	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION	(X3) DATE SUR COMPLET	
		345263	B. WING		C 02/22/2	2019
NAME OF PF	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		95 OLD MURPHY ROAD ANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE CO	(X5) DMPLETIO DATE
E 000	Initial Comments		E 000			
F 000		5.73, Emergency t ID #W68Q11.	F 000			
F 561 SS=D		encies cited as a result of ation. Event ID #W68Q11. (3)(8)	F 561		3/1	1/19
	promote and facilitate through support of res	right to and the facility must resident self-determination sident choice, including but is specified in paragraphs (f)				
	activities, schedules (waking times), health					
		ident has a right to make s of his or her life in the cant to the resident.				
	with members of the	ident has a right to interact community and participate in both inside and outside the				
	§483.10(f)(8) The res participate in other ac	ident has a right to tivities, including social,				
		SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE	()(0)	DATE

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.

			0.00				<u>D. 0938-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	· · ·	E SURVEY PLETED
		345263	B. WING				C / 22/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	02	/22/2015
					195 OLD MURPHY ROAD		
MACON V	ALLEY NURSING AND I	REHABILITATION CENTER			RANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 561	Continued From pag	e 1	F	561			
		unity activities that do not		501			
		nts of other residents in the					
	facility.						
	-	T is not met as evidenced					
	by:						
	Based on observation	on, record review, and			F561		
		erviews the facility failed to					
		or scheduled smoking times			How will corrective action be		
		nt's choice and care plan for			accomplished for those residents found	l to	
:		wed for smoking (Resident #			be affected by the deficient practice?		
	283).				Dec # 22 was accompanied by a staff		
	Findings included				Res # 23 was accompanied by a staff member out to the smoking area on		
	Findings included:				2/20/2019.		
	Resident #283 was a	admitted to the facility on					
		ses included depression,			How will facility identify other residents		
		Artery Disease, hypertension,			having potential to be affected by the		
	Cerebral Vascular Di	isease, and hemiplegia of the			same deficient practice?		
	left lower extremity.						
	A	ante Minimum Data Oat			The facility's other 2 residents that choo	ose	
		erly Minimum Data Set 2018 revealed Resident			to smoke were accompanied to the	Ч	
		s intact. Resident #283 was			approved smoking area by the assigned staff member.	u	
	-	staff member for locomotion			Stan member.		
		dent #283 was coded as a			Measures to be put into place or system	nic	
	current tobacco user				changes made to ensure that the defici		
					practice will not recur?		
		e plan dated 1/30/19 revealed					
		vith appropriate smoking or			Revision of the Supervised smoking		
		ucts related to decreased			assignment times was completed by the	е	
		he goal was that the resident			Administrator to include other ancillary		
	-	in a designated area with erventions included following			departments.		
		posted on the wall in the			The Department Head Compliance		
		nursing station, and on the			Rounds monitoring tool was revised to		
		ne courtyard where the			include interview questions of supervise	ed	
		area was located. The			smokers regarding adherence to smoki		
		ere locked in a secure area			times, assistance to smoking area by st		
		n and obtained by Resident			members and any concerns regarding t		

Facility ID: 923019

If continuation sheet Page 2 of 16

	S FOR MEDICARE &						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		CONSTRUCTION	1 Y /	TE SURVEY
			A. BOILDIN				С
		345263	B. WING)2/22/2019
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
				31	195 OLD MURPHY ROAD		
MACON V	ALLEY NURSING AND H	REHABILITATION CENTER		FF	RANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 561	Continued From page	e 2	F 50	61			
		it and returned to the nursing			smoking process.		
	station after smoking	. Resident #283 was to be			51		
		ng area by staff, and not be			The facility staff were re-educated on		
		noking apron was to be worn			Resident Rights related to the	1	
	by Resident #283 wh	lie smoking.			self-determination regarding Supervis Smoking process by 3/11/2019. Any s		
	A review of the smoki	ing assessment dated			member unable to complete training b		
		sident #283 was an unsafe			aforementioned date will not be allowed	5	
		direct supervision while			work their assigned shift until re-education		
a ç v v	smoking. It stated Re	esident #283 was alert with			completed.		
		inction, good hand dexterity,					
	-	not endanger others or self			Any new hires will receive the		
	was to smoke only in	ther revealed Resident #283 the designated area and h a cigarette safely and			aforementioned education during their orientation period.	ſ	
	completely using the				How the facility plans to monitor its performance to make sure that solution	ons	
		sident #283 on 02/18/2018 at ne day shift told her they			are sustained?		
		ke her out to smoke. She			The Department Head Compliance		
		ssed as being an unsafe			Rounds monitoring tool will be brough		
		assisted and supervised			the stand-down meeting 3 times a we		
		smoke. Resident #283 slept in most mornings, so			for 4 weeks, then weekly for an addition 8 weeks.	JIIGI	
	-	AM smoke break, but always					
		the 11:30 AM smoke break.			Results of the audits will be presented	l to	
	-	led on 3 days of last week			the QAPI meeting monthly x 3 months		
		the exact days) she missed			until a time determined by the QAPI		
	her they were busy.	day shift because staff told She revealed that evening			members for sustained compliance.		
	shift took her out, and smoke.	d always took her out to			The Interdisciplinary Team Members responsible for the Plan of Correction the Administrator is responsible for		
		d smoking schedule on the smoking times were			sustained compliance.		
	5:30 PM, 7:30 PM, ar	1:30 AM, 1:30 PM, 3:30 PM, nd 9:30 PM. Nursing staff			Date of Compliance 3/11/2019.		
	were to take them ou	t to smoke. There was no					

