERVICES				FOR	MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>). 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	` '	E SURVEY PLETED
		345263	B. WING				C / <b>05/2019</b>
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
		EHABILITATION CENTER		3	3195 OLD MURPHY ROAD		
	ALLET NORSING AND R			F	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)	3E	(X5) COMPLETION DATE
F 550 SS=D	Resident Rights/Exer CFR(s): 483.10(a)(1)( §483.10(a) Resident I The resident has a rig self-determination, ar access to persons an outside the facility, ind this section. §483.10(a)(1) A facilit with respect and dign resident in a manner promotes maintenancher quality of life, reco individuality. The facil promote the rights of §483.10(a)(2) The faci access to quality care severity of condition, must establish and m practices regarding tr 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 faci	cise of Rights (2)(b)(1)(2) Rights. In to a dignified existence, id communication with and d services inside and cluding those specified in by must treat each resident ity and care for each and in an environment that we or enhancement of his or ognizing each resident's ity must protect and the resident. Clifty 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. Df Rights. right to exercise his or her i the facility and as a citizen		550	DEFICIENCY)	ΙΑΤΕ	2/4/19
	free of interference, c reprisal from the facili rights and to be supp	sident has the right to be oercion, discrimination, and ty in exercising his or her orted by the facility in the SUPPLIER REPRESENTATIVE'S SIGNATUR	=		TITLE		(X6) DATE

**Electronically Signed** 

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.

01/28/2019

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/1 FORM APPR OMB NO. 0938	ROVE
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	(
		345263	B. WING		C 01/05/201	9
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	)E	
				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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPL	(5) LETION ATE
F 550	Continued From page	e 1	F 55	0		
			1 33	6		
	subpart.	rights as required under this				
		Γ is not met as evidenced				
	by:					
	Based on observation	ons, record reviews, resident		F550 Resident Rights/Exerci	se of Rights	
		he facility failed to treat				
		ed manner by not covering an		How will corrective action be		
		tering resident rooms		accomplished for those reside		
		mission from the resident to g which resident required		be affected by the deficient p	ractice ?	
	-	sampled residents reviewed		Resident #6 and #15 have no	further	
	for dignity (Resident	-		concerns.		
		-,,		Resident #28 was provided p	rivacy upon	
	The findings included	1:		observation by the facility sta	ff.	
	1. Resident #28 was	admitted to the facility on		Staff member identified during	a survev by	
		ses of seizure disorder and		resident #15 is no longer is e		
		e most recent quarterly				
		ADS) assessment dated		How will facility identify other		
		esident #28 had severe		having potential to be affected	d by the	
	- ·	and required extensive		same deficient practice?		
	MDS also indicated F	ctivities of daily living. The		Residents residing in the facil	lityworo	
	behaviors of rejecting			interviewed regarding resider	-	
	On 01/05/19 at 3:56 l	PM an observation was		Measures to be put into place	e or systemic	
		ay of Resident #28 lying on		changes made to ensure that		
		inmade bed sleeping with		practice will not recur?		
	the bottom half of her					
		#28 was wearing a gown		Licensed and non-licensed fa	-	
	that was visible from	bove her waist and a brief		were re-educated by 2/4/2019 the F550 Resident Rights/Exe		
		are nanway.		Rights specific to treating res		
	Observations of Resi	ident #28 from the hallway		dignified manner; maintaining		
		at 4:00 PM, at 4:07 PM, at		by ensured they are covered,		
		and at 4:20 PM revealed		and asking to enter residents	-	
	she was lying in bed			regulation by the corporate cl		
	uncovered and expos			consultants and the Staff Dev	-	
	observations, the res	ident's exposed legs and her		Director. Education included	hands on	

Facility ID: 923019

If continuation sheet Page 2 of 59

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVEY COMPLETED
		345263	B. WING		C 01/05/2019
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	• • • • • • • •
MACON V	ALLEY NURSING AND R	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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIO
F 550	Continued From page	e 2	F 550		
	4:20 PM, three staff m were observed to pas door while she was ly and with her lower too three staff members w room did not interven protect her from being On 01/05/19 at 4:20 F Quality Assurance Nu Resident #28's door a During an interview w 4:22 PM she stated s privacy curtain becau observed that the res During an interview w (DON) on 01/05/19 at expected the staff to I room as they passed exposures. The DON expected to pull Resig prevent her from bein During an interview w 01/05/19 at 5:43 PM s	on 01/05/19 from 4:00 PM to nembers and one resident as by Resident #28's opened ving in her bed uncovered rso and brief exposed. The who passed by the resident's e to cover the resident to g exposed to others. PM observed the Corporate urse (CQAN) knocked on and entered the room. vith the CQAN on 01/05/19 at the pulled Resident #28's use from the hallway she ident was exposed. vith the Director of Nursing t 4:24 PM she stated she look into each resident's to monitor for issues like stated the staff was dent #28's privacy curtain to ag exposed. vith Nurse Aide (NA) #5 on she stated on 01/05/19 she		scenarios and interactive training sessions. All new hires will receive education during their orientation to facility. How the facility plans to monitor its performance to make sure that solut are sustained? The Department Managers and/or designee began monitoring residen rights 1/21/2019 with a Compliance Monitoring Tool that includes observ of resident privacy, knocking on the resident doors, and maintaining resid dignity by covering if exposed. Moni 10% of the census 3x/week times 4 weeks, then weekly times 8 weeks. Results of the monitoring tool will be brought to the stand-down meeting 8 times/weekly x 4 weeks, then weekly weeks. Results of the audits will be presented the QAPI meeting monthly x3 months or until a time determined the QAPI members for sustained compliance.	t s rations dents toring 5 y x 8 ed to
	exposed and uncover the vital sign machine the dayroom before s Resident #28. The N	A stated when she went 's room someone had		The Interdisciplinary Team Members responsible for the Plan of Correctio the Administrator is responsible for sustained compliance. Date of Compliance 2/04/2019	

If continuation sheet Page 3 of 59

		ID HUMAN SERVICES MEDICAID SERVICES				F	TED: 02/13/201 ORM APPROVE NO: 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		ONSTRUCTION		DATE SURVEY
		345263	B. WING				C 01/05/2019
NAME OF P	ROVIDER OR SUPPLIER	•		STR	EET ADDRESS, CITY, STATE, ZIP COD	E	
MACON V	ALLEY NURSING AND R	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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 550	Resident #28 was ex lying in her bed, but s staff to cover her up i 2. Resident #15 was 02/12/18 with diagnor neuropathy and catar eyes. The most recer Set (MDS) assessme he was cognitively int assistance with most and his vision was se On 01/02/19 at 5:50 F overheard to holler lo here" and "she yells a in here."Several staff rush to Resident #15" During an interview w 01/03/19 at 10:05 AW became upset during because "the girl"(did delivered his supper it down on my table a Resident #15 stated to door before she came the third time that day way." The Resident of room was his home. On 01/05/19 at 12:18 conducted with the fa one of the staff memb #15's room on the ev Scheduler stated Res	posed and uncovered while she would have expected the f they were aware of it. admitted to the facility on ses which included diabetic racts and blindness in both at quarterly Minimum Data ent dated 10/08/18 revealed tact, required limited of his activities of daily living everely impaired. PM Resident #15 was udly "get this d food out of at me every time she comes member were observed to 's room.	F	550			

Facility ID: 923019

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 02/13/2019 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345263	B. WING		_	( 01/	) 05/2019
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, ST	TATE, 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	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	when she came into heven knock on his dou Scheduler stated she person was that Reside During an interview w (DON) on 01/05/19 at staff member that Reside thered his room una 01/02/19 in a loud ma The DON stated she would knock on Reside resident's doors and w they entered a reside 3. Resident #6 was at 4/21/09. The quarter 10/08/18 revealed Re impairment and requir assistance for all active During an interview of 11:18 AM, Resident # headache and was of at 11:21 AM. While co Resident #6, Nurse A door and entered the announcing her prese roommate's bed. NA at Resident #6's roomma get another NA to hell back. NA #10 exited to or acknowledging F returned to the room w to the call light station	) that the girl was too loud his room and that she did not or before she entered. The did not know who the staff dent #15 referred to. With the Director of Nursing t 4:24 PM, she explained the sident #15 referred to who nnounced on the evening of uner was a new employee. expected that all employees dent #15's door and all wait for an invitation before nt's room. Admitted to the facility by Minimum Data Set dated esident #6 had mild cognitive red supervision to limited wities of daily living (ADL's). In 01/03/19 beginning at 66 stated she had a bserved to use her call light ontinuing the interview with ide (NA) #10 opened the room without knocking or ence and went directly to the #10 was overheard telling ate that she was going to p her and she would be right the room without speaking Resident #6. NA #10 with a second NA and went in on the wall and turned it stated she had used the	F 550				

	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	2: 02/13/2019 APPROVED 0: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		345263	B. WING		_	01/0	C 05/2019
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)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	During an interview of #10 stated she had be that Resident #6's roo so she entered the roo roommate's bed. NA room assuming the lig roommate. NA #10 al protocol was to knock but she just forgot to o During an interview of housekeeper stated s the hallway for Reside NA that assistance wa housekeeper stated s person needed help b that information. During an interview of Resident #6 stated the room without knocking stated it irritated her th time to knock on the o room. She also stated call light, but when sh medication. Resident does use her call light it's for her roommate I used it multiple times request assistance for During an interview of Director of Nursing (D was for all staff to kno resident's room and w	n 01/03/19 at 11:31 AM, NA een told by a housekeeper immate needed assistance, om and went directly to the #10 stated she entered the ght was for Resident #6's iso stated the proper on the door before entering do it. n 01/03/19 at 11:45 AM, the he had seen the light on in ent #6's room and told the as needed in that room. The he did not specify which ecause she did not know n 01/05/19 at 9:27 AM, e NA's often entered her g. Resident #6 further nat the NA's did not take the loor before they entered her d she hardly ever used her e did it was usually for pain #6 further stated when she the staff usually assume because her roommate throughout the day to om staff. n 01/05/19 at 1:17 PM, the ON) stated her expectation ck before entering a vait for a response or an all staff should verify which	F 550				

Facility ID: 923019

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
					с
		345263	B. WING		01/05/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
F 561	Continued From page	9 6	F 561		
F 561	Self-Determination		F 561		2/4/19
SS=D	CFR(s): 483.10(f)(1)-	(3)(8)			
	§483.10(f) Self-deterr	nination.			
		right to and the facility must			
		resident self-determination			
	0 11	sident choice, including but ts specified in paragraphs (f)			
	(1) through (11) of this				
	8483 10(f)(1) The res	ident has a right to choose			
		including sleeping and			
		care and providers of health			
		ent with his or her interests,			
	assessments, and pla				
	applicable provisions	of this part.			
		ident has a right to make s of his or her life in the			
	facility that are signific	cant to the resident.			
	§483.10(f)(3) The res	ident has a right to interact			
		community and participate in			
	community activities I facility.	ooth inside and outside the			
	§483.10(f)(8) The res	ident has a right to			
		tivities, including social,			
		nity activities that do not			
	•	ts of other residents in the			
	facility. This REQUIREMENT	is not met as evidenced			
	by:				
		n, record reviews, staff and e facility failed to honor the		561 Self-Determination	
		vater at bedside for 1 of 4		How will corrective action be	
	sampled residents rev			accomplished for those residents foun	d to
	(Resident #21).			be affected by the deficient practice?	

