PRINTED: 05/10/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345263	B. WING		C <b>04/02/2024</b>	
NAME OF PR	ROVIDER OR SUPPLIER	I	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	T 04/02/2024	
				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 CORRECTION	(X5) COMPLETION	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 000	0 INITIAL COMMENTS		F 000			
F 602 SS=E	from 04/01/24 to 04/0 The following intake v NC00214458. One ( allegation was resulted	1) of the 1 complaint ed in deficiency.	F 602	2	4/26/24	
	Substances  System in English in the substances  The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.  This REQUIREMENT is not met as evidenced by:  Based on record review and interviews with resident, staff, and the Medical Director (MD), the facility failed to protect residents' rights to be free from misappropriation of controlled substances for 1 of 1 resident (Resident #1) reviewed for misappropriation of residents' property.  The findings included:  The facility's Abuse, Neglect, or Misappropriation of Resident property policy, last revised on September 11, 2017, revealed in part the facility would ensure all residents to remain free from abuse or misappropriation of their property.  Resident #1 was admitted to the facility on 02/10/24 with diagnoses including osteoporosis and hip fractures.			Macon Valley -F602 Free from Misappropriation/Exploitation " Macon Valley Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencie and proposes this Plan of Correction to the extent that the summary of findings factually correct and in order to mainta compliance with applicable rules and provisions of quality of care of resident The Plan of Correction is submitted as written allegation of compliance.  " Macon Valley Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement Deficiencies nor does it constitute an admission that any deficiency is accura	os is in in is. a	
ARORATORY I	 	SUPPLIER REPRESENTATIVE'S SIGNATUR	F	TITLE	(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

04/23/2024

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.

**Electronically Signed** 

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345263	B. WING_				C / <b>02/2024</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	102/2024
	101.52.1 0.1 00.1 2.2.1				195 OLD MURPHY ROAD		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER			RANKLIN, NC 28734		
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(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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 602	Continued From page	÷ 1	F 6	602			
	A review of the physician's order dated 02/10/24 revealed Resident #1 had an order to receive 1 tablet of oxycodone (a semi-synthetic narcotic analgesic for pain) 5 milligrams (mg) by mouth once every 3 hours as needed for pain.  The admission Minimum Data Set (MDS) dated 02/16/24 coded Resident #1 with an intact cognition.  A review of the medication administration records (MARs) revealed Resident #1 had received 1 tablet of oxycodone 5 mg as needed on 02/19/24 and 03/07/24.  A review of the controlled substance count sheet for orange halls on 03/07/24 at 7:00 PM revealed when Nurse #1 took over the medication cart from Nurse #4, the total number of controlled substance cards in the cart was 50 cards according to the count, but it was documented as 48 cards on the count sheet. As Nurse #2 depleted one card during the shift, the balance became 49 cards before the shift transition on 03/08/24 at 7:00 AM. However, Nurse #2 did not update the balance and it remained unchanged at 48 cards.				Further, Tower Nursing and Rehabilitat Center reserves the right to refute any the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or lega proceeding.  "The facility administrator will ensur that this plan of correction is initiated a followed as it is written. Problem Statement:  "It was alleged that Nurse #1 did no update the count sheet for controlled	of I re nd	
					medication, Oxycodone 5mg, for Resider #1. During an audit by the Assistant Director of Nursing, it was noted that Oxycodone 5mg tablets were missing. investigation began immediately, and appropriate actions were taken per pol and procedure and to meet regulatory requirements. Resident #1 did not missiany doses of medications and did not have any concerns with pain related to this concern.  Address how the corrective action will accomplished for those residents found have been affected by the deficient	An icy s	