Facility ID: 923019

If continuation sheet Page 3 of 16

	TMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED ERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391						
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE	
		345263	B. WING				C 22/2019
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
				3195	OLD MURPHY ROAD		
	ALLET NURSING AND R	ERABILITATION CENTER		FRA	NKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRIDEFICIENCY) F 561 F 561			(X5) COMPLETION DATE	
F 561	N OF CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345263 DE FOROVIDER OR SUPPLIER IN VALLEY NURSING AND REHABILITATION CENTER IN VALLEY NURSING AND REHABILITATION CENTER IDENTIFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 661 Continued From page 3 An interview with Nursing Assistant (NA) #1 on 02/20/2019 at 9:37 AM revealed the smoking schedule was posted in the resident's rooms and was every 2 hours. NA #1 reported he was trained on watching residents while they smoked, how to put on a smoking apron on the resident and making sure the residents put out their cigarettes appropriately. NA #1 stated when they are short-staffed they cannot take the smokers out to smoke. The interview further revealed Resident # 283 wanted to smoke multiple cigarettes when she goes out and he did not have time to spend out there when things needed to be done. An interview with NA #2 on 02/20/2019 at 9:43 AM revealed that the residents that smoke could go during the times posted on the smoking schedule, every 2 hours. On 02/20/2019 at 11:10 AM an observation was made of NA #1 telling Resident #283 that he could not take her out to smoke because he was busy and did not have the time.		F 5	61			
	02/20/2019 at 9:37 Al schedule was posted was every 2 hours. N trained on watching re how to put on a smok and making sure the cigarettes appropriate are short-staffed they out to smoke. The inte Resident # 283 wante cigarettes when she g time to spend out the done. An interview with NA AM revealed that the go during the times pe schedule, every 2 hou On 02/20/2019 at 11: made of NA #1 telling could not take her our busy and did not have A review of the nursin there were 3 staff sch Resident #283's hall of An interview with Res 12:00 PM revealed sh 11:30 AM smoke breat they were busy and w next smoke break.	M revealed the smoking in the resident's rooms and IA #1 reported he was esidents while they smoked, ing apron on the resident residents put out their ely. NA #1 stated when they cannot take the smokers erview further revealed ed to smoke multiple goes out and he did not have re when things needed to be #2 on 02/20/2019 at 9:43 residents that smoke could osted on the smoking urs. 10 AM an observation was Resident #283 that he t to smoke because he was e the time. g staff schedule revealed eduled for day shift on on 02/20/2019. ident #283 on 02/20/2019 at he was not taken out for the ak because she was told yould have to wait until the					
		Director of Nursing (DON) PM stated it was her					

If continuation sheet Page 4 of 16

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) D4	TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · /	MPLETED
			-			С
		345263	B. WING		0	2/22/2019
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		
	1		F	RANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 561	Continued From page	e 4	F 561			
	expectation that resid	ents who smoked were				
		to smoke at the designated				
	break time. The DON resident's right.	I further stated it was the				
	An interview with the	Administrator on 02/22/2019				
		expectations concerning				
		d was they had the right to				
	choices regarding sm	Id adhere to the resident				
F 582		overage/Liability Notice	F 582			3/11/19
SS=B						
	§483.10(g)(17) The fa	acility must				
		aid-eligible resident, in				
		admission to the nursing resident becomes eligible for				
	Medicaid of-	resident becomes eligible for				
		rvices that are included in				
	• •	es under the State plan and				
	for which the resident					
		and services that the which the resident may be				
		ount of charges for those				
	services; and					
	(ii) Inform each Medio	caid-eligible resident when				
	-	the items and services				
	specified in §483.10(g)(17)(i)(A) and (B) of this				
	resident before, or at periodically during the	acility must inform each the time of admission, and e resident's stay, of services				
		y and of charges for those				
		ny charges for services not are/ Medicaid or by the				
	facility's per diem rate					
		coverage are made to items				

Facility ID: 923019

If continuation sheet Page 5 of 16

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 03/13/2019 APPROVED . 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				LETED
		345263	B. WING		_	(02/:	_ 22/2019
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER	3	195 OLD MURPHY ROAD			
			F	RANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 582	Medicaid State plan, t notice to residents of reasonably possible. (ii) Where changes ar items and services that facility must inform the 60 days prior to imple (iii) If a resident dies of transferred and does facility must refund to representative, or esta deposit or charges all per diem rate, for the resided or reserved of facility, regardless of a discharge notice requ (iv) The facility must r resident representativ the resident within 30 date of discharge from (v) The terms of an ac behalf of an individual facility must not conflit these regulations. This REQUIREMENT by: Based on record revi facility failed to provid and Medicaid Service Facility Advanced Ber and/or a CMS Notice (NOMNC) prior to disc	by Medicare and/or by the he facility must provide the change as soon as is e made to charges for other at the facility offers, the e resident in writing at least mentation of the change. or is hospitalized or is not return to the facility, the the resident, resident ate, as applicable, any ready paid, less the facility's days the resident actually r retained a bed in the any minimum stay or irements. efund to the resident or e any and all refunds due days from the resident's in the facility. dmission contract by or on e seeking admission to the ct with the requirements of is not met as evidenced ew and staff interview, the e a Centers for Medicare s (CMS) Skilled Nursing heficiary Notice (SNF ABN) of Medicare Non-Coverage charge from Medicare Part 2 of 3 residents reviewed for notification review	F 582	F 582 How will corrective accomplished for th be affected by the of Resident's #1 and a facility without any	nose residents found deficient practice? #29 remain in the concerns regarding and/or SNFABN and	the	
	0						