Event ID: YJKF11

Facility ID: 923019

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					CONSTRUCTION		NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	· /	ATE SURVEY OMPLETED
			A. DOILDING				С
		345263	B. WING			01/05/2019	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
				319	95 OLD MURPHY ROAD		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		FR	RANKLIN, NC 28734		
(X4) ID		IMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 561	Continued From page	e 7	F 56	51			
	The findings included	:			Resident #21 was provided fresh ice		
					water upon notification.		
		mitted to the facility on					
		ses which included chronic			How will facility identify other residents	6	
		y disease (COPD). The			having potential to be affected by the		
		Minimum Data Set (MDS) /30/18 revealed Resident			same deficient practice?		
		ion and required supervision			Facility residents were observed to en	euro	
		ities of daily living. The MDS			they had fresh ice water and/or fluids a		
		ent #21 received oxygen.			their bedside as ordered; services		
		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			provided accordingly.		
	On 01/05/19 at 3:23 F	PM during an interview with					
	Resident #21 she sta				Measures to be put into place or syste		
	-	to treat her COPD and the			changes made to ensure that the defic	cient	
		ntinuous oxygen, her mouth			practice will not recur?		
		ad requested ice water be Resident #21 explained that			Licensed and unlicensed staff were		
	-	les (GCA's) were supposed			re-educated by 2/4/2019 regarding F5	61	
		but she ended up having to			Self-Determination, specific to providir		
	-	ost every day because it was			water at resident s bedside by the	.9	
	not being done and th				corporate nurse consultants and the S	taff	
	course." Resident #2	1 stated that eairler in the			Development Director. New hires will		
		urse Aide (NA) #4 to get her			receive the education during their		
		use there were no GCA's on			orientation to the facility. Education		
	her hall today.				included hands on scenarios and		
		on 01/05/19 at 3:51 PM			interactive training sessions.		
		21 had asked him to get her			How the facility plans to monitor its		
		efore dinner. The NA stated			performance to make sure that solution	ns	
		approximately 1/4 full with			are sustained?	-	
		maybe two pieces of melted					
		tcher. The NA explained that			The Department Managers and/or		
	-	oat halls when he came into			designee began monitoring on 1/21/20		
		11:00 AM and did not know if			monitoring 10% of the resident census		
		en passed on Resident #21's			Ice Water at bedside and within reach	TOP	
	hall or not.				3x/weekly x4 weeks, then weekly x8 weeks.		
	An interview conducte	ed with NA #5 on 01/05/19 at					
		e worked on Resident #21's			Results of the monitoring tool will be		

Facility ID: 923019

TATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING		C	
		345263	B. WING		01/05/2019	
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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMF	(X5) IPLETIO DATE
F 561		e 8 nd admitted they did not all of the residents because	F 561	brought to stand-down meeting x4 weeks, then weekly x8 weeks	-	
	completing their tasks	eir work and ended up s late. The NA stated the d out the ice water, but they on the hall that day.		of the on-going audits will be pre- the QAPI meeting x3 months or time determined by the QAPI me for sustained compliance. The Interdisciplinary Team Mem	esented to until a embers	
	stated the GCAs usuant they did not have a G NA admitted Residen	on 01/05/19 at 4:07 PM ally passed out ice water but iCA on the hall today. The t #21 was "big on having ice not pass out the ice water		responsible for the Plan of Correct the Administrator is responsible sustained compliance.		
	because they got beh could not get to it. Th	nind on the hall tasks and e NA stated she should have hat they were not going to be				
		aily Assignment Sheet 7-3 ed no Geriatric Care Aides led.				
	01/05/19 at 4:24 PM responsibility of the G water and it should be the shift. The DON ex there were no GCAs was the NAs response out and if they knew to done then they should	ector of Nursing (DON) on revealed, it was the SCAs to pass out the ice e done at the beginning of kplained that in the event assigned to the hall then it biblity to pass the ice water they were unable to get it d have informed the Nurse et done they should inform				
F 583 SS=D	-	nfidentiality of Records -(3)(i)(ii)	F 583		2/4/1	9
		nd Confidentiality. ght to personal privacy and or her personal and medical				

Facility ID: 923019

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
		345263	B. WING			01/0	, )5/2019
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, S	TATE, ZIP CODE		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734	)		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION           FIX         (EACH CORRECTIVE ACTION SHOULD E           G         CROSS-REFERENCED TO THE APPROPRI           DEFICIENCY)         DEFICIENCY			(X5) COMPLETION DATE
F 583	records. §483.10(h)(I) Persona accommodations, me telephone communica and meetings of famil this does not require private room for each §483.10(h)(2) The fac residents right to pers right to privacy in his written, and electronic the right to send and mail and other letters materials delivered to including those delive than a postal service. §483.10(h)(3) The res and confidential personal (i) The resident has the of personal and medii provided at §483.70(if federal or state laws. (ii) The facility must and Office of the State Lo to examine a residential administrative records law. This REQUIREMENT by: Based on observatio facility failed to protect on 3 of 4 units (Orang SPARK) by leaving co	al privacy includes edical treatment, written and ations, personal care, visits, ly and resident groups, but the facility to provide a resident. cility must respect the sonal privacy, including the or her oral (that is, spoken), c communications, including promptly receive unopened , packages and other the facility for the resident, ered through a means other sident has a right to secure onal and medical records. he right to refuse the release cal records except as )(2) or other applicable llow representatives of the ng-Term Care Ombudsman t's medical, social, and s in accordance with State is not met as evidenced ns, and staff interviews, the ct private health information ge hall, Green hall and onfidential medical	F	583 F583 Personal Pr Records How will corrective	rivacy/Confidentiality of		
	information unattende the public on 3 of 4 m	ed in an area accessible to nedication carts.			those residents found deficient practice? censed staff were	to	

Facility ID: 923019

If continuation sheet Page 10 of 59

		MEDICAID SERVICES				<u> 0938-03</u>	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION		E SURVEY PLETED	
						с	
		345263	B. WING			/05/2019	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DDE .		
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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
F 583	Continued From page	e 10	F 58	33			
	The findings included			provided with privacy cover	sheets to		
		a.		utilize during med pass for r			
		rvation on 01/03/19 of the on cart from 11:51 AM to		confidentiality.	<del>ر</del>		
	-	ne Medication Administration		How will facility identify othe	er residents		
		was open and a resident's		having potential to be affect	ed by the		
	(Resiident #29) infori			same deficient practice?			
		e Orange hall. Nurse #2					
		ve the MAR opened to a on the medication cart and		Measures to be put into place changes made to ensure the			
		ttended when she went to		practice will not recur?			
		et tubing for a resident's					
	oxygen.			Licensed and unlicensed st	aff were		
				re-educated by 2/4/2019 reg	garding the		
		5/19 at 1:16 PM with Nurse		F583 Personal Privacy/Con	•		
		not realized she had left the		Records specifically protect			
		ew it should be covered so no		health information by the co	•		
	resident information	was visible.		nurse consultants and the S Development Director. Educ			
	An interview on 01/0	5/19 at 6:00 PM with the		hands on scenarios and inte			
		DON) revealed it was her		training sessions.			
		Rs be covered any time the					
		dication Aide (CMA) was not		How the facility plans to mo	nitor its		
	•	cation cart. The DON stated		performance to make sure t	hat solutions		
		ed sheets to cover the		are sustained?			
		when the nurse was giving					
	not lose their place ir	to step away, so they would		The Department Managers designee will monitor perso			
		I THE DOOK.		privacy/confidentiality of rec			
	2. A continuous obse	rvation on 01/03/19 of the		Compliance Monitoring Too			
		n cart from 4:08 PM until		1/21/2019, the monitoring w			
	4:13 PM revealed the	e Medication Administration		observation of the protection			
		was open and a resident's		confidential medical informa			
		t #26) was visible on the		medication carts 3x/week til			
		e Green hall. Nurse #4 was		then weekly x 8 weeks at va	arious		
	observed to leave the resident's information			medication pass times.			
		ended to go the supply room		Results of the monitoring to	ol will be		
	to get intravenous flu			brought to stand-down mee			

Facility ID: 923019

	DF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		O. 0938-039 E SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	` '	G		PLETED		
						С		
		345263	B. WING		01	/05/2019		
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	ODE			
		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 ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE		
F 583	Continued From page	e 11	F 58	33				
				discussion 5x/week times 4	weeks, then			
		bservation on 01/03/19 of		weekly x 8 weeks. Results				
		ation cart from 4:43 PM until		will be presented to the QA	-			
		th MAR books were left s' (Resident #s 31 and 32)		QAPI members for sustaine				
	-	le on the medication cart.		The Director of Nursing is r				
		red to leave both MARs		the Plan of Correction and the				
		information when she left the		Administrator is responsible				
	-	minister medications in a		compliance.				
				Date of Compliance 2/04/20	019			
		3/19 at 4:43 PM with the Unit						
	- · ·	valked up to the medication						
		evealed resident MAR's all times when the nurse is						
		cart to protect the resident's						
		ation. The UM manager						
	reminded Nurse #4 to	b keep her MARs covered						
		from the medication cart and						
	the nurse quickly cov	ered the information.						
	An interview on 01/0	5/19 at 6:00 PM with the						
		DON) revealed it was her						
		Rs be covered any time the						
		ng at the medication cart.						
		had made colored sheets to ormation when the nurse						
		ns and had to step away, so						
		neir place in the book.						
		rvation on 01/05/19 of the						
		art from 4:48 PM to 5:12 PM						
		ion Administration Record						
		n and a resident's (Resident ble on the medication cart in						
		ified Medication Aide (CMA)						
		eave the MAR opened and						
		as unattended while he was						
	in the medication pre							

Facility ID: 923019

If continuation sheet Page 12 of 59

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/13/2019 FORM APPROVED OMB NO. 0938-0391		
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345263	B. WING		C 01/05/2019		
	ROVIDER OR SUPPLIER	EHABILITATION 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 583	Continued From page	e 12	F 583				
	Director of Nursing (E expectation that MAR nurse or Certified Me standing at the medic she had made colore resident information v	when the nurse was giving to step away, so they would					
F 607 SS=D	CFR(s): 483.12(b)(1)		F 607	,	2/4/19		
	§483.12(b) The facilit implement written pol	y must develop and licies and procedures that:					
	§483.12(b)(1) Prohibit neglect, and exploitat misappropriation of re	ion of residents and					
	§483.12(b)(2) Establi to investigate any suc	sh policies and procedures ch allegations, and					
	paragraph §483.95,	e training as required at is not met as evidenced					
	Based on record rev facility failed to opera procedures in the are	iews and staff interviews the tionalize abuse policies and a of staff reporting of an		F607 Develop/Implement Abuse/Neg Policies	lect		
		hen staff did not e resident's allegations of re to the administrator which		How will corrective action be accomplished for those residents four be affected by the deficient practice?	d to		

Event ID: YJKF11

Facility ID: 923019

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED	
					С	
		345263	B. WING		01/05/2019	
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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETIC	
F 607	Continued From page	e 13	F 60	7		
		the facility's investigation of				
	an allegation of abus			Resident #18 received a head-to	-toe skin	
	residents reviewed for	or abuse and neglect		evaluation and was interviewed r	egarding	
	(Resident #18).			the allegation.		
	Findings included:			How will facility identify other res	dents	
				having potential to be affected by		
	A review of the facility	y Abuse, Neglect, or		same deficient practice?		
		Resident Property Policy				
		revised date of 03/10/17		Facility residents were interviewe	-	
	revealed in part: The	-		Social Worker regarding any alle	gations	
		ght to be free from abuse, seclusion, exploitation, or		of staff mistreatment.		
		property. Any employee who		Measures to be put into place or	systemic	
		s that abuse, neglect,		changes made to ensure that the		
		ppropriation of property has		practice will not recur?		
		ately report the alleged				
		rvisor, who will immediately		Licensed and unlicensed staff we	ere	
		the Administrator. Failure to		re-educated regarding		
	report any concern re			Development/Implementation of		
		or misappropriation of disciplinary action and		Abuse/Neglect Policies specification to reporting allegations of abuse;		
	possible termination			the abuse coordinator, procedure		
		onsible to ensure that		reporting, and timeframes require		
		neglect, exploitation, or		corporate nurse consultants and		
	misappropriation of p	property and injuries of		Development Coordinator. Educa	ation	
	unknown origin are ir	nvestigated.		included hands on scenarios and		
				interactive training sessions. Edu		
		Imitted to the facility on ses which included heart		will be completed by 2/04/2019, some members will not be allowed after		
	failure, peripheral vas			without receiving the education p		
		iabetes, respiratory failure		reporting to shift. New hires will r		
	and dementia.			the education during their orienta the facility.		
	A review of a care pla	an dated 06/10/18 revealed a				
		Resident #18 had acts		How the facility plans to monitor		
		ppropriate behavior and was		performance to make sure that s	olutions	
		treatment and the goals esident #18 would receive		are sustained?		

Facility ID: 923019

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	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345263	B. WING		C 01/05/2019
NAME OF P	ROVIDER OR SUPPLIER	•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•
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 SHC CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE COMPLETIO
F 607	Continued From page	e 14	F 607		
	care within his choices and preferences. The interventions were listed in part to report behaviors to Nurse and Physician.			Department managers and/or des will monitor abuse prevention and notification utilizing a compliance monitoring tool, the monitoring tool	DI
	(MDS) dated 11/09/18 moderately impaired making. The MDS al required extensive as	erly Minimum Data Set 8 revealed Resident #18 was in cognition for daily decision so revealed Resident #18 ssistance for bed mobility, bileting and hygiene and no		includes interview questions for the regarding abuse prevention and m On 1/21/2019 the monitoring begat will continue 3x/weekly times 4 we then weekly for 8 weeks.	eporting. an and
	rejection of care or be A review of an initial 2 facility became aware	ehaviors were indicated. 24 Hour Report indicated the e of an incident which related		Results of the monitoring tool will brought to the stand down meetin 5x/weeks times 4 weeks, and wee times 8 weeks.	g
	section labeled Allega "Resident allegation of Details of Physical or revealed a handwritte	of abuse." A section labeled Mental Injury/Harm en statement "No harm or d the report was signed by		Results of the audits will be prese the QAPI meeting x3 months or u time determined by the QAPI mer for sustained compliance.	ntil a nbers
	which was included w the initial 24 hour rep Resident #18 made a	itten statement by Nurse #10 vith documents in a file with ort dated 12/07/18, revealed accusations to Nurse #10 on		The Interdisciplinary Team Membri responsible for the Plan of Correct the Administrator is responsible for sustained compliance.	tion and
	them and "they were me." The statement if witnessed Resident # medication pass and mean or to kick Resident PM. The statement a went into Resident #1	and stated he was hurt by being mean" and "kicked further revealed Nurse #10 #18 from the hallway during did not observe NAs to be dent #18 on 12/07/18 at 8:30 also revealed Nurse #10 18's room on 12/08/18 at blood sugar and he had no		Date of Compliance 2/04/2019.	