	(DON) and Administra count of Resident #1' revealed discrepancy Resident #1 still had a prescribed narcotic m narcotic medications	ecame aware of the esidents' property on when the Director of Nursing ator were notified that a			practice:  " A pain assessment was conducted the licensed nurse on duty for Residen on 3/8/24 with no pain reported during assessment.  " On 3/8/24, a reconciliation of controlled medications was conducted Resident #1 with no additional concernidentified.  " All missing medications that were identified as missing were replaced at the second controlled co	t #1 the for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED
		345263	B. WING _		C 04/02/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/02/2024
				3195 OLD MURPHY ROAD	
MACON V	ALLEY NURSING AN	ID REHABILITATION CENTER		FRANKLIN, NC 28734	
(X4) ID	SUMMAR'	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION (X5)
PREFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	SHOULD BE COMPLETION
F 602	Continued From page 2		F 6	02	
		3-9-		expense of the facility and any	changes
	The 5-day investig	gation report dated 03/13/24		that were billed to the resident	_
		3/24, a blister card of 30 tablets		refunded on 4/19/24.	Weie
		g was noted missing from the		Address how the facility will ide	entify other
	· -	r orange halls during shift		residents having the potential to	- I
		ing to the investigation		affected by the same deficient	
		#1 had a family emergency on		" On 3/8/24, the Director of	
	•	PM and needed to leave the		Nursing/Assistant Director of N	ursing
	facility immediatel	y. She asked Nurse Aide (NA)		completed a 100% audit of all r	esident⊟s
	#1 who happened	to be in the parking lot at		Controlled Substance Count sh	neets in
	• •	5 PM to hold the medication		comparison to the narcotic med	
	· -	rse #2 arrived to relieve her.		blister packs in the medication	
		at the facility around 9:45 PM		the order in the Medication Adn	
		medication cart keys from NA#1		Record to ensure there were no	
		She went ahead to start her		discrepancies in the count of th	
		ting the medication cart with any		medications or medication card areas of concern identified.	IS. INO
	_	e facility. On 03/08/24 at 0 AM, Nurse #3 came on shift		" On 3/8/24, the Director of	
		2. She noted a blister card of 30		Nursing/Assistant Director of N	ursing
		one 5 mg went missing when		conducted pain assessments for	_
		cation cart with Nurse 2. Nurse		residents. Any pain expressed	
		were drug screened with		during assessments were addre	
		nd the allegation of		immediately.	
	•	of residents' property was		" All assessments and audit	s were
	unsubstantiated.			completed by 3/8/24.	
				Address what measures will be	put into
		was conducted with Nurse #4		place or systemic changes mad	
		10 PM. She recalled working the		ensure that the deficient practic	ce will not
		/24 and was relieved by Nurse		recur:	
	_	She counted the controlled		" On 3/8/24, the Director of	
		lurse #1 during the shift		Nursing/Assistant Director of N	_
		noticing any discrepancy. She		Development Coordinator initia	
	·	ation cart keys to Nurse #1 after		in-servicing with all licensed nu	
	count sheet.	ned the controlled substance		medication aides to include age regarding controlled substance	-
	Count SHEEL.			to include: the definition, implication	
	During a phone in	terview conducted on 04/01/24		diversion and the process for p	
		#1 stated when she counted		receiving and returning medica	· · ·
		stances with Nurse #4 on		the pharmacy. The in-service a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI		<del></del>	Ι,	С	
		345263	B. WING				02/2024	
NAME OF PI	ROVIDER OR SUPPLIER	1	<u> </u>	S <sup>-</sup>	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	02/2024	
					195 OLD MURPHY ROAD			
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER		F	RANKLIN, NC 28734			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 602	Continued From page 3			602				
	· ·	:00 PM, she checked the		002	included how to appropriately transitior	1 2		
		ile Nurse #4 verified the			medication cart to the nurse or medication			
		count sheets. She stated			aide.			
	she should verify the	actual numbers shown in			" On 3/8/24, the Nurse Consultant			
	_	nce count sheets, but it did			conducted education with the nursing			
	not happen. The initi	al count indicated there were			leadership team to include the Director	of		
	48 cards of controlled	d substance in the			Nursing, the Assistant Director of Nursi	ng,		
	medication cart. A recount confirmed the actual balance was 50 cards. She signed the controlled				Unit Manager and Staff Development			
					Coordinator. This in-service included h			
	substance count sheet but had forgotten to				to appropriately complete a medication			
	update the total number of cards to 50. She stated she had a family emergency at				cart audit.			