Event ID: W68Q11

Facility ID: 923019

If continuation sheet Page 6 of 16

		MEDICAID SERVICES		LE CONSTRUCTION		<u>NO. 0938-039</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			MPLETED
						С
		345263	B. WING			2/22/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		
				3195 OLD MURPHY ROAD		
MACON	ALLET 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	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE JENCY)	(X5) COMPLETION DATE
F 582	Continued From page	e 6	F 58	2		
	1. Resident #1 was a 08/15/18.	admitted to the facility on		How will facility identify having potential to be a same deficient practice	affected by the	
	A review of the medic					
		and a CMS-10055 SNF		The Business Office ma	÷ .	
		to Resident #1 or their P) which indicated Medicare		a look back review of 4 2/25/2019 of residents	•	
		killed services would end on		Part A Services that we		
		1 remained in the facility.		Medicare Part A to dete	-	
		- -		documentation of the n	otification is on file.	
	During an interview o	n 02/22/19 at 12:50 PM the				
	-	ed the Social Worker who		Measures to be put into		
		for issuing the NOMNC and		changes made to ensu	re that the deficient	
		ident's Medicare Part A		practice will not recur?		
		was no longer employed at		The Business Office M	anagor and Social	
		inistrator was unable to ation a NOMNC and SNF		The Business Office Ma Services Director were	•	
	-	o Resident #1 or their RP		regarding the Medicare		
	when Medicare Part A			the Administrator on 2/2		
	11/22/18. She was u	nable to explain why the				
	notices were not prov			Effective 2/22/19 during		
		ive a process in place to		the facility IDT team wil		
	ensure required notic discharge from Medic	es were issued prior to		NONMC and SNFABN for compliance with upo		
		Lare services.		from MCR Part A cover	• •	
	2. Resident #29 was	admitted to the facility on				
	09/27/18.			The NOMNC will be give	ven at least 48	
				hours prior to end of co		
	A review of the medic			Services Director or de		
	telephone conversation			responsible for maintain	• •	
		nt #29's Responsible Party		reflects the residents th		
		MS-10123 NOMNC. The RP was notified Medicare		a MCR Part A covered	slay.	
		ervices would end on		How the facility plans to	o monitor its	
		rights were reviewed.		performance to make s		
	Resident #29 remaine			are sustained?		
	There was no docum	entation a CMS-10055 SNF		The NONMC AND SNF	ABN notebook	
		Resident #29 or their RP.		audit tool will be review		

Event ID: W68Q11

Facility ID: 923019

If continuation sheet Page 7 of 16

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/13/2019 M APPROVED D. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		PLETED
		345263	B. WING _				C / 22/2019
NAME OF PF	OVIDER OR SUPPLIER			ST	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	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
	Administrator explain had been responsible SNF ABN when a res coverage was ending the facility. The Admi locate any documenta provided to Resident Medicare Part A cove She was unable to ex provided but stated ge a process in place to were issued prior to de services. Accuracy of Assessme CFR(s): 483.20(g) §483.20(g) Accuracy The assessment must resident's status. This REQUIREMENT by: Based on record revit facility failed to accura Data Set (MDS) to ref Screening and Reside 2 residents reviewed for (Resident #22). Findings included: 1. Resident #57 adm 01/15/14 with multiple	n 02/22/19 at 12:50 PM the ed the Social Worker who e for issuing the NOMNC and ident's Medicare Part A was no longer employed at inistrator was unable to ation a SNF ABN was #29 or their RP when rage ended on 12/14/18. splain why the notice was not oing forward she would have ensure required notices lischarge from Medicare ents of Assessments. t accurately reflect the ' is not met as evidenced ew and staff interviews the ately code the Minimum flect a Level II Preadmission ent Review (PASRR) for 1 of for PASRR (Resident #57) dication use for 1 of 5 r unnecessary medications	F	582	On-going during the IDT meeting for notification to beneficiaries by the Administrator. Results of the audits will be presented to the QAPI meeting monthly x 3 months of until a time determined by the QAPI members for sustained compliance. The Interdisciplinary Team Members arresponsible for the Plan of Correction at the Administrator is responsible for sustained compliance. Date of Compliance 3/11/2019. F641 How will corrective action be accomplished for those residents found be affected by the deficient practice? The MDS nurse corrected and resubmitted the MDS for resident structures and #57 on 2/22/2019. How will facility identify other residents having potential to be affected by the same deficient practice?	or re ind I to	3/11/19
	major depression, un schizoaffective disord				100% MDS audit was completed on		

Facility ID: 923019

If continuation sheet Page 8 of 16

		MEDICAID SERVICES			OMB NO. 0938-0
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345263	B. WING		C 02/22/2019
NAME OF P	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STATE, ZIP CO	DE
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROF DEFICIENCY)		DN SHOULD BE COMPLETI DATE DATE
F 641	Continued From page	e 8	F 64	1	
	Review of the annual Minimum Data Set (MDS) dated 06/07/18 revealed Resident #57 was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review was used for formulating a determination of need, appropriate care setting and a set of recommendations for services to help develop an individual's plan of care.			3/01/2019 by the MDS Coorr resident s on Antipsychotic correct coding on the MDS. noted were corrected and re the RAI manual process. 100% PASRR Audit was corr Administrator on 3/6/2019; c in place accordingly in residu and in newly created 2019 F and Screen notebook.	s to determine Any errors submitted per npleted by the locumentation ent records
	Screening Tool (NC N 02/19/19 indicated un detail Resident #57 h	nder the PASRR history nad a Level II PASRR for the ntal illness. Further review PASRR number was		Measures to be put into plac changes made to ensure tha practice will not recur? On 2/21/2019 Unit Manager Nurses, Social Services Dire manager received inservicin the PASRR process and coo	at the deficient s, MDS ector and AR g regarding
	Coordinator #1 confir for coding Section A, the MDS. She review dated 02/19/19 and s Resident #57 had a L Coordinator #1 ackno	on 02/21/19 at 3:20 PM, MDS med she was responsible Identification Information on wed the NC MUST printout stated she was unaware Level II PASRR. MDS owledged the annual MDS ncorrectly coded and a		by the Corporate Support Te Upon admission of a resider 2 PASRR, the IDT will review Admission MDS prior to sub PM IDT meeting for accurac Residents that have new orc psychoactive medications w	eam. It with a Level w the mission in the y of coding. ders for
		submitted to to reflect		using the Psychoactive Med tool during the AM IDT meet	ication Audit
	-	on 02/21/19 at 3:58 PM, the she expected for MDS ccurately coded.		How the facility plans to mor performance to make sure th are sustained?	
		admitted to the facility on ses that included depression		The facility IDT members will Psychoactive Medication Au the PASRR Log and Screen monitor 20% of scheduled a	dit tool and notebook to