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		345263	B. WING				C 05/2019
NAME OF PI	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 1	
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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 607	Continued From page	9 15	F6	607			
	Aide (NA) #7 with no included in a folder w	ith the initial 24 hour report led she went in Resident					
	An attempt to contact AM was unsuccessfu	: NA #7 on 01/05/19 at 10:48 I.					
	with no date or time b documents in a file w	ith the initial 24 hour report led she worked on 12/07/18					
	AM, NA #8 explained facility for a couple of abuse and neglect tra by the Director of Nur aware she was support abuse to the Nurse in she did not recall deta Resident #18 had acc and kicked him but sh the hallway when it has stated she had written had been asked to write						
	there was no stateme	nents in the folder revealed ent or interview notes with of the facility's investigation on of staff abuse.					
	Resident #18 stated a	n 01/03/19 at 10:48 AM a NA had been rough with a did not recall her name and					

Facility ID: 923019

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION		O. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · /	IPLETED	
				С			
		345263	B. WING		01/05/2019		
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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 607	Continued From page	e 16	F 607				
		ported it to anyone but he					
	had not seen the NA in a while. He further stated he did not recall the details of the incident on 12/07/18.						
		le (fax) confirmation report					
		hour report was submitted					
to the state a the report wa 12/10/18. A review of a confirmation section label revealed Rea member duri revealed sev with resident abuse howe Information i witness. During an int Administrato Cordinator. during the da #18 had beh statf had bee stated when asking quesi		n 12/10/18 at 8:43 PM and					
		d by the Administrator on					
	confirmation date of section labeled Origin revealed Resident #1 member during resid revealed several staf with resident care an abuse however, a se Information indicated	ing Day Report with fax 12/16/18 at 4:30 PM in a nal Allegation Details 18 alleged abuse from a staff ent care. The report further f were in the room helping d no witnesses saw any ction labeled Witness Nurse #10 was listed as a					
	During an interview of Administrator confirm Cordinator. She exp during the day on Mo #18 had behaviors du staff had been mean stated when she rece asking quesitons and	on 01/05/19 at 5:53 PM, the ned she was the Abuse lained it was reported to her onday 12/10/18 that Resident uring care and he reported and had kicked him. She eived the report she started I gathered information and on. She explained she filed					
	the 24 hour report be submitted to the state after Resident #18 al She further stated sta allegation of abuse o 12/07/18. She explain facility policy and pro	ecause it had not been e agency within 24 hours leged staff had abused him. aff should have reported an n the day it happened on ned Nurse #10 did not follow cedures to report allegations #10 who was employed by a					

If continuation sheet Page 17 of 59

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		345263	B. WING	C 01/05/2019	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	STR 3199		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ANKLIN, NC 28734 PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLET E APPROPRIATE DATE
F 607	She stated it was her have reported the inc abuse when it happen have been started rig the facility policies an regulatory and were w language. She expla needed to do a better of abuse and neglect training at a level that	nger worked at the facility. expectation staff should ident as an allegation of ned so an investigation could ht away. She further stated d procedures were very written in regulatory ined she felt the facility staff job of reporting allegations and they needed to put	F 607		
F 609 SS=D	CFR(s): 483.12(c)(1)( §483.12(c) In response		F 609		2/4/19
	involving abuse, negli- mistreatment, includir source and misappro- are reported immedia hours after the allegat that cause the allegat serious bodily injury, the events that cause abuse and do not res the administrator of th officials (including to the adult protective service for jurisdiction in long	ng injuries of unknown priation of resident property, itely, 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			

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CENTERS FOR MEDICARE & MEDICAID SERVICES           TATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-03 (X3) DATE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING			COMPLETED C 01/05/2019	
		345263					
NAME OF PF	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	ALLEY NURSING AND R	REHABILITATION CENTER		31	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 609	Continued From page	e 18	E E	609			
		administrator or his or her		003			
		ative and to other officials in					
	- ·	e law, including to the State					
		n 5 working days of the					
		leged violation is verified					
		e action must be taken. F is not met as evidenced					
	by:	is not met as evidenced					
		iews and staff interviews the			F609 Reporting of Alleged Violations		
		t an allegation of abuse to					
		in 24 hours when a resident			How will corrective action be		
		n of staff abuse during care eviewed for abuse and			accomplished for those residents four	nd to	
	neglect (Resident #1				be affected by the deficient practice?		
		-).			Resident #18 received a head to toe	skin	
	Findings included:				evaluation and was interviewed regar the allegation.	ding	
		mitted to the facility on			How will facility identify other resident	S	
		ses which included heart			having potential to be affected by the		
	failure, peripheral vas	abetes, respiratory failure			same deficient practice?		
	and dementia.	abortos, respiratory railure			Facility residents were interviewed by	the	
					facility Social Worker regarding any		
		erly Minimum Data Set			allegations of staff mistreatment.		
		8 revealed Resident #18 was					
		in cognition for daily decision so revealed Resident #18			Measures to be put into place or syste changes made to ensure that the defi		
		ssistance for bed mobility,			practice will not recur?	GGIIL	
	transfers, dressing, to						
					Licensed and unlicensed were		
		24 Hour Report revealed the			re-educated by 2/4/2019 regarding F6		
	•	e of an incident which related			Reporting allegations of abuse timely within the required timeframes. Staff	, and	
		2/07/18 at 11:45 PM. A ation Details revealed			members that have not completed		
		of abuse." A section labeled			education by 2/4/2019 will be educated	ed	
	Details of Physical or	Mental Injury/Harm			before able to work their next schedu		
		en statement "No harm or			shift. Newly hired staff will receive the		
	change in affect."				education during their facility orientati		1

Event ID: YJKF11

Facility ID: 923019

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TATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 01/05/2019	
		345263	B. WING			
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	I	
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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIOI DATE
F 609	Continued From page	e 19	F 60			
	A review of a handwr	itten statement by Nurse #10 vith documents in a file with	1 00	and interactive training sessions		
	the initial 24 hour rep Resident #18 made a 12/07/18 about NAs a them and "they were	oort dated 12/07/18, revealed accusations to Nurse #10 on and stated he was hurt by being mean" and "kicked further revealed Nurse #10		The Administrator or Designee is responsible for submitting initial allegations reports to the Health Personnel Registry.		
	witnessed Resident # medication pass and mean or to kick Resid	#18 from the hallway during did not observe NAs to be dent #18 on 12/07/18 at 8:30 also revealed Nurse #10		How the facility plans to monitor performance to make sure that s are sustained?		
		18's room on 12/08/18 at blood sugar and he had no		The Administrator and Director of will audit the other regarding the submission of initial allegations.	•	
	An attempt to contact 10:45 AM was unsuc	t Nurse #10 on 01/05/19 at ccessful.		The Department Managers and/ designee will monitor Abuse Pre and notification with targeted qu	vention	
	Aide (NA) #7 with no	itten statement by Nurse date or time but was ents in a file with the initial 24		specific to reporting requirement the Compliance Monitoring Tool monitoring tool includes staff into	ts utilizing . The	
	hour report dated 12/	07/18 revealed she went in and no one "kicked" or hit		questions regarding reporting of allegations initiated 1/21/2019, t 2 staff members 3x weekly x 4 v then weekly times 8 weeks.	o include	
	AM was unsuccessfu			Results of the monitoring tool wi brought to stand-down meeting	5x weekly	
	with no date or time to documents in a file w	ith the initial 24 hour report		times 4 weeks, then weekly time weeks. Results of audits will be presented to the QAPI meeting 2	x3 months	
	dated 12/07/17 revea and did not kick Resi	aled she worked on 12/07/18 dent #18.		or until a time determined by the members for sustained compliar		
	#8 explained she had for a couple of month and neglect training of	on 01/05/19 at 11:02 AM, NA d only worked at the facility is and had received abuse during her orientation by the She stated she was aware		The Interdisciplinary Team Mem responsible for the Plan of Correct the Administrator responsible su compliance.	ection and	

Facility ID: 923019

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/13/2019 MAPPROVED D: 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		PLETED
		345263	B. WING				C 105/2019
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	ALLEY NURSING AND R	REHABILITATION CENTER			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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 609	Continued From page	e 20	F	609			
F 609	she was supposed to to the Nurse immedia not recall details of th #18 had accused NAA him but she recalled a when it had happened the Nurse was. A review of the docur statement or interview part of the facility's im allegation of staff abu During an interview of Resident #18 stated a him in the past but he did not recall if he rep had not seen the NA he did not recall the of 12/07/18. A review of a facsimil revealed the initial 24 submitted to the state PM and the report wa Administrator on 12/1 A review of a 5 Worki confirmation date 12/ section labeled Origin revealed Resident #1 member during reside revealed several staff	e report allegations of abuse ately. She explained she did be incident when Resident s of being mean and kicked a Nurse was in the hallway d but did not remember who ments revealed there was no w notes with Resident #18 as vestigation regarding his use. In 01/03/19 at 10:48 AM a NA had been rough with e did not recall her name and borted it to anyone but he in a while. He further stated details of the incident on e (fax) confirmation report hour initial report was e agency on 12/10/18 at 8:43 as signed by the 10/18. Ing Day Report with fax 16/18 at 4:30 PM in a hal Allegation Details 8 alleged abuse from a staff ent care. The report further f were in the room helping	F	609	Date of Compliance 2/04/2019.		
	abuse.	d no witnesses saw any					
	Administrator explain	n 01/05/19 at 5:53 PM, the ed she received a report on t Resident #18 had reported					

If continuation sheet Page 21 of 59

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVE	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	B	COMPLETED	1
		245062			С	
		345263	B. WING		01/05/20	19
NAME OF Pr	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE COMP	(X5) IPLETIO DATE
				DEFICIENCY)		
F 609	Continued From page	e 21	F 60	09		
	staff had been mean	and had kicked him. She				
	stated when she rece	ived the report on Monday				
	12/10/18 she started	asking questions and				
	started an investigation	on. She further stated she				
	realized an initial 24 h	nour report had not been				
	submitted to the state	agency so she submitted				
:	the initial 24 hour rep	ort the day she was				
	informed to cover the	facility. She explained when				
	she had questioned s	taff about the incident they				
	stated Resident #18 I	nad behaviors during care				
		to report it as abuse. She				
		ould have reported an				
		n the day it happened on				
		nour initial report should				
		to the state agency at that				
	•	Nurse #10 did not follow				
		cedures to report allegations				
		histrator and Nurse #10 who				
		taffing agency no longer She stated it was her				
	expectation staff show					
	incident as an allegat	•				
		al 24 hour report could have				
	been faxed within 24	-				
E 656			E 65		2/4/1	0
F 656 SS=D	CFR(s): 483.21(b)(1)	Comprehensive Care Plan	F 65	00	2/4/13	9
	§483.21(b) Compreh	ensive Care Plans				
		cility must develop and				
		iensive person-centered				
		sident, consistent with the				
		th at §483.10(c)(2) and				
	§483.10(c)(3), that in	•				
		ames to meet a resident's				
		mental and psychosocial				
		ied in the comprehensive				
		nprehensive care plan must				

Facility ID: 923019

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/13/2 FORM APPRO OMB NO. 0938-0	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 01/05/2019	
		345263	B. WING			
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLET	
F 656	Continued From page	e 22	F 656			
		are to be furnished to attain	1 000			
		ent's highest practicable				
		l psychosocial well-being as				
		24, §483.25 or §483.40; and would otherwise be required				
		.25 or §483.40 but are not				
	provided due to the r	esident's exercise of rights				
	<b>-</b>	ding the right to refuse				
	treatment under §483	3.10(c)(6). ervices or specialized				
		s the nursing facility will				
	provide as a result of					
		a facility disagrees with the				
	findings of the PASAI	RR, it must indicate its				
		the resident and the				
	resident's representa					
		als for admission and				
	desired outcomes.	forence and natential for				
		eference and potential for silities must document				
	-	s desire to return to the				
	-	ssed and any referrals to				
		s and/or other appropriate				
	entities, for this purpo (C) Discharge plans i	in the comprehensive care				
		in accordance with the				
	-	h in paragraph (c) of this				
	section.	Γ is not met as evidenced				
	by:	ו וא ווטג וווכג מא לאועלוונלע				
	-	on, record review, resident		F656 Develop/Implement Compreh	ensive	
		the facility failed to develop		Care Plans		
		e plan for vision care for 1 of		How will corrective action be		
	-	t #17) and failed to follow the esidents (Resident #14)		How will corrective action be accomplished for those residents fo	und to	
	reviewed for compret			be affected by the deficient practice		

Facility ID: 923019

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 02/13/2019 M APPROVED O. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		345263	B. WING		01	C / <b>05/2019</b>
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI		
				3195 OLD MURPHY ROAD		
MACON V	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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	Continued From page	e 23	F 65	6		
	1. Resident #17 was 10/06/18 with diagnos glaucoma and macula admission Minimum I 10/13/18 indicated Res vision and had correct further indicated Resi impairment and requi with most activities of Review of the admiss (CAA) for visual funct wore eye glasses and cataract. The CAA fu would be initiated to be concerns for Residen Record review of the plan had been create Resident #17. Record review of the History and Physical #17 had decreased v	admitted to the facility on ses including cataracts, ar degeneration. The Data Set (MDS) dated esident #17 had impaired trive lenses. The MDS ident #17 had mild cognitive red extensive assistance f daily living. sion Care Area Assessment tion revealed the resident d had a diagnosis of a urther indicated a care plan begin addressing vision tt #17. care plans revealed no care d to address vision for Physician's admission (H&P) revealed Resident isual acuity and visual field revealed Resident #17		<ul> <li>reflect no longer requiring Inta Output. IDT members reviewe and determined resident #14 d warrant monitoring Intake and Resident #17 care plan was u reflect her glasses.</li> <li>How will facility identify other in having potential to be affected same deficient practice?</li> <li>The facility consultant reviewed days of Comprehensive Assess included were 11 residents ide triggered for the Visual CAA. 2 assessments reviewed require according to the RAI Manual. were updated accordingly. Measures to be put into place changes made to ensure that practice will not recur?</li> <li>The Interdisciplinary Team Me contribute to the MDS assess re-educated by the Corporate Clinical Quality and Reimburs 1/18/19 and 1/22/19 regarding</li> </ul>	ed care plan did not l Output. pdated to residents d by the ed past 90 ssments; entified that 2 of the 11 ed correction Care plans or systemic the deficient embers that ment were AVP of ement on	
	Resident #17 was ob with her glasses on. state how long she ha	n on 01/03/19 at 11:14 AM, served sitting in her room Resident #17 was unable to ad been wearing her glasses able to see out of them.		documentation and care plan on the comprehensive assess include development and impl of the care plan for vision care following the care plans as de	ment, to lementation e and	
	Nurse Assistant (NA) had glasses and wore	n 01/03/19 at 1:11 PM, #11 revealed Resident #17 e them regularly. n 01/03/19 at 4:28 PM, the		How the facility plans to monit performance to make sure that are sustained? The Interdisciplinary Team Me and/or designee will monitor c	at solutions embers	

Facility ID: 923019

STATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
					С	
		345263	B. WING		01/05/2019	
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIC	
F 656	MDS Coordinator rev and CAA for Resident should have been a c Coordinator also revia care plans for Reside had been created and no care plan had bee problems. During an interview o Coordinator #2 stated completed in an area create a care plan. M she had written the C could not explain why but thought it was jus During an interview o Director of Nursing (D expectations were for comprehensive, up to resident in his or her 2. Resident #14 was 06/13/15 with a recent hospitalization on 09/ The admission Minim 09/28/18 indicated Re cognitive deficits and activities of daily living revealed Resident #1 catheter due to Benig (BPH) as well as urin admission Care Area urinary incontinence i	ewed the admission MDS #17 and stated there are plan. The MDS ewed all previously written int #17 to verify if a care plan d resolved but did validate in created for vision n 01/03/19 at 4:35 PM, MDS after the CAA was she would go ahead and IDS Coordinator #2 verified AA for Resident #17 but a care plan was not written, t an accidental oversight. n 01/05/19 at 1:17 PM, the ON) stated her care plans to be date, and reflect the current state. admitted to the facility on t readmission after a 21/18. um Data Set (MDS) dated esident #14 had mild required assistance with all	F 65	<ul> <li>condition and/or concerns utilizing t change of condition audit tool to inc care planned revision, and implementation of interventions to maintain the residents highest pract physical, mental, and psychosocial well-being. Residents that will be monitored include through this proc indicated by care plan revisions.</li> <li>Results of the audit tool will be revise in stand down meeting 5x weekly tir weeks, then weekly times 8 weeks. Results of the on-going audits will b presented to the QAPI meeting x3 r or until a time determined by the QA members for sustained compliance.</li> <li>The Interdisciplinary Team Members responsible for the Plan of Correction the Administrator is responsible for sustained compliance.</li> <li>Date of Compliance 2/04/2018.</li> </ul>	lude iical, ess as ewed mes 4 e nonths API s are	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345263	B. WING			C 01/05/2019	
NAME OF P	ROVIDER OR SUPPLIER	L		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)	3E	(X5) COMPLETION DATE
F 656	Review of the admiss Resident #14 had an elimination with indwe infection - urinary rete the care plan indicate clean, dry and free fro and to be free of urina the interventions was of shift observe and re Review of urinary out days revealed five ins greater time when uri recorded. These day 12/07/18, 12/14/18, 1 During an observation Resident #14 was ob dining room while sitt catheter was observe catheter and tubing w During an interview o Director of Nursing (E output sheets for Res days. The DON state the NA's to document urinary output was for During an interview o Nurse Assistant (NA) a catheter that had to shift unless it seemed empty it a second tim also stated that she n document his output sure. NA #6 further s emptying his catheter	ion care plan revealed "altered pattern of urinary elling cath (foley) at risk for ention, BPH." Goals listed on ad for Resident #14 to be om odor or skin breakdown ary tract infections. One of "empty drainage bag at end ecord output." put for the most recent 30 stances of 12 hours or nary output was not s included 12/04/18, 2/19/18 and 12/27/18. In on 01/02/19 at 6:04 PM, served eating dinner in the ing in his wheelchair. His id in a privacy bag and the vere off the floor. In 01/03/19 at 6:09 PM, the DON) reviewed the urinary ident #14 for the past 30 ed her expectation was for t on each shift what the total r Resident #14. In 01/04/19 at 1:39 PM, #6 stated Resident #14 had be emptied at least once a d overly full and you might e during the shift. NA #6	F	356			

Facility ID: 923019

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345263	B. WING				05/2019
NAME OF PF	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	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656 F 677 SS=D	#3 stated Resident #1 stayed in a privacy bac catheter tubing. NA # the catheter bag when and then checks it ag shift. NA #3 stated he to document the urine but it was possible it h During an interview o #12 stated Resident # usually had an output NA #12 stated he emp shift and documented #12 also stated he mac and forgotten to docu but he wasn't sure. During an interview of Coordinator #2 stated information put into the the kardex (system N care needs) but some in. MDS Coordinator that was listed on the for the NA's to "obser end of each shift nor bag was to be emptie ADL Care Provided for CFR(s): 483.24(a)(2) A resid out activities of daily I	n 01/04/19 at 1:52 PM, NA 14 had a catheter and it ag off the floor along with the 53 also stated he looked at in he first comes on his shift ain before he leaves his e didn't think he ever forgot e output for Resident #14, had happened. In 01/04/19 at 2:02 PM, NA #14 had a catheter and of 800-1000 cc's per shift. otied his catheter bag every what the output was. NA ay have emptied the bag ment Resident #14's output, In 01/04/19 at 2:18 PM, MDS I that much of the the care plan flowed over to A's use to view resident e of it had to be manually put #2 stated the information care guide had not reflected ve and record output" at the did it indicate the catheter d at the end of each shift. or Dependent Residents		656			2/4/19
	CFR(s): 483.24(a)(2) §483.24(a)(2) A resid out activities of daily I services to maintain g	ent who is unable to carry iving receives the necessary good nutrition, grooming, and					

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/13/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345263	B. WING		C 01/05/2019
NAME OF PI	ROVIDER OR SUPPLIER		5	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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 677	by: Based on observatio	is not met as evidenced	F 677	F677 ADL Care Provided for Depe	endent
	fingernail care and ke 2 of 5 dependent resi of daily living (Reside			Residents How will corrective action be accomplished for those residents for be affected by the deficient practice	
		: admitted to the facility ses which included diabetes		Resident #5 and #18 were provide care by the facility staff. How will facility identify other reside having potential to be affected by t same deficient practice?	ents
	12/23/18 revealed Red deficits and required for most Activities of I MDS also revealed R of care.	m Data Set (MDS) dated esident #18 had cognitive extensive to total assistance Daily Living (ADL's). The esident #18 had no rejection an revealed no rejection of		On 1/8/19 The Treatment Nurse completed 100% observation of dependent residents for nail care a provided accordingly. Care Plans v updated to reflect resident interven based on resident preferences and requirements.	were htions
	that were directed tow lookback period.	vere some behavioral issues vard others during the		Measures to be put into place or sy changes made to ensure that the o practice will not recur?	
	Resident #18 was ob	n on 01/02/19 at 5:47 PM, served to have long ands with brown debris under		Nursing Staff were re-educated by 2/4/2019 regarding F677 ADL Care Dependent Residents by the corporclinical nurses and staff development	e for prate
	Resident #18 was ob	n on 01/03/19 at 10:48 AM, served to have long ands with brown debris under		coordinator. Education included has scenarios and interactive training sessions including fingernail care a cleanliness of fingernails.	ands on
	Resident #18 was ob	n on 01/04/19 at 5:53 PM, served to have long ands with brown debris under		How the facility plans to monitor its performance to make sure that solare sustained?	

Facility ID: 923019

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345263	B. WING		01/05/2019
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIO
F 677	Continued From page each fingernail.	28	F 677	, The Department Managers and/or	
Re fin ea An	Resident #18 was ob fingernails on both ha each fingernail.	inds with brown debris under		designee will monitor ADL Care del specifically related to fingernail care cleanliness of fingernails for 10% o current census 3x times a week x4 weekly times 8 weeks utilizing the Compliance Monitoring Tool.	e and f the
	An interview on 01/05/19 beginning at 2:57 PM with Nurse Aide (NA) #13 revealed she had not offered to clean the fingernails of Resident #18 today or requested that the nurse cut his fingernails. NA #13 also stated that Resident #18 did not like showers and was only given bed baths. Resident #18 was asked in the presence of NA #13 about his fingernails. Resident #18 stated his nails were too long and they were dirty, and he could no longer care for them because of his arthritis. NA #13 proceeded to clean the fingernails of Resident #18 and stated she would report to her nurse that his fingernails needed to be cut.		Results of the monitoring tool. Results of the monitoring tool will b brought to stand-down meeting 5 ti weekly times for 4 weeks, then wee 8 weeks. Results of the on-going a will be presented to the QAPI meet x3months or until a time determine the QAPI members for sustained compliance. The Interdisciplinary Team Member responsible for the Plan of Correcti the Administrator is responsible for sustained compliance.	mes ekly for udits ing d by rs are on and	
	#9 revealed he had o insulin this morning s Medication Aide (CM, noticed his fingernails			Date of Compliance 2/04/2019.	
	revealed he gave Res completed 2 capillary checks and he did no #6 also stated he pro did not notice Reside	5/19 at 4:17 PM with CMA #6 sident #18 his oral meds and blood glucose (CBG) t notice his fingernails. CMA bably got task oriented and nt #18's fingernails, but he fingernails when he gives be of care.			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 02/13/2019 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	LETED
		345263	B. WING				, )5/2019
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE	E, 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 CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ED TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 677	<ul> <li>should observe a resiprovide nail care as n diabetic.</li> <li>2. Resident #5 was an 02/18/13 with diagnosperipheral vascular dimost recent quarterly assessment dated 11 had severe cognitive extensive assistance MDS also indicated R behaviors of rejecting</li> <li>A Care Plan revised of Resident #5 required hygiene and would be on a daily basis. Interwould provide intermi and guidance and wo the portions of the tas attempt.</li> <li>Observation of Reside PM revealed he was a brown debris under th hands.</li> <li>Subsequent observat 01/02/19 at 6:43 PM, 01/03/19 at 5:00 PM, 01/03/19 at 1:00 PM a revealed the fingernal continued to be uncle underneath them.</li> </ul>	ring delivery of care a nurse ident's fingernails and needed when the resident is dmitted to the facility on ses which included isease and dementia. The Minimum Data Set (MDS) /16/18 revealed Resident #5 impairment and required with personal hygiene. The Resident #5 had no pare. on 12/17/18 indicated assistance with personal e neat, clean and odor free ventions included the staff ttent supervision with cues ould discuss with Resident #5 sk that he would be willing to ent #5 on 01/02/19 at 3:21 sitting in the hallway with he fingernails on both of his ions of Resident #5 on 01/03/19 at 2:14 PM, 01/04/19 at 9:33 AM, and 01/04/19 2:50 PM ils on both of his hands	F 677				

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	S FOR MEDICARE &					IO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	· · ·	TE SURVEY MPLETED
			A. BUILDING			С
		345263	B. WING		n	1/05/2019
NAME OF PI	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE		
				3195 OLD MURPHY ROAD		
	ALLET NORSING AND P	REHABILITATION CENTER		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 COR (EACH CORRECTIVE ACTION ( CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 677	Continued From pag	e 30	F 67	7		
		are. The Bather stated				
		one to refuse his bath and				
	was cooperative to his nails being trimmed and cleaned.					
	Interview with Nursin	g Assistant (NA) #3 on				
		/ revealed Resident #5 was				
		and received nail care				
	during his baths and	daily as needed.				
	Interview with NA #3	on 01/04/19 at 2:50 PM				
	revealed he had wor	ked on Resident #5's hall all				
		cleaned Resident #5's				
	-	ne Resident #5's fingernails NA #3 and he continued to				
	have brown debris u					
	fingernails. NA #3 sta me clean his nails".	ated "I will see if he will let				
	Interview with Nurse	#8 on 01/04/19 at 2:56 PM				
	-	ed Resident #5's fingernails				
		eaned on his bath days and Jlarly needed cleaned every				
	shift. At this time, Nu					
	condition of Resident	t #5's fingernails while NA #3				
		f cleaning his fingernails.				
	cleaned".	ould say they needed to be				
	During an interview v	with the Director of Nursing				
	(DON) on 01/05/19 a	at 4:24 PM she stated she				
	-	5's nails to be kept clean.				
F 690		tinence, Catheter, UTI	F 69	0		2/4/19
SS=D	CFR(s): 483.25(e)(1)	)-(3)				
	§483.25(e) Incontine	nce.				
	§483.25(e)(1) The fa	cility must ensure that				
	resident who is conti					