Facility ID: 923019

If continuation sheet Page 9 of 16

	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
			A. BUILDING		C
		345263	B. WING		02/22/2019
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 PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)		D BE COMPLETIC
F 641	Continued From page	9	F 64	1	
	Review of the most re Data Set (MDS) date Resident #22 was ale cognitive impairment. Resident #22 had a d taking an antianxiety, antipsychotic medicat (MAR) for December antipsychotic medicat routinely or as neede During an interview w on 02/22/19 at 2:53 P for December of 2018 quarterly MDS dated Resident #22 had not	ecent quarterly Minimum d 12/28/18 revealed ert and oriented with mild The MDS also revealed liagnosis of anxiety and was antidepressant and tion daily. Attion Administration Record 2018 revealed no tions had been given d throughout the month. With the MDS Coordinator #2 PM, she reviewed the MAR B and compared it to the 12/28/18 and stated to been administered an		 during the PM Stand down meeting weeks, then 10% of scheduled wee assessments for an additional 8 we Results of the audits will be present the QAPI meeting monthly x 3 monuntil a time determined by the QAP members for sustained compliance The Interdisciplinary Team Member responsible for the Plan of Correction the Administrator is responsible for sustained compliance. Date of Compliance 3/11/2019. 	kly eks. red to ths or l s are
F 644	December of 2018. A stated she thought th checked and she wou resubmit the MDS. During an interview w on 02/22/19 at 5:57 F expectations were for coded.	tion during the month of MDS Coordinator #2 further is had been unintentionally uld correct the error and with the Director of Nursing PM, she stated her the MDS to be accurately	F 64	1	3/11/19
F 644 SS=D	CFR(s): 483.20(e)(1) §483.20(e) Coordinat A facility must coordin pre-admission screen (PASARR) program u of this part to the max	(2)		*	3/11/19

Facility ID: 923019

If continuation sheet Page 10 of 16

						RM APPROVE 10. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		TE SURVEY MPLETED
		345263	B. WING		0	2/22/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER		3195 OLD MURPHY ROAD FRANKLIN, NC 28734		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 644	Continued From page 10 §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.		F 644			
	all residents with new serious mental disord related condition for I a significant change i This REQUIREMENT by:	ing all level II residents and vly evident or possible der, intellectual disability, or a evel II resident review upon in status assessment. Γ is not met as evidenced riew and staff interviews the		F644		
	PASRR (Preadmissio	an assessment for a Level II on Screening and Resident mpled residents (Resident vel II PASRR.		How will corrective action be accomplished for those resid be affected by the deficient p	lents found to	
	Findings included: Resident #26 was admitted to the facility on 09/20/2016. The diagnosis included dementia without behaviors, bipolar disorder, anxiety, and			On 2/21/19, Resident #26 Mi corrected and resubmitted per manual. How will facility identify other	er the RAI	
	depression.			having potential to be affected same deficient practice?	ed by the	
	Data Set (MDS) date Resident #26 had be PASRR and determin illness was coded wit	omprehensive Minimum d 07/13/2018 revealed that en evaluated by Level II ned to have a serious mental th a no. The diagnosis that mentia, anxiety disorder, nic depression.		On 2/21/19 the Corporate CI Consultant reviewed all Leve residents including appropria the MDS and documentation resident is care plan. The a another resident with Level II requiring MDS correction and	el II PASRR ate coding on on the udit identified I PASRR	
	A review of a quarter revealed in Section I	ly MDS dated 01/02/2019		resubmission per the RAI ma	anual.	

Facility ID: 923019

If continuation sheet Page 11 of 16

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	OMB NO. 093 (X3) DATE SURVE	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED	
					С	
		345263	B. WING		02/22/20	19
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	FIX (EACH CORRECTIVE ACTION SHOULD BE		
F 644	Continued From page	e 11	F 64	4		
	An interview with the at 11:00 AM reported Worker (SW) was res PASRR. She also rep was working on Resid She stated that she h for the resident on 02 Level II had expired of 1423492). An interview with the revealed she had bee years and would not a Level II PASRR. Si expected the SW did since working at the f Resident #26 was a L An interview with the usually social service the evaluations for Le revealed that the prev facility for another poor	Administrator on 02/19/2019 that historically the Social sponsible for the Level II ported that their sister facility dent #26's Level II PASRR. had submitted a screening t/19/2019 since the previous on 10/21/2013 (ref # MDS Registered Nurse #1 en in the MDS position for 2 have known the resident had he further revealed that she the Level II PASRR and facility she did not know		 performed by the administrator to that current PASRR documentatic place and available for review. New residents will be reviewed previewed previews and if they require specialized setting be responsible for maintaining accurate list of LEVEL II PASRR Measures to be put into place or changes made to ensure that the practice will not recur? On 2/21/2019 the Social Services was in-serviced by the corporate department on the PASRR procerequirements. On 2/21/2019 MDS nurses were re-inserviced on the coding of LE PASRR on the MDS assessment subsequent Newly hired employees in the MI Social Services Departments will the aforementioned education dufacility orientation. How the facility plans to monitor performance to make sure that s are sustained? 	on is in rior to coding rvices. lesignee g an s. systemic e deficient s Director clinical ss and EVEL II s DS and/or receive uring their its olutions	
				The Director of Nursing will revie Level II PASRR residents on a que basis for accurate coding on the subsequent documentation on the care.	uarterly MDS and	