Facility ID: 923019

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		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 02/13/2019 FORM APPROVED OMB NO. 0938-0391		
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		STRUCTION	(X3) D	ATE SURVEY OMPLETED	
		345263	B. WING				C 01/05/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE			
MACON V	ALLEY NURSING AND R	REHABILITATION CENTER			LD MURPHY ROAD KLIN, 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 690	maintain continence of condition is or become not possible to mainta §483.25(e)(2)For a re- incontinence, based of comprehensive assess ensure that- (i) A resident who ent- indwelling catheter is resident's clinical con- catheterization was n (ii) A resident who en- indwelling catheter or is assessed for remo- as possible unless th- demonstrates that ca and (iii) A resident who is receives appropriate prevent urinary tract if continence to the exter §483.25(e)(3) For a re- incontinence, based of comprehensive assess ensure that a residen receives appropriate restore as much norm possible. This REQUIREMENT by: Based on record rev staff and physician in clarify the diagnosis f catheter on admission for the possible remo	ervices and assistance to unless his or her clinical less such that continence is ain. esident with urinary on the resident's asment, the facility must ters the facility without an not catheterized unless the idition demonstrates that ecessary; ters the facility with an subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to infections and to restore ent possible. esident with fecal on the resident's assment, the facility must t who is incontinent of bowel treatment and services to	F	Ca Ho aco	590 Bowel/Bladder Incontine theter, UTI w will corrective action be complished for those reside affected by the deficient pra	nts found to		

Facility ID: 923019

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		ND HUMAN SERVICES				FO	ED: 02/13/20 <sup>,</sup> RM APPROVE NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		STRUCTION		TE SURVEY MPLETED C
		345263	B. WING			0	1/05/2019
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
				3195 C	DLD MURPHY ROAD		
MACON V	ALLET NURSING AND P	REHABILITATION CENTER		FRAN	KLIN, 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	(X5) COMPLETION DATE
F 690	Continued From page	e 32	F 6	90			
	#12).						
					esident #12' s catheter was		
	The findings included	1:		dis	scontinued.		
	Resident #12 was ori	iginally admitted to the facility		He	ow will facility identify other reside	nts	
		noses that included diabetes			iving potential to be affected by th		
	and renal failure.			sa	me deficient practice?		
	Poviow of the discha	rge summary from the			n 1/8/19 the RN Consultant comp	lotod	
		a diagnosis for urinary			00% audit of residents with cathete		
	1 · ·	r diagnosis for the urinary		-	lidate appropriate diagnosis for u		
	catheter.	, ,			dwelling foley catheters, and cont		
				ra	tionale for use.		
		s orders upon admission		NA.	accuracite he put into place or ou	otomio	
	catheter.	an indwelling urinary			easures to be put into place or sy- anges made to ensure that the de		
	Callielei.				actice will not recur?	Silcient	
	Review of the care pl	lan for Resident #12 dated					
	11/16/18 indicated 1)	an altered pattern of urinary		Th	ne Director of Nursing and/or design	gnee	
		elling catheter and 2) at risk			II monitor new orders for catheter		
	for infection due to ur	rinary retention.			ilizing a catheter audit tool beginn	-	
	Deview of the physici	ian's History and Physical			21/2019, upon admission residen dwelling urinary catheters will be	ts with	
		8 revealed no diagnoses			viewed for appropriate diagnosis	and	
		f an indwelling urinary			tionale for continued use or	and	
	-	urther revealed the following			scontinuance. The results of the r	eview	
		of both bowel and bladder,"		wi	Il be reviewed with the attending		
		urination), and "frequency			iysician if an appropriate diagnosi	s not	
		" A second follow-up visit		-	ailable.		
		aled "patient is continent of			esults of the auditing tool will be		
		der," "no dysuria," and ncy normal." For both			viewed in stand down meeting 5x eekly times 4 weeks, then weekly		
		8 the physical examination			weeks.		
	for genitourinary was				-		
				Ho	ow the facility plans to monitor its		
	-	Minimum Data Set (MDS)			erformance to make sure that solu	tions	
		aled Resident #12 had some		ar	e sustained?		
		and had been admitted from			culte of the cudite tool will be an	contod	
	une nospital with an ir	ndwelling urinary catheter.		R	esults of the audits tool will be pre	sented	

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STATEMENT		MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		)	COMP	
						2
		345263	B. WING			05/2019
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 OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 690	Continued From page	e 33	F 69	0		
	The admission Care / revealed Resident #1 could cause incontine	Area Assessment (CAA) 2 took medications that ence but gave no specific		to the QAPI meeting x3 month time determined by the QAPI r for sustained compliance.		
	information to address the catheter or assessment and monitoring for the catheter's use and possible removal. The 14-day MDS dated 11/29/18 also revealed the resident had some cognitive impairment along with an indwelling catheter and diagnoses of diabetes and renal failure. No other related diagnoses were listed.			The Director of Nursing is resp the Plan of Correction and the Administrator is responsible fo compliance. Plan of Correction 2/04/2019.		
	Review of nurse's not	tes dated 11/28/18 revealed liagnosis of urinary retention				
	revealed a urinalysis	results dated 12/10/18 had indicated Resident #12 nary Tract Infection (UTI).				
		an's progress note dated sident #12 had a urinary o urinary retention.				
	Review of nurse's not the catheter was in pl drainage.	tes dated 01/02/19 revealed ace with clear yellow				
	Review of nurse's not revealed no assessm monitoring to assess removal prior to 01/02	ent had been completed or the need for catheter				
	and right indicating "r why he had a urinary tubing were observed	he shook his head to the left no" when asked if he knew catheter. The catheter and d during this interview to be wrapped in a clear plastic				

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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:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345263	B. WING				C 05/2019
NAME OF PI	ROVIDER OR SUPPLIER	L		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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 690	0 Continued From page 34		F	690			
	Review of nurse's not a late entry note to dis to monitor for urination nurse's note dated 01 had occurred yet, the and oral fluids were b Review of nurse's not Resident #12 was inconote from skin wound revealed Resident #1 During an interview w 01/05/19 at 11:40 AM admission MDS and w diagnosis listed for th catheter but wanted to file to verify if there w During a second inter Coordinator on 01/05 she was must have o have a diagnosis for a the assessment. She recognized it she wou diagnosis from the ph During an interview w 01/05/19 at 12:45 PM stated Resident #12 of a urinary catheter. Th a resident has a urina be a diagnosis and if the catheter. The phy could be removed if e with the resident with	tes dated 01/03/19 revealed scontinue the catheter and n and residual. A second //03/19 revealed no voiding bladder was non-distended being pushed. tes dated 01/04/19 revealed continent of urine. A second I treatment dated 01/04/19 2 was voiding freely. with the MDS Coordinator on I, she reviewed the verified there was no e use of Resident #12's o look back at his admission as a diagnosis present. view with the MDS /19 at 12:09 PM, she stated verlooked that he did not a catheter when she put it in e further stated if she had uld have requested a hysician. with the physician on I, he reviewed his notes and did not have a diagnosis for ne physician further stated if ary catheter there needs to not, they need to remove sician also stated a catheter everything was going well in 2 weeks in a best-case					
		s if there were extenuating nically there was a diagnosis					

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If continuation sheet Page 35 of 59

	OF DEFICIENCIES	MEDICAID SERVICES		ECONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
			/		с
		345263	B. WING		01/05/2019
IAME OF PF	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	•
			3	195 OLD MURPHY ROAD	
	ALLET 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	DATE
F 690	Continued From page	35	F 690		
		ccording to the physician,			
	however he stated of	en things fall through the			
		nt is transferred from setting			
		n had to try to pick up the the diagnosis for the			
	catheter fell through t	-			
	outlieter fen tilleugit t				
	During an interview w	ith the Director of Nursing			
	. ,	2:57 PM, she revealed her			
	•	the nurse to notify the			
		dent's admission to the			
	-	diagnosis for an indwelling a diagnosis for the catheter			
	or an order to remove				
F 695		tomy Care and Suctioning	F 695		2/4/19
SS=D	CFR(s): 483.25(i)				
	§ 483.25(i) Respirato	ry care, including			
	tracheostomy care ar				
		ire that a resident who			
	• •	e, including tracheostomy			
		tioning, is provided such			
		professional standards of ensive person-centered			
		its' goals and preferences,			
	and 483.65 of this sul	•			
		is not met as evidenced			
	by:				
		ns, record reviews and nd staff interviews the facility		F695 Respiratory/Tracheostomy Care and Suctioning	
		essments and vital signs for		and Suctioning	
	•	ed oxygen and was sent to		How will corrective action be	
	the hospital with resp	iratory distress (Resident		accomplished for those residents found	to
		led to connect oxygen		be affected by the deficient practice?	
	tubing to an oxygen ta			Decident #2 was seened was a	
		who was ordered to receive		Resident #2 was assessed upon return the facility and orders verified. Residen	
	above 90 percent (Re	en saturation percentages		stable at time of survey.	u

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If continuation sheet Page 36 of 59

	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY IPLETED
		345263	B. WING		0,	C 1/05/2019
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		
		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	SY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETIO DATE
F 695	Continued From page	e 36	F 695	5		
		eviewed for respiratory care.				
				On 1/3/19 Resident #25's Oxyger	n was	
	Findings included:			reconnected to concentrator and orders verified.	current	
		admitted to the facility on				
	respiratory failure wit	ses which included chronic		How will facility identify other resi having potential to be affected by		
		ve sleep apnea (breathing		same deficient practice?	uie	
		COPD (chronic obstructive				
		ease), atelectasis (partial or		Residents with oxygen ordered w	ere	
		a lung), shortness of breath		reviewed and verified for appropr		
	and dementia.			order vs. oxygen administered. N		
				residents were identified to have	а	
		an's orders dated 11/12/18		variance from orders.		
	revealed the following	ent nebulizer every 6 hours		Measures to be put into place or	evetomia	
	Duoneb inhaler 3 mil	•		changes made to ensure that the		
		gram inhaler 1 puff 2 times a		practice will not recur?	denoient	
	Oxygen 2 liters per n	ninute via nasal cannula		Nursing Staff were re-educated b	у	
	continuous to mainta			2/4/2019 regarding Respiratory C		
	percentage above 90	) percent.		specifically respiratory assessme		
	• • • • •			include vital signs and ensuring o		
		an with a created date of esident #2 had the potential		being delivered per physician ord		
		ve breathing pattern related		oxygen tubing connected as orde Education included hands on sce		
		al was Resident #2's airway		and interactive training sessions.		
	-	. The interventions were		hired staff will receive education of	-	
		ss and monitor for signs or		facility orientation.	0	
		ient breathing pattern, rapid				
		estlessness, shortness of		The Director of Nursing and/or De		
	-	ng followed by decreased		will monitor respiratory care delive		
	<b>_</b>	en decrease in activity		appropriate orders utilizing the ch		
		of lips, fingers and face, or pleuritic chest pain in the		condition audit, to include assess completion and documentation of		
	lung areas.			assessment to begin1/21/2019 5		
				for 4 weeks then weekly times 8 v		
	A review of an admis	sion Minimum Date Set				
	(MDS) dated 11/19/1	8 indicated Resident #2 was		How the facility plans to monitor i	ts	

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		NO. 0938-039 ATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	ì í			OMPLETED		
						С		
		345263	B. WING			01/05/2019		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE			
MACON V	ALLEY NURSING AND R	REHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734				
					000000000			
(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	(X5) COMPLETION DATE		
F 695	Continued From page	e 37	F 69	5				
	moderately impaired making. The MDS fur	in cognition for daily decision ther indicated Resident #2		performance to make sure the are sustained?	nat solutions			
	required extensive assistance for dressing and toileting but required limited assistance for bed mobility, transfers and locomotion off the unit and required supervision for locomotion on the unit and eating. The MDS also revealed oxygen was indicated.		Results of the monitoring too brought to stand-down 5x we weeks then weekly times 8 we discussion with the IDT Men the monthly QAPI meeting.	eek for 4 weeks for nbers and to Results of the				
11/26/18 at 2 revealed Res and unlabore Resident #2 oxygen on at orders but go A review of a 11/26/18 at 9 revealed aron Nurse #1 and phone becau The note furt in Resident # of anxiety bu assessment sounds or vit Resident #2 Emergency M	revealed Resident #2	progress note dated documented by Nurse #2 's respirations were even notes further revealed		audits will be presented to the meeting x3 months or until a determined by the QAPI me sustained compliance.	i time			
	oxygen on at 2 liters orders but got short c	hortness of breath and had per minute per physician's of breath with exertion.		The Director of Nursing is re the Plan of Correction and th Administrator is responsible compliance.	ne			
	revealed around 8:45 Nurse #1 and informe phone because Resid The note further reve in Resident #2's room of anxiety but there w assessment of Resid sounds or vital signs.	documented by Nurse #1 5 PM a receptionist called ed her that 911 was on the dent #2 had called them. aled when Nurse #1 arrived in she appeared to have a lot vas no documentation of an ent #2 which included lung The notes also revealed sferred to the hospital by Services (EMS) for		Date of Compliance 2/04/20	18.			
	bedside at 8:38 PM. Present Illness indica facility at Resident #2 breathing difficulties. Resident #2 was sittin	A section labeled History of ted EMS was called to the so request because of						

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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 05/2019	
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		BE ATE	(X5) COMPLETION DATE		
F 695	The report indicated F #1 if Resident #2 had treatment and Nurse Resident #2 a breathi PM." The report furth had respiratory wheat in the bases of her lun Resident #2 had oxyg her blood pressure wa 130, respirations were temperature was 98.8 report further revealed administered Duoneb treatment at 8:48 PM mg intravenously at 8 Resident #2 at 8:56 F emergency room at 9 A review of an Emerg 11/26/18 revealed Rese emergency room with The notes further revealed abreathlessness. A se Assessment/Plan rev a fairly large pleural es lung) on the left that w previous x-ray dated Diagnosis/Disposition exacerbation, worsen debility. A review of a hospital 11/29/18 revealed Rese effusion with a thorac remove fluid from the fluid was obtained, ow percent on 2 liters of	EMS personnel asked Nurse received a breathing #1 stated she had given ng treatment "about 5:30 per indicated Resident #2 zes and little air movement ngs. The report revealed gen on at 3 liters per minute, as 203/84, heart rate was e 30 and labored and 8 degrees Fahrenheit. The d EMS personnel 3 milligram (mg) nebulizer , Solumedrol (steroid) 125 :52 PM, left the facility with PM and arrived at the :04 PM. ency Room report dated sident #2 presented to the e severe shortness of breath. ealed Resident #2 was short rd to understand due to her isction labeled ealed a chest x-ray revealed offusion (excess fluid in the vas much changed from a 11/09/18. A section labeled in revealed COPD ing pleural effusion and discharge summary dated sident #2 had a left pleural	F	695				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 02/13/2019 // APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345263	B. WING				C 05/2019
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
		EHABILITATION CENTER		319	95 OLD MURPHY ROAD		
	ALLET NORSING AND R			FR	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 695	Continued From page	39	F 6	95			
	Nurse #1 who was as #2 during second shif received report on 11. #2 that Resident #2 h reported no other com Resident #2 requeste help her breathe bette scheduled breathing t stated she gave Resid treatment and though Resident #2's lungs b had heard. She expla giving medications to reported Resident #2 breathing treatment b breathing problems a her Resident #2 had o went to Resident #2's	reatment at 6:00 PM. She dent #2 a breathing					
	took Resident #2 to the Resident #2's medical she documented a put of 92 in the electronic at 5:47 PM and confir oxygenation percental documented after that was transported to the PM. She confirmed the describe Resident #2' because she had not of Resident #2 in the stated she did not reco oxygenation percental not recall checking Resident in the During a telephone in	he hospital. After review of I record Nurse #1 confirmed alse oxygenation percentage medical record on 11/26/18 med there was no pulse ge or vital signs t time or before Resident #2 hospital by EMS after 8:30 here were no other notes to 's respiratory condition documented assessments nurse's notes. Nurse #1					

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	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/13/2019 MAPPROVED D: 0938-0391
DEFICIENCIES ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
	345263	B. WING				C 05/2019
VIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
LEY NURSING AND R	EHABILITATION CENTER		3	3195 OLD MURPHY ROAD		
			F	RANKLIN, NC 28734		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
95 Continued From page 40 he responded to the facility on 11/26/18 after Resident #2 called 911 because it was his routine to respond with the EMS crew on that type of call. He stated when he arrived in Resident #2's room she was sitting in a wheelchair by her bed and was having obvious respiratory distress with difficulty breathing. He described her as leaning forward trying to breathe and she was emotionally upset because she felt she had not gotten treatment she needed. He stated Resident #2 was hooked to an oxygen concentrator with oxygen on at 3 liters per minute and a Nurse was in the room but he could not recall her name. He further stated he asked the Nurse if Resident #2 had received a breathing treatment for her current episode and the Nurse reported she had given Resident #2 a breathing treatment at 5:00 PM. He explained EMS personnel treated Resident #2 according to their protocols for COPD and Asthma excerbation and transported her to the emergency room for evaluation and treatment.		F	695			
he time and had bee 11/26/18. She explain o document assessme when a resident had n urther explained Nur- o the resident's lungs oxygen saturation per hem in the resident's During a telephone in PM, the Physician wh	ses were expected to listen s, check vital signs and rcentages and document medical record. terview on 01/03/19 at 12:22 to was also the facility					
urther o the i oxyger hem ir During PM, th Medica Nurse'	explained Nur- resident's lungs a saturation per the resident's a telephone in e Physician wh al Director state s to evaluate th	a resident had respiratory problems. She explained Nurses were expected to listen resident's lungs, check vital signs and a saturation percentages and document in the resident's medical record. a telephone interview on 01/03/19 at 12:22 e Physician who was also the facility al Director stated it was his expectation for is to evaluate the resident and investigate a resident had respiratory problems. He	explained Nurses were expected to listen resident's lungs, check vital signs and a saturation percentages and document in the resident's medical record. a telephone interview on 01/03/19 at 12:22 e Physician who was also the facility al Director stated it was his expectation for s to evaluate the resident and investigate	explained Nurses were expected to listen resident's lungs, check vital signs and a saturation percentages and document in the resident's medical record. a telephone interview on 01/03/19 at 12:22 e Physician who was also the facility al Director stated it was his expectation for s to evaluate the resident and investigate	explained Nurses were expected to listen resident's lungs, check vital signs and a saturation percentages and document in the resident's medical record. a telephone interview on 01/03/19 at 12:22 e Physician who was also the facility al Director stated it was his expectation for s to evaluate the resident and investigate	explained Nurses were expected to listen resident's lungs, check vital signs and a saturation percentages and document in the resident's medical record. a telephone interview on 01/03/19 at 12:22 e Physician who was also the facility al Director stated it was his expectation for s to evaluate the resident and investigate

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			()() · · · · -			10. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		· · ·	TE SURVEY MPLETED
						С
		345263	B. WING		0	1/05/2019
NAME OF PR	ROVIDER OR SUPPLIER	•	- I	STREET ADDRESS, CITY, STATE, ZIP COL		
		REHABILITATION CENTER		3195 OLD MURPHY ROAD		
	ALLET NORSING AND P	CENTER		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 OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 695	Continued From page	e 41	F 69	15		
		hould be documentation as	1 00			
		evaluation revealed and the				
		d be a footprint with the				
		ate what the Nurse did.				
		nterview on 01/03/19 at 4:47				
	PM, NA #9 who was	•				
	•	econd shift on 11/26/18				
		Resident #2 told her she was thing and wanted a breathing				
		ained she told Resident #2				
		#1 but when she went to the				
		#1 stated Resident #2 had				
		her explained she did not				
		or documented Resident				
	#2's vital signs on 11	/26/18 because everything				
	had happened so fas	st.				
	During an interview of	on 01/04/19 at 9:54 AM, the				
	Director of Nursing s					
	Resident #2's medica	al record Nurse #1 failed to				
	document assessme	nts of Resident #2. She				
		expectation for Nurses to				
	-	sments they did and vital				
		to be taken at the first of				
		pposed to be documented at				
	the point of care whe					
		tation of assessments and ccurred on 11/26/18 before				
	•	11. She further stated she				
		at had happened with				
		on because there were no				
		ented. She explained				
	Nurses were suppose	ed to document as care was				
		rse went into a resident's				
		nt was having respiratory				
		nould make quick decisions				
	and listen to lung sou	unds, get vital signs and all of	1			
		Id be documented in the				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 02/13/2019 APPROVED 2: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	-	(X3) DATE COMP	LETED
		345263	B. WING				, 05/2019
NAME OF PF	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, S	STATE, ZIP CODE		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		3195 OLD MURPHY ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRI	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	01/12/18 with diagness chronic lung disease, depression and deme A review of a care plat the potential for or acc pattern related to pne Resident #25's airway interventions were list signs or symptoms of pattern, notify Physici insufficient breathing therapy as ordered. A review of the most r Minimum Data Set (M revealed Resident #2 in cognition for daily of also revealed Resident assistance for med m required limited assist unit and oxygen was in A review of the month 01/01/19 through 01/3 was to wear oxygen to percentages above 90	re-admitted to the facility on ses which included anemia, history of pneumonia, intia. In dated 10/18/18 indicated tual ineffective breathing umonia and the goal was would be maintained. The red in part to monitor for insufficient breathing an of signs or symptoms of pattern and provide oxygen recent significant change IDS) dated MDS 10/26/18 5 was moderately impaired lecision making. The MDS int #25 required extensive obility and transfers but tance with locomotion on the indicated. Ily Physician's orders dated 81/19 revealed Resident #25 to keep his oxygen saturation c.	F 69				
	which started at 11:28 sitting in a wheelchair of his room into the ha revealed Resident #2 back of the wheelchai	AM Resident #25 was and propelled himself out allway. The observations 5 had an oxygen tank on the ir, he had a nasal cannula in holding oxygen tubing in his					

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	FED: 02/13/2019 RM APPROVED NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DA	ATE SURVEY DMPLETED
		345263	B. WING				C 01/05/2019
NAME OF P	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	(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	(X5) COMPLETION DATE
	propel himself in the nurse's station and ne giving medications to was asked by the sur trouble breathing whi next to Nurse #2 and old lungs." The obse continued to pull medicate cart and did not spea observations continue propelled himself dow room while holding the tubing in his lap then	nt #25 was then observed to wheelchair around the ext to Nurse #2 who was residents. Resident #25 veyor if he was having le seated in his wheelchair he stated "no, I just have ervations revealed Nurse #2 lications out of a medication k to Resident #25. The ed and Resident #25 vn a hallway and back to his ie disconnected oxygen came back out of his room de (NA) #10 in the hallway.					
	himself in the wheelc continued to hold the which was not conne- the back of his wheel continued until 11:53 Coordinator walked in	not stop or speak to ent #25 then propelled hair inside of a dayroom and oxygen tubing in his lap cted to the oxygen tank on chair. The observations					
	oxygen tubing to the Resident #25's wheel further revealed the N check Resident #25's percentage before or oxygen tubing to the During a telphone inte	oxygen tank on the back of Ichair. The observations ADS Coordinator did not s oxygen saturation after she connected the					
	expectations for Nurs orders. He futher sta Nurses to assess a re	es to follow Physician's ted it was his expectation for esident's respiratory status ordered to have oxygen they					