Event ID: W68Q11

Facility ID: 923019

If continuation sheet Page 12 of 16

	<u>S FOR MEDICARE &</u> DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		<u>10. 0938-03</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	, ,		· · ·	MPLETED
		345263	B. WING		0	2/22/2019
iame of Pi	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CO	DE	
IACON V	ALLEY NURSING AND R	EHABILITATION CENTER		195 OLD MURPHY ROAD RANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 644	Continued From page	2 12	F 644			
				Results of the audits will be p the QAPI meeting monthly x until a time determined by th members for sustained comp	3 months or e QAPI	
				The Interdisciplinary Team M responsible for the Plan of C the Administrator is responsi sustained compliance.	orrection and	
F 812 SS=E		ore/Prepare/Serve-Sanitary 2)	F 812	Date of Compliance 3/11/20	19.	3/11/19
	§483.60(i) Food safet The facility must -	y requirements.				
	state or local authoriti (i) This may include for from local producers, and local laws or regu (ii) This provision doe	ed satisfactory by federal, es. bod items obtained directly subject to applicable State ulations. s not prohibit or prevent				
	gardens, subject to co safe growing and foo (iii) This provision doe	roduce grown in facility ompliance with applicable d-handling practices. as not preclude residents s not procured by the facility.				
	serve food in accorda standards for food se This REQUIREMENT	•				
		ns and staff interviews the nove two expired nutritional		F812		

Facility ID: 923019

If continuation sheet Page 13 of 16

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY IPLETED
		345263	B. WING _			02	C 2/22/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER			195 OLD MURPHY ROAD RANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	3E	(X5) COMPLETIO DATE
					DEFICIENCY)		
F 812	Continued From pag	e 13	F٤	812			
	supplements from sh				How will corrective action be		
		l a bag containing individual			accomplished for those residents foun	d to	
		e walk in freezer, 3) allow tray r removal from the dish			be affected by the deficient practice?		
		h a dirty tray cover after			The items were immediately discarded	d by	
		h machine and prior to			the Certified Dietary manager on		
		shware and 4) clean a soiled			2/18/2019.		
	ceiling vent in the fac	cility kitchen.			On 2/22/2019 the ceiling vent was		
					cleaned by the Maintenance Director.		
	The findings included	d:					
					How will facility identify other residents	5	
	-	our of the facility kitchen on			having potential to be affected by the		
	2/18/19 from 10:30 A concerns were identi	M-11:00 AM the following fied:			same deficient practice?		
		vidual servings of nutritional			Remaining refrigerators and storage		
		anufacturer's expiration date			rooms were visually audited by the		
		ed on shelving in the walk in			Certified Dietary Manager for any othe	er	
		od Service Director (FSD)			expired items on 2/18/2019; items		
		me of the observation and ce individual servings of			discarded accordingly.		
	expired nutritional su	pplement should have been			All dietary department vents were clea	ned	
	removed from the wa	alk in refrigerator. The FSD			on 2/22/2019 by the Maintenance		
	-	all staff to check the walk-in y basis and remove any			Director.		
	expired foods.				Measures to be put into place or syste	emic	
		of individual servings of fish			changes made to ensure that the defic	cient	
	was observed in a ba	ag, in a cardboard box,			practice will not recur?		
		the walk in freezer. The					
		en and the bag containing			On 2/18/2019 the Corporate Dietary		
	-	cposing the individual			Consultant re-educated the CDM		
		. The Food Service Director			regarding discarding expired items,		
		t the time of the observation			labeling opened items, and cleaning o	f	
		hould have been repackaged			equipment including vents.		
	in a new bag to preve	ent exposure to air.					
					On 2/28/2019 the Corporate Dietary		
		5 PM observations were			Consultant reviewed and revised the		
	-	le working at the dish			duties of the AM and PM cooks as it		
		y aide removed a rack of tray			pertains to the areas of storage, labeli	ng	
	covers from the clear	n side of the dish machine			and expiration dates.		1