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	-					FORM	APPROVED 0. 0938-0391
STATEMENT O	DEPARTMENT OF HEALTH AND HUMAN SERVICES         DENTERS FOR MEDICARE & MEDICAID SERVICES         ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION       (1) PROVIDER/SUPPLIERCLIA IDENTIFICATION NUMBER:         MAME OF PROVIDER OR SUPPLIER         MACON VALLEY NURSING AND REHABILITATION CENTER         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         F 695       Continued From page 44 Physician.         During a telephone interview on 01/05/19 at 11:02 AM, NA #10 stated she had only worked at the facility for about 3 months. She further stated she was familiar with Resident #25 and was aware he wore oxygen. She stated she recalled seeing Resident #25 in the hallway on 01/03/19 and saw he had his oxygen tubing in his lap but did not realize it was not connected to the oxygen tank because she was on her way to another unit         During an interview on 01/05/19 at 11:38 AM, the MDS Coordinator stated she recalled a couple of days ago she saw Resident #25 holding oxygen tubing in his lap. She confirmed she was walking by the day room and she went into the room and adjusted the nasal cannula in his nose and connected the oxygen tubing to the tank on the back of his wheelchair. She stated Resident #25 said his oxygen machine was in his room but she reminded him he had an oxygen tank on the back of his wheelchair. She explained then Resident		· ,			(X3) DATE COMP	SURVEY PLETED
		MEDICARE & MEDICAID SERVICES       OMB NO.0938         INDUES       (X1) PROVIDER/SUPPLER/CLIA       (X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         345263       B. WING       C       01/05/201         DR SUPPLER       STREET ADDRESS, CITY, STATE, ZIP CODE       3195 OLD MURPHY ROAD         STREET ADDRESS, CITY, STATE, ZIP CODE       3195 OLD MURPHY ROAD       FRANKLIN, NC 28734         SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION OF CORRECTION       COMB         Leck-IDEPICIENCY MUST BE PRECEDED BY FULL       PRETIX       TAG       PROVIDER'S PLAN OF CORRECTION DECONSTRUCTION       COMB         Judge From page 44       F 695       F 695       COMS-REFERENCE TO THE APROPRIATE       COMB         a telephone interview on 01/05/19 at 11:02       #11:02       F 695       Company       Company       Company         with a bis oxygen tubing in his lap but realize it was not connected to the oxygen cause she was on her way to another unit.       F 695       F       F       695       Company       Company <t< td=""><td>-</td></t<>	-				
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER					
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	х	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
F 695	Physician. During a telephone in AM, NA #10 stated sh facility for about 3 mo she was familiar with aware he wore oxyge seeing Resident #25 and saw he had his o did not realize it was tank because she was During an interview of MDS Coordinator stat days ago she saw Re tubing in his lap. She by the day room and adjusted the nasal ca connected the oxyger back of his wheelchai said his oxygen mach reminded him he had of his wheelchair. Sh #25 asked if he was s when he went out of h on and the MDS Coor his oxygen tubing nee oxygen tank on the ba he was out of his roor Resident #25 did not oxygen tubing and sh staff did not make sur connected to the oxyg wheelchair.	terview on 01/05/19 at 11:02 he had only worked at the nths. She further stated Resident #25 and was n. She stated she recalled in the hallway on 01/03/19 xygen tubing in his lap but not connected to the oxygen s on her way to another unit. In 01/05/19 at 11:38 AM, the ted she recalled a couple of isident #25 holding oxygen e confirmed she was walking she went into the room and nnula in his nose and n tubing to the tank on the r. She stated Resident #25 hine was in his room but she an oxygen tank on the back e explained then Resident supposed to tell someone his room to put his oxygen rdinator stated she told him eded to be connected to the ack of his wheelchair when m. She further stated refuse for her to connect the e was not sure why other re his oxygen tubing was gen tank on the back of his	F	695			
	medications during he						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345263	B. WING				C 105/2019
NAME OF P	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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 695 F 725 SS=E	have his oxygen tubin tank on the back of hi she did recall hearing if he was having trout stated he just had old she should have look and should have mad was connected to the Resident #25's wheel During an interview of Director of Nursing sta a resident was in the oxygen tubing that was oxygen tank staff sho oxygen tubing and ma turned on to the liter f physician. Sufficient Nursing Sta CFR(s): 483.35(a)(1)( §483.35(a) Sufficient The facility must have the appropriate comp provide nursing and m resident safety and at practicable physical, n well-being of each res resident assessments and considering the n diagnoses of the facili accordance with the f at §483.35(a)(1) The fac by sufficient numbers types of personnel on	In the second se		695			2/4/19

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 02/13/20 <sup>7</sup> MAPPROVE 0. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		COM	E SURVEY PLETED C
		345263	B. WING			/05/2019
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		100/2010
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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 725	Continued From page	e 46	F 72	5		
	resident care plans:					
		ed under paragraph (e) of				
	this section, licensed					
	(ii) Other nursing personal limited to nurse aides	sonnel, including but not				
	§483.35(a)(2) Except					
		section, the facility must nurse to serve as a charge				
	nurse on each tour of	•				
		is not met as evidenced				
	by:	is not met as evidenced				
	-	ns, record reviews and staff,		F725 Sufficient Nursing Staff		
		in interviews the facility failed				
		ursing staffing to perform		How will corrective action be		
	-	vital signs, to provide		accomplished for those reside	nt(s) found	
		vide ice water at the bedside		to be affected by the deficient	. ,	
	for 4 of 11 sampled re				•	
	respiratory care, prov	ision of activities of daily		Resident #2 remains in the fac	cility and	
	living (ADL) care to d	ependent residents and		remains stable.		
	choices (Residents #	2, #21, #18 and #5).		Resident #5 and #18 were pro	vided nail	
				care by the facility staff.		
	This citation is crosse			Resident #21 was provided fre water upon notification.	esh ice	
		observations, record				
	reviews and resident,			How will facility identify other r		
	interviews the facility	•		having potential to be affected	by the	
		al signs for a resident who		same deficient practice?		
		was sent to the hospital with		Decidente who are deresident		
		or 1 of 4 residents reviewed		Residents who are dependent		
	for respiratory care (F	·		audited regarding care and se interventions provided accordi		
		se Aide (NA) #9 conducted PM revealed she observed		Measures to be put into place	or systemic	
		hard time breathing and the		changes made to ensure that		
	-	she could not breathe. The		practice will not recur?		
		ed the Nurse about Resident				
	#2 having difficulty br	eathing but did not go back		A wage analysis was complete	ed as a	

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB	NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	· · ·	ATE SURVEY OMPLETED
		345263	B. WING				C 01/05/2019
NAME OF P	ROVIDER OR SUPPLIER	·		ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
MACON V	ALLEY NURSING AND R	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	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 725	Continued From page	e 47	F7	725			
	thirty other residents have time.			implementation of sign-on bonus and recruitment bonus to facilitate staff recruitment in all departments.			
	on observation, recorr interviews, the facility care and keep the fin- dependent residents daily living (Resident c. F-0561: Self Detern observation, record re- interviews the facility having ice water at be residents reviewed fo An interview with Batt PM revealed there we pulled to the hall to w another aide who was explained that made in residents and could in could. The Bather stat tasks like toileting, pro- turning had to be put	mination: Based on eviews, staff and resident failed to honor the choice of edside for 1 of 4 sampled or choices (Resident #21). her #1 on 01/03/19 at 12:08 ere days when she was ork with just herself and s newly hired. The Bather			The Administrator and Director of Nur- will meet staffing patterns and shift assignments for appropriate coverage weekly and prior to the weekend base needs in conjunction with on-boarding process. Director of Nursing will ensur- adequate staffing is provided daily for performance of assessments including vital signs, provision of nail care, and provision of ice water at the bedside. How the facility plans to monitor its performance to make sure that solution are sustained? Results of the monitoring tool which includes ADL Care, Call Light Respon- time, and passing water to the resider will be brought to stand-down meeting 5x/week times 4 weeks, then weekly times 8 weeks for discussion with the Members and to the monthly QAPI meeting. Results of the audits will be presented to the QAPI meeting x mon	ed on pre g ons se nts g IDT	
	what resident care wa During an interview w 12:51 PM she stated new staff recently wh when they were assig staff member that ma the resident's daily ca because the new staff	on to the oncoming shift as not completed. with Bather #2 on 01/03/19 at the facility had hired a lot of ich was a good thing but gned to a hall with only a new ide it difficult to provide all of are needs in a timely manner if member doesn't know the es. The Bather stated when			or until a time determined by the QAP members for sustained compliance. The Director of Nursing is responsible the Plan of Correction and the Administrator is responsible for sustai compliance. Date of Compliance 2/04/2019	for	

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						10. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• • •	PLE CONSTRUCTION G		TE SURVEY MPLETED
					С	
		345263	B. WING		0	1/05/2019
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 PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 725	Continued From page	<u> </u>	F 72	25		
1725				25		
		as assigned to work by hat she had to provide the				
		needs and what resident				
		t done she passed on to the				
	-	stated she knew for a fact				
		n knew how hard it was to				
	-	hire and be expected to get				
	all of the resident car	e tasks done.				
	During an interview w	rith Nurse #3 on 01/03/19 at				
	-	was difficult for the aides				
		facility aide and an agency				
		gh as they needed to be with				
	providing resident car	-				
		nd feeding the residents but				
	· ·	as much as she could with				
		hts in order to free the aides de more resident care.				
	-	vith Nursing Assistant (NA)				
		46 AM he explained it was				
		mplete the daily care needs				
	-	uired when he worked the d aide because he was				
	tasked to orient the a					
		ties of daily living. The aide				
		unable to complete the tasks				
	he passed what was	undone on to the oncoming				
	shift.					
	During an interview w	rith NA #6 on 01/05/19 at				
	4:07 PM she stated to	-				
	-	new hire and they were				
		tasks the whole shift. The				
		vo meals to feed, answer call				
		ide as much resident care as not seemed to get caught up				
	with their tasks. The I					
		ice water but was unable to	1			

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPI	LE CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · ·	MPLETED
					С	
		345263	B. WING			1/05/2019
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD		<u> </u>	
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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 725	Continued From page	e 49	F 72	5		
0		to go to the other hall to	172			
	work another eight ho					
	During an interview w	vith NA #17 on 01/05/19 at				
	9:55 AM she explaine	ed she was a newly hired				
	employee that was gi					
		ift then was expected to cond shift on a hall by				
		ed that although that was				
		on she felt that she had no				
		II by herself. The aide stated				
	she did the best she	-				
	she knew about them	needs considering how little				
	On 01/05/19 at 12:58	PM during an interview with				
		explained she was aware of				
	the facility's current s	•				
	-	ge of 80 percent of agency				
	-	orked at the facility. The				
		facility had initiated several				
		as offering both referral and ring shift differential pay,				
		pay scale to hire new facility				
	staff.					
		PM during an interview with				
		ig (DON) she explained that				
		/as cited for insufficient				
	-	etting agency staff in the				
		ted she was aware that the				
		was staffed with agency				
		as a core of the long term				
		the facility and the majority st shift which left second				
		st shift which left second taffed with agency staff and				
	that made it difficult to					
	orientation to the age					1

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TATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345263	B. WING				C / <b>05/2019</b>
NAME OF P	ROVIDER OR SUPPLIER		<b>I</b>	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				31	95 OLD MURPHY ROAD		
	ALLET NORSING AND R	REHABILITATION CENTER		F	RANKLIN, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIO DATE
F 725	Continued From page	<del>2</del> 50	Í F	725			
0		e DON stated she needed to		125			
	-	t a time and the biggest one					
	was bringing staff into						
F 759	Free of Medication E	rror Rts 5 Prcnt or More	F	759			2/4/19
SS=D	CFR(s): 483.45(f)(1)						
	SADD AF(f) Madiantia						
	§483.45(f) Medication The facility must ensu						
	The facility must choo						
	§483.45(f)(1) Medica	tion error rates are not 5					
	percent or greater;						
		is not met as evidenced					
	by:	no record reviews and staff			EZEO Error of Madiantian Error Data E	D/	
	interviews, the facility	ns, record reviews and staff			F759 Free of Medication Error Rate 5 <sup>o</sup> or More	%	
	-	per cent (%) or less error					
		5 medication administration			How will corrective action be		
		rtunities for a medication			accomplished for those resident(s) four	nd	
		4 of 14 residents (Resident			to be affected by the deficient practice	?	
	#s 11, 9, 27, and 26)	during medication pass.					
	The findings included				Resident s #9 and #27 remain in the facility and are stable.		
	The findings included				Resident #11 was administered the		
	1. Resident #11 was	readmitted to the facility on			correct dose of insulin.		
		ses which included type 2			Resident #26 s Flonase was obtained	I	
		review of his January 2019			from the pharmacy.		
	Medication Administra	. ,					
		inger stick blood sugars and at bedtime with sliding			How will facility identify other residents	i	
		and at bedtime with sliding			having potential to be affected by the same deficient practice?		
	scheduled insulin as						
		-			Resident medication orders were		
		AM during the observation			reviewed to ensure all medications we	re	
	•	Nurse #1 was giving			available as written by 2/4/2019.		
		ent #11 which included 6					
		lin for a FSBS of 280 and a			Measures to be put into place or system		
	scheduled dose of No	ovolog 10 units before lunch			changes made to ensure that the defic	ient	1

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						<u>NO. 0938-03</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
			A. BUILDING	J		С
		345263	B. WING			1/05/2019
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP O		
				3195 OLD MURPHY ROAD		
ACON V	ALLEY NURSING AND R	REHABILITATION CENTER		FRANKLIN, NC 28734		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLETIC
F 759	Continued From page	e 51	F 75	59		
		sulin syringe and showed				
		read at 10 units of Novolog.		Licensed Nurses and Med		
		medication cart and was		were re-educated regardin	-	
		the medication to Resident opped and asked to verify		Administration/Safety spec	-	
		in the syringe. Nurse #1		medication administration and administration, medica		
		again and saw that it only		common mistakes to avoid		
	had 10 units in the sy			transcription of medication	•	
				administration record by th		
	An interview on 01/03	3/19 at 11:34 AM with Nurse		clinical nurses, the Staff D		
	#1 revealed she had	drawn up the wrong amount		Director, and the Consulta		
		ankful it was corrected		by 2/4/2019. Education in		
		Nurse #1 stated she had		on scenarios and interactiv	e training	
		of the plunger in the syringe		sessions.		
	-	he plunger. Nurse #1 stated ble checked the syringe		The Director of Nursing an	d/or Designee	
		rt to give the medication.		will monitor new medicatio		
				medications available on c	,	
	An interview on 01/05	5/19 at 3:00 PM with the		medication administration		
	Director of Nursing (E	OON) revealed she expected		insulin. The monitoring beg	gan 1/28/2019	
		g medications to follow the 5		and will include transcription		
	-	administration including right		orders to the Medication a		
	-	ion, right dose, right route		record and treatment admi		
	and right time.			record, availability of new i		
	2 Resident #0 was re	eadmitted to the facility on		ordered, and resident's me schedules when out on ap		
		ses which included type 2		utilizing the Compliance M		
		review of her January MAR		Insulin administration will b	-	
		neduled insulin prior to lunch.		utilizing the monitoring too		
		sident #9 to receive Novolog		observation of administrati		
		ly (SQ) before lunch. Nurse		resident census will be mo		
		n in an insulin syringe and		for 4 weeks, then weekly for		
		hat was read at 6 units of		consultant pharmacist will	•	
	Novolog.			medication pass observation monthly visits.	UN ON NEL	
	On 01/03/19 at 12:00	PM during the observation				
	of a medication pass,			How the facility plans to m	onitor its	
		nd cleaned an area around		performance to make sure		
	her belly button on he	er stomach and gave the		are sustained?		