Facility ID: 923019

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		CONSTRUCTION		ATE SURVEY OMPLETED
		345263	B. WING				C 02/22/2019
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	1	52,22,2015
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 PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 812	and wiped the moistur cloth prior to placing of storage. The first tray pulled from the dish in brownish substance of cover and the dietary with the cloth, placed storage and continue moisture from the rem Food Service Directo dish machine after thi she expected staff to the dish machine to a soiled, to be rewashe she was nervous and cloth to wipe moisture out of the dish machine dishware that was so storage. 3. On 2/21/19 from 4 observations were ma supper meal and place for supper meal servi made of the ceiling ai of the steam table wh was stored. The indiv had a build-up of dus vent's entire surface a On 2/22/19 at 3:25 Pl (FSD) stated mainten clean ceiling vents ar requested maintenan weeks ago. The FSD agreed it needed to b	re from tray covers with a each tray cover in clean dish y cover on the rack that was nachine was noted to have a on the interior of the tray aide wiped the substance the tray cover in clean dish d to use the cloth to wipe the naining tray covers. The r came to the area of the is observation and reported allow dishes coming out of itr dry and, if dishes were d. The dietary aide reported knew she should not use a e from dishware that came he and knew to re-wash iled prior to clean dish c. Observations were r vent positioned in the area here food and clean dishware vidual grates of the air vent t which encompassed the area. M the Food Service Director hance was responsible to ad that she verbally ce clean the vent a couple o looked at the air vent and he cleaned.	F	812	New hires in the Dietary Departmereceive the education during their orientation period. Maintenance Director will perform cleaning of the dietary vents as paweekly preventative maintenance schedule. How the facility plans to monitor its performance to make sure that solare sustained? The Administrator will perform Wee Dietary Sanitation Rounds with the Certified Dietary Manager for 4 we then monthly thereafter. Results of the audits will be presert the QAPI meeting monthly x 3 mor until a time determined by the QAF members for sustained compliance. The Dietary Manager and mainten Director are responsible for the Pla Correction and the Administrator is responsible for sustained compliant.	weekly rt of the utions ekly eks, nted to nths or Pl ance an of	
		M the maintenance director are of the need to clean the					

If continuation sheet Page 15 of 16

						FORM	APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		345263	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER					
							(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
F 812	Continued From page	. 15	Í -	040			
F 012	1.0	COR MEDICARE & MEDICAID SERVICES OMB NO. 0936 DEFICIENCIES IRRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVE COMPLETED A. BUILDING					

Facility ID: 923019

If continuation sheet Page 16 of 16

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			FOR	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	COM	E SURVEY PLETED
		345263	B. WING			R-C
NAME OF P	ROVIDER OR SUPPLIER	040200		TREET ADDRESS, CITY, STATE, ZIP CODE	02	/22/2019
				195 OLD MURPHY ROAD		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		RANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS		{F 000}			
{F 561} SS=D	Service Regulation, N Certification conducte some deficiencies cite complaint investigatio corrected effective 02 out of compliance. Self-Determination CFR(s): 483.10(f)(1)-	on on 01/05/19 were 2/04/19, the facility remains (3)(8)	{F 561}			3/11/19
	promote and facilitate through support of rea	right to and the facility must e resident self-determination sident choice, including but ts specified in paragraphs (f)				
	activities, schedules (waking times), health					
		ident has a right to make s of his or her life in the cant to the resident.				
	with members of the	ident has a right to interact community and participate in both inside and outside the				
	religious, and commu	ident has a right to stivities, including social, inity activities that do not ts of other residents in the				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE
Electroni	cally Signed					03/11/2019

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.

				LE CONSTRUCTION		10. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			TE SURVEY MPLETED
			A. BUILDING			R-C
		345263	B. WING			2/22/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	2/22/2019
				3195 OLD MURPHY ROAD		
MACON V	ALLEY NURSING AND R	REHABILITATION CENTER		FRANKLIN, NC 28734		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)		COMPLETION
{F 561}	Continued From page	- 1	{F 56	13		
()	facility.		1.00	, i		
		is not met as evidenced				
	-	n, record review, and		F561		
		erviews the facility failed to				
	take a resident out fo	r scheduled smoking times		How will corrective action be		
		t's choice and care plan for		accomplished for those residents		
		ident # 283) reviewed for		be affected by the deficient prac	tice?	
	smoking.					
	Findings included:			Res #283 was accompanied by		
R	Findings included:			member out to the smoking area 2/20/2019.	i on	
	Resident #283 was a	dmitted to the facility on				
		es included depression,		How will facility identify other res	sidents	
		Artery Disease, hypertension,		having potential to be affected b		
	Cerebral Vascular Dis left lower extremity.	sease, and hemiplegia of the		same deficient practice?		
				The facility □s other 2 residents t	hat	
		erly Minimum Data Set		choose to smoke were accompa		
		018 revealed Resident		the approved smoking area by the	ne	
	-	intact. Resident #283 was		assigned staff member.		
		staff member for locomotion				
	current tobacco user.	lent # 283 was coded as a		Measures to be put into place or	•	
				changes made to ensure that the practice will not recur?	e delicient	
	Resident #283's care	plan revealed she had a				
		iate smoking or use of		Revision of the Supervised smol	king	
		ated to decreased safety		assignment times was complete	-	
		was that the resident would		Administrator to include other an		
	smoke safely in a des			departments.		
		rventions included following				
		posted on the wall in the		The Department Head Complian		
		nursing station, and on the		Rounds monitoring tool was revi		
	-	e courtyard where the area was located. The		include interview questions of su smokers regarding adherence to		
		ere locked in a secure area		times, assistance to smoking are		
		and obtained by Resident		members and any concerns rega		
		it and returned to the nursing		smoking process.		
		Resident #283 was to be				

Facility ID: 923019

If continuation sheet Page 2 of 5

STATEMENT	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345263	B. WING		R-C 02/22/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/22/2019
				195 OLD MURPHY ROAD	
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
{F 561}	Continued From page	<u>م</u>	{F 561}		
	assisted to the smokin left unattended. A sm by Resident #283 whi A review of the smokin 1/30/19 revealed Ress smoker and required smoking. It stated Re adequate cognitive fu good vision, and did m while smoking. It furth was to smoke only in able to extinguish a c completely using the stated she stated she was asses smoker, and must be when she went out to further reported she s she missed the 9:30 A wanted to go out for the Resident #283 reveal (she could not recall the the smoke breaks on her they were busy. S shift took her out, and smoke. A review of the posted 02/18/2019 revealed f 7:30 AM, 9:30 AM, 11 5:30 PM, 7:30 PM, an	ng area by staff, and not be noking apron was to be worn ile smoking. ng assessment dated ident #283 was an unsafe direct supervision while esident #283 was alert with nction, good hand dexterity, not endanger others or self her revealed Resident #283 the designated area and igarette safely and		The facility staff were re-educated Resident Rights related to the self-determination regarding Supe Smoking process by 3/11/2019. A member unable to complete training aforementioned date will not be all work their assigned shift until re-en- completed. Any new hires will receive the aforementioned education during to orientation period. How the facility plans to monitor its performance to make sure that so are sustained? The Department Head Compliance Rounds monitoring tool will be bro the stand-down meeting 3 times a for 4 weeks, then weekly for an act 8 weeks. Results of the audits will be presen- the QAPI meeting monthly x 3 mo until a time determined by the QAI members for sustained compliance. The Interdisciplinary Team Memb responsible for the Plan of Correct the Administrator is responsible for sustained compliance. Date of Compliance 3/11/2019.	ervised ny staff ng by lowed to ducation their s lutions e ught to week ditional nted to nths or PI e. ers are tion and

Facility ID: 923019

If continuation sheet Page 3 of 5

		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 03/13/2019 RM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DA CO	TE SURVEY MPLETED
		345263	B. WING				R-C 2/22/2019
NAME OF PI	ROVIDER OR SUPPLIER	l		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER			195 OLD MURPHY ROAD RANKLIN, NC 28734		
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU	_D BE	(X5) COMPLETION DATE
TAG	REGULATORY OR	REGULATORY OR LSC IDENTIFYING INFORMATION)			CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
{F 561}	schedule was posted	M revealed the smoking in the resident's rooms and	{F 5	61}			
	trained on watching r how to put on a smok and making sure the	VA #1 reported he was esidents while they smoked, king apron on the resident residents put out their					
	they are short-staffed smokers out to smokers NA # 1 that Resident	e. It was further reported by # 283 wants to smoke					
		nen she goes out and he did nd out there when things					
	AM revealed that the	#2 on 02/20/2019 at 9:43 residents that smoke could osted on the smoking urs.					
	made of NA #1 telling could not take her ou						
	could not take her out to smoke because he was busy and did not have the time. A review of the nursing staff schedule revealed there were 3 staff scheduled for day shift on Resident #283's hall on 02/20/2019.	neduled for day shift on					
	12:00 PM revealed sl 11:30 AM smoke brea	sident #283 on 02/20/2019 at he was not taken out for the ak because she was told vould have to wait until the					
	on 02/21/2019 reveal AM, 11:30 AM, 2:30 F 9:00 PM. It revealed	ed posted smoking schedule led smoking times were 8:30 PM, 4:30 PM, 7:30 PM, and that housekeeping, floor ls, and nursing staff could					

Facility ID: 923019

If continuation sheet Page 4 of 5

	-	ID HUMAN SERVICES MEDICAID SERVICES				RINTED: 03/13/2019 FORM APPROVED MB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			(3) DATE SURVEY COMPLETED
		345263	B. WING		_	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE	02/22/2013
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	(EACH CORREC CROSS-REFEREN	TIVE ACTION SHOULD BE CED TO THE APPROPRIATE	(X5) COMPLETION E DATE
{F 561}	Continued From page	2.4	/E 56	1		
		to smoke at the designated	UMAN SERVICES FORM APPR DICAID SERVICES OMB NO. 0938 PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED 345263 B. WING R-C 345263 B. WING 02/22/2011 BILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE R-C 3195 OLD MURPHY ROAD FRANKLIN, NC 28734 R ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPL DA Semoke at the designated {F 561} [F 561] COMPL Catalons concerning as the resident's right. [F 561] inistrator on 02/22/2019 ctations concerning as they had the right to here to the resident ID ID ID			
	An interview with the 02/22/2019 at 2:44 Pl	Director of Nursing on M stated it was her				
	offered and taken out	ents who smoked were to smoke at the designated it was the resident's right.				
	at 2:45 PM revealed e residents who smoke	Administrator on 02/22/2019 expectations concerning d was they had the right to d adhere to the resident oking.				

Facility ID: 923019

If continuation sheet Page 5 of 5

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			FOR	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	COMF	E SURVEY PLETED
		345263	B. WING			R-C
NAME OF P	ROVIDER OR SUPPLIER	0.0200		TREET ADDRESS, CITY, STATE, ZIP CODE	02	/22/2019
				195 OLD MURPHY ROAD		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		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 CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 000			
{F 561} SS=D	Service Regulation, N Certification conducte some deficiencies cite complaint investigatio corrected effective 02 out of compliance. Self-Determination CFR(s): 483.10(f)(1)- §483.10(f) Self-determ The resident has the promote and facilitate	on on 01/05/19 were 2/04/19, the facility remains (3)(8) nination. right to and the facility must e resident self-determination	{F 561}			3/11/19
	not limited to the right (1) through (11) of thi	sident choice, including but is specified in paragraphs (f) s section. ident has a right to choose				
	activities, schedules (waking times), health	including sleeping and care and providers of health ent with his or her interests, an of care and other				
		ident has a right to make s of his or her life in the cant to the resident.				
	with members of the	ident has a right to interact community and participate in poth inside and outside the				
	religious, and commu	ident has a right to tivities, including social, nity activities that do not ts of other residents in the				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE
Electroni	cally Signed					03/11/2019

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.