Facility ID: 923019

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,	LE CONSTRUCTION	OMB NO. 0938-03
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345263	B. WING		C 01/05/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIC
F 759	Continued From page	e 52	F 75	9	
	to the stomach instead the stomach. The inst intradermal at a 5 deg a 90 degree angle. T induration of the skin An interview on 01/05 #2 revealed she had Nurse #2 stated that taught to do insulin in way she had always of An interview on 01/05 Director of Nursing (D aware that Nurse #2 intradermal at a 5 deg The DON stated the f checklists on the nurse a part of the skills che not locate a skills che DON stated she exper medications to follow administration includi medication, right dose The DON demonstrat to give insulin injection a 90 degree angle wit in to the stomach or b 3. Resident #27 was 04/26/18 with diagnost diabetes mellitus. An MAR revealed he was at bedtime with SSI fot to lunch on 01/03/19 his orders he was to b	at the injection site. 5/19 at 1:16 PM with Nurse given the insulin "sideways." was the way that she was jections and that was the done them. 5/19 at 3:00 PM with the DON) revealed she was not was giving insulin gree angle to the stomach. facility did have skills ses and giving injections was ecklist; however, she could ecklist for Nurse #2. The ected the staff administering the 5 rights of medication ng right person, right e, right route and right time. ted she expected the nurses ns with an insulin syringe at th the needle going straight		Results of the monitoring tool will be brought to stand-down meeting 5x of times 4 weeks, then weekly times 8 weeks for discussion with the IDT Members and to the monthly QAPI meeting. Results of the on-going au will be presented to the QAPI meetin months or until a time determined be QAPI members for sustained comp The Director of Nursing is responsite the Plan of Correction and the Administrator is responsible for sus compliance. Date of Compliance 2/04/2019	week Idits ng x3 y the liance. Dle for

If continuation sheet Page 53 of 59

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. I 345263 B. V NAME OF PROVIDER OR SUPPLIER MACON VALLEY NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES						FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	, í		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345263	B. WING				C 05/2019
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0.	
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER			3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 759	Continued From page	2 53	F	759			
	of a medication pass, Resident #27's room his belly button on his insulin holding the syn to the stomach instea the stomach. The ins intradermal at a 5 deg a 90 degree angle. T induration of the skin An interview on 01/05 #2 revealed she had Nurse #2 stated that taught to do insulin in way she had always of An interview on 01/05 Director of Nursing (D aware that Nurse #2 v intradermal at a 5 deg The DON stated the f checklists on the nurs a part of the skills che not locate a skills che DON demonstrated s give insulin injections 90 degree angle with to the stomach or boo 4. Resident #26 was 12/22/18. A review of revealed the physicia 01/02/19 for Flonase nostril twice a day (bir rhinitis.	Nurse #2 went in to and cleaned an area around a stomach and gave the ringe sideways and parallel d of at a 90 degree angle to sulin was administered gree angle instead of SQ at here was no noted at the injection site. 5/19 at 1:16 PM with Nurse given the insulin "sideways." was the way that she was jections and that was the done them. 5/19 at 3:00 PM with the DON) revealed she was not was giving insulin gree angle to the stomach. acility did have skills ses and giving injections was ecklist; however, she could cklist for Nurse #2. The he expected the nurses to with an insulin syringe at a the needle going straight in					

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		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 02/13/2019 DRM APPROVED NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		345263	B. WING				C 01/05/2019
NAME OF P	ROVIDER OR SUPPLIER	1		STI	REET ADDRESS, CITY, STATE, ZIP CODE	•	
MACON V	ALLEY NURSING AND F	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 PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 759	<ul> <li>(CMA) #5 was not ab #26's Flonase nasal a received from the pha was omitted; howeve physician's order to h received from the pha administer the medica available from the pha the administration tim</li> <li>An interview on 01/03 revealed she had not because it was not available for the medications in the Box (EMB). CMA #5 absence of the medica nurse.</li> <li>An interview on 01/04 Unit Manager revealed on 01/03/19 sometim on 2nd shift to hold th from pharmacy. The after she realized the available to be given stated there had been medication because to been faxed to the pha been written.</li> <li>An interview on 01/05 Director of Nursing (E aware there had been #26's medication and called in to the pharm stated she expected</li> </ul>	<ul> <li>A Certified Medication Aide le to administer Resident spray because it was not armacy so the medication r, there was not a hold the medication until armacy. CMA #5 did not ation because it was not armacy and simply circled he as not given.</li> <li>B/19 at 9:15 AM with CMA #5 given the medication vailable and was not one of e Emergency Medication stated she would report the cation to her supervising</li> <li>A/19 at 10:00 AM with the ed she had written an order e (could not remember time) he Flonase until received UM stated it was written medication was not to Resident #26. The UM in a delay in getting the the original order had not armacy promptly after it had</li> <li>D/19 at 3:00 PM with the DON) revealed she was not in a delay in getting Resident is stated it should have been nacy for delivery. The DON the staff administering the 5 rights of medication</li> </ul>	F	759			

Facility ID: 923019

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 02/13/2019 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345263	B. WING		-	( 01/0	; 05/2019
NAME OF PF	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		195 OLD MURPHY ROAD			
(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 TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 759	<ul> <li>5. Resident #26 was not a 12/22/18. A review of revealed the physician 01/02/19 for Flonase nostril twice a day (bid rhinitis.</li> <li>On 01/03/19 at 4:06 F of a medication pass, administer Resident # because it was not reso the medication was was not a physician's until received from the available and simply of time as not given.</li> <li>An interview on 01/03 #4 revealed she would pharmacy to find out a spray was and when it and shift to hold the from pharmacy. The after she realized the available to be given the available to be given to the stated there had beer medication because to the stated the stated the stated there had beer me</li></ul>	e, right route and right time. readmitted to the facility on f his January 2019 MAR n had written an order on nasal spray 2 sprays in each d) for 4 weeks for allergic PM, during the observation Nurse #4 was not able to #26's Flonase nasal spray ceived from the pharmacy s omitted; however there order to hold the medication e pharmacy. Nurse #4 did edication because it was not circled the administration F/19 at 4:10 PM with Nurse d have to contact the where the resident's nasal it would be delivered. F/19 at 10:00 AM with the d she had written an order e (could not remember time) e Flonase until received UM stated it was written	F 759		EFICIENCY)		
	An interview on 01/05	5/19 at 3:00 PM with the OON) revealed she was not					

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CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         345263		(X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED C 01/05/2019	
		B. WING					
NAME OF PROVIDER OR SUPPLIER MACON VALLEY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3195 OLD MURPHY ROAD FRANKLIN, NC 28734				
(X4) ID PREFIX TAG	(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 A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 759 F 760 SS=D	#26's medication and called in to the pharm stated she expected is medications to follow administration includi medication, right dos Residents are Free o CFR(s): 483.45(f)(2) The facility must ensu §483.45(f)(2) Residen medication errors. This REQUIREMENT by: Based on record rev interviews, the facility significant medication physician orders to a for 1 of 3 residents (F anticoagulant therapy The findings included Resident #18 was rea 12/03/18 with diagnos embolism and thromt extremity, peripheral long term use of antic A review of Resident minimum data set (M the resident was mod decision making, had and received dressing	<ul> <li>a delay in getting Resident</li> <li>I stated it should have been hacy for delivery. The DON the staff administering the 5 rights of medication ng right person, right</li> <li>e, right route and right time.</li> <li>f Significant Med Errors</li> <li>ure that its- ints are free of any significant</li> <li>T is not met as evidenced</li> <li>iew, staff, and physician</li> <li>i failed to prevent a</li> <li>in error by not following</li> <li>dminister an anticoagulant</li> <li>Resident #18) reviewed for</li> <li>/.</li> <li>admitted to the facility on ses which included acute</li> <li>posis of deep veins of upper vascular disease (PVD),</li> <li>coagulants and others.</li> <li>#18's most recent quarterly</li> <li>DS) dated 11/19/18 revealed</li> <li>derately impaired for daily</li> <li>an open lesion on his foot</li> <li>gs to his feet. The MDS also</li> <li>had received anticoagulants</li> </ul>	F 75		nt(s) found practice? Iministered late. esidents by the vere audited red per or systemic the deficient	2/4/19	

Facility ID: 923019

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		MEDICAID SERVICES				0938-03	
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP		(X3) DATE SURVEY COMPLETED			
			A. BUILDING		с		
	345263		B. WING			01/05/2019	
IAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		2015	
				3195 OLD MURPHY ROAD			
ACON V	ALLEY NURSING AND R	REHABILITATION CENTER		FRANKLIN, NC 28734			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPF DEFICIENCY)		THE APPROPRIATE	COMPLETIC DATE	
F 760	Continued From page	e 57	F 76	0			
	A review of Resident #18's care plan dated			for the next day and notifyi	ng the		
		e resident had a care plan		physician to obtain orders			
	for potential for bleed	ling related to anticoagulant		be put into place or system			
		as the resident would be free		made to ensure that the de			
	of signs/symptoms of	f bleeding. The interventions		will not recur?			
	included in part, administer medications as						
	ordered by the physic	cian.		Licensed Nurses and Med			
				were re-educated by 2/4/2			
		18's monthly January 2019		Medication Administration/	•		
	physician orders reve			specifically related to antic	-		
		5 milligram tablet of Eliquis		anticoagulant administration			
	-	dication) twice a day by		physician orders. Educatio			
	mouth.			hands on scenarios and in	teractive		
	A review of Desident	#101a Madiastian		training sessions.			
	A review of Resident				d/ar daaimaaa		
	Administration Record (MAR) for January of 2019, revealed in part, the resident had an order			The Director of Nursing an will monitor new medicatio	-		
		ication in the morning:		medications available on c			
		ication in the morning.		medication administration			
	Eliquis 5 milligram (m	a) tablet - 1 tablet by mouth		anticoagulants beginning 1			
	Eliquis 5 milligram (mg) tablet - 1 tablet by mouth twice daily at 8:00 AM and 8:00 PM.			10% of residents on antico			
				weekly times 4 weeks, and	-		
	0n 01/04/19 Residen	nt #18 was scheduled for a		weeks utilizing the Complia			
	physician appointment and was scheduled to			Tool.			
		veen 7:00 AM and 7:30 AM.					
	Review of the resider			How the facility plans to me	onitor its		
	01/04/19 the resident had not received his Eliquis			performance to make sure			
	prior to leaving for his appointment. The MAR			are sustained?			
	revealed the medication had not been given and			Results of the monitoring tool will be			
	the medication was circled by Certified			brought to stand-down meeting 5x week			
	Medication Aide (CMA) #1.			for 4 weeks, and weekly fo	•		
	Ì			discussion with the IDT Me			
	An interview on 01/05/19 at 10:01 AM with CMA			the monthly QAPI meeting. Results of the			
	#1 revealed she had not given the Eliquis to			on-going audits will be pre-			
	Resident #18 because she had not counted			QAPI meeting x3 months of	or until a time		
	narcotics with the off	going nurse. CMA #1 stated		determined by the QAPI members for			
		ny medications until she was		sustained compliance.			
		e nurse that had worked the					
	previous night shift.			The Director of Nursing is	responsible for		

Facility ID: 923019

CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         345263         NAME OF PROVIDER OR SUPPLIER		(X2) MULTIPLE A. BUILDING	(X3) DATE	<u>D. 0938-039</u> E SURVEY PLETED		
		B. WING		C		
		STREET ADDRESS, CITY, STATE, ZIP CODE		01/05/2019		
		EHABILITATION CENTER	3	195 OLD MURPHY ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPE DEFICIENCY)		HOULD BE	(X5) COMPLETIO DATE
F 760	with Nurse #6 who ha 01/04/19 revealed sh #18 his Eliquis becau than her medication p Resident #18 left the Nurse #9 and CMA # his medications prior stated Resident #18 h before he left and had with him to his appoir Resident #18 had left medications with Nur- probably should have him prior to him leavin An interview on 01/05 Medical Director (MD have wanted Resider the facility to an appo morning medications. #18 not getting his El medication due to the An interview on 01/05 Director of Nursing (E have expected Nurse #18 his medications p	on 01/05/19 at 2:16 PM ad worked the night shift on e had not given Resident se it was scheduled later bass. Nurse #6 stated facility at 7:00 AM and 1 knew she had not given to him leaving. Nurse #6 had an early breakfast d a bagged lunch to take htment. Nurse #6 stated before she had counted se #9 or CMA #1 and she e given his medications to	F 760	the Plan of Correction and the Administrator is responsible for compliance. Plan of Compliance 2/04/2019.		

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