		MEDICAID SERVICES		LE CONSTRUCTION		10. 0938-039 TE SURVEY
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			IE SURVEY MPLETED
			A. BUILDING			R-C
		345263	B. WING			2/22/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0	2/22/2019
				3195 OLD MURPHY ROAD		
MACON V	ALLEY NURSING AND R	REHABILITATION CENTER		FRANKLIN, NC 28734		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETION
{F 561}	Continued From page	<u>a</u> 1	{F 56	13		
(,	facility.		1 00	''		
	This REQUIREMENT	is not met as evidenced				
	by: Based on observatio	n, record review, and		F561		
		erviews the facility failed to				
		r scheduled smoking times		How will corrective action be		
		t's choice and care plan for		accomplished for those residents	s found to	
	1 of 1 residents (Resi	ident # 283) reviewed for		be affected by the deficient pract	ice?	
	smoking.					
				Res #283 was accompanied by		
R	Findings included:			member out to the smoking area 2/20/2019.	on	
	Resident #283 was a	dmitted to the facility on				
		es included depression,		How will facility identify other res	idents	
		Artery Disease, hypertension,		having potential to be affected by		
	Cerebral Vascular Dis left lower extremity.	sease, and hemiplegia of the		same deficient practice?		
				The facility s other 2 residents t	hat	
		erly Minimum Data Set		choose to smoke were accompa		
		018 revealed Resident		the approved smoking area by the	ne	
	-	intact. Resident #283 was		assigned staff member.		
		staff member for locomotion				
	current tobacco user.	lent # 283 was coded as a		Measures to be put into place or changes made to ensure that the	•	
				practice will not recur?	euencient	
	Resident #283's care	plan revealed she had a				
		iate smoking or use of		Revision of the Supervised smol	king	
		ated to decreased safety		assignment times was completed	-	
		was that the resident would		Administrator to include other an	cillary	
	smoke safely in a des			departments.		
		rventions included following				
		posted on the wall in the		The Department Head Complian		
		nursing station, and on the e courtyard where the		Rounds monitoring tool was revi include interview questions of su		
	-	area was located. The		smokers regarding adherence to		
		ere locked in a secure area		times, assistance to smoking are		
		and obtained by Resident		members and any concerns rega		
		it and returned to the nursing		smoking process.		
		Resident #283 was to be				

Facility ID: 923019

If continuation sheet Page 2 of 5

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURV	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETE	D
		345263	B. WING		R-C 02/22/2	010
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/22/2	013
				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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COM	(X5) MPLETION DATE
{F 561}	Continued From page	a 2	(5.64)			
(1 001)	1.0		{F 561			
		ing area by staff, and not be noking apron was to be worn		The facility staff were re-educated Resident Rights related to the	ווע	
	by Resident #283 wh			self-determination regarding Super	vised	
				Smoking process by 3/11/2019. An		
	A review of the smoking	ing assessment dated		member unable to complete training		
		sident #283 was an unsafe		aforementioned date will not be allo	• •	
	smoker and required	direct supervision while		work their assigned shift until re-ed	ucation	
		esident #283 was alert with		completed.		
		unction, good hand dexterity,				
w w a		not endanger others or self		Any new hires will receive the		
		ther revealed Resident #283		aforementioned education during th	neir	
	able to extinguish a c	the designated area and		orientation period.		
	completely using the			How the facility plans to monitor its		
		donially provided.		performance to make sure that solu	itions	
	An interview with Res	sident #283 on 02/18/2018 at		are sustained?		
		ne day shift told her they				
		ke her out to smoke. She		The Department Head Compliance		
	stated she was asses	ssed as being an unsafe		Rounds monitoring tool will be brou		
		assisted and supervised		the stand-down meeting 3 times a v		
		smoke. Resident #283		for 4 weeks, then weekly for an add	litional	
		slept in most mornings, so		8 weeks.		
		AM smoke break, but always				
	•	the 11:30 AM smoke break.		Results of the audits will be presen		
		led on 3 days of last week the exact days) she missed		the QAPI meeting monthly x 3 mon until a time determined by the QAP		
		day shift because staff told		members for sustained compliance		
		She revealed that evening				
		d always took her out to		The Interdisciplinary Team Membe	rs are	
	smoke.			responsible for the Plan of Correcti		
				the Administrator is responsible for		
		d smoking schedule on		sustained compliance.		
		the smoking times were				
		1:30 AM, 1:30 PM, 3:30 PM,		Date of Compliance 3/11/2019.		
		nd 9:30 PM. Nursing staff				
	time limit posted for t	t to smoke. There was no				
		ne shioke bicaks.				
		rsing Assistant (NA) #1 on				

Facility ID: 923019

If continuation sheet Page 3 of 5

	MENT OF HEALTH AN S FOR MEDICARE &	F	PRINTED: 03/13/2019 FORM APPROVED OMB NO. 0938-0391				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3)	(X3) DATE SURVEY COMPLETED R-C	
		345263	B. WING			02/22/2019	
NAME 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)		ID PREFIX TAG	(EACH CORREC CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE	
{F 561}	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		{F 56	51}			

	-	ID HUMAN SERVICES MEDICAID SERVICES				INTED: 03/13/2019 FORM APPROVED IB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345263		B. WING			R-C 02/22/2019		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STAT	E, ZIP CODE	02/22/2013	
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		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 SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
{F 561}	Continued From page	<u>а</u> Л	{F 56				
[1 001]	take the residents out to smoke at the designated times.		{F 50				
	An interview with the Director of Nursing on 02/22/2019 at 2:44 PM stated it was her						
	expectation that resid offered and taken out	ents who smoked were to smoke at the designated it was the resident's right.					
		Administrator on 02/22/2019					
	at 2:45 PM revealed e residents who smoke	expectations concerning d was they had the right to I adhere to the resident					

If continuation sheet Page 5 of 5