					Any newly filled, roddine facility	am.		
		PM that night and had to ediately. She did not count			nursing staff and nursing leadership tea members to include agency staff will	3111		
	·	nce in the medication cart			complete education during orientation	and		
		f before leaving as she was			prior to the start of their first shift.	411G		
		king family emergency. While			" All in-service education was			
	_	er family in the parking lot,			completed by 3/10/24.			
	she saw NA #1 in the	e car and decided to pass the						
	medication cart keys	to her so that she could			Indicate how the facility plans to monitor	or		
		ssible. She told NA #1 that			its performance to make sure that			
		nce count was good before			solutions are sustained:			
		ner. The DON tried to contact			" The Director of Nursing/Assistant			
	_	n 03/08/24 regarding the			Director of Nursing will audit all	I. :£4		
		ue to the nature of the family			medication carts to include controlled s			
		unable to talk to the DON. several days later and was			to shift count with cart transition, count sheets and declination sheets to ensur			
		negative result. She denied			compliance with company policy and	5		
		edication except taking			procedure. This monitoring will occur 5			
		ription for many years.			times per week for 6 weeks. All areas of			
		, , , ,			concern will be taken to the administration			
	A phone interview wa	as conducted with NA #1 on			and the Director of Nursing and			
		She stated she was a			addressed immediately, including			
	,	) and had a habit of coming			re-education of nurses or medication			
		g lot early to take a nap			aides as appropriate.			
		03/07/24 at around 9:20 PM,			" The Director of Nursing/Administra	ıtor		
	Nurse #1 told her tha	-			or Director of Nursing will present the			
	emergency and want				findings of the Audit Tools to the Quality	/		
	medication cart keys	for orange halls until Nurse			Assurance Performance Improvement		1	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345263	B. WING				02/2024	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 3195 OLD MURPHY ROAD FRANKLIN, NC 28734			V=1-1-1-1	
(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 SHOU			(X5) COMPLETION DATE	
F 602	#2 arrived at the facili told her that she had substances, and the approximately 9:45 P keys from her in the p #2 did not ask her to substances in the me started her shift. NA # the facility until appronight.  The timecard dated 0 started her shift at 10 03/08/24 at 7:05 AM.  A phone interview wa on 04/01/24 at 2:47 F arrived at the facility's around 9:45 PM, she parked next to her cathe medication cart ke #1 if she had counted Nurse #1 and was tol #1 stated Nurse #1 to cart was counted, and assumed the medication cart with a seeing anything unus during the shift and simedication cart keys completed a drug scr result was negative. So not following the facili controlled substances	ity to relieve her. Nurse #1 counted the controlled count was good. At M, Nurse #2 picked up the parking lot. However, Nurse count the controlled dication cart together before #1 stated she did not enter ximately 10:42 PM that  3/07/24 revealed NA#1 :42 PM and clocked out on  s conducted with Nurse #2 PM. She stated when she is parking lot on 03/07/24 at found that NA #1 was r and told her that she had eys for her. She asked NA I the medication cart with d it had not been done. NA old her that the medication d it was fine. As she tion cart was counted by discrepancies, she stated like to start the shift without red substances in the any nursing staff. She denied ual with her medication cart	F	602	(QAPI) Committee monthly for 2 month. The QAPI Committee will meet monthl for 2 months and review the Audit Tool determine trends and/or issues that maneed further interventions and the need for additional monitoring.  Date of Compliance: 4/26/24	y s to ay		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345263	B. WING _			1	02/2024
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			
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 602		stated she noticed there	F	602			
	only 48 controlled sub medication cart for or transition on 03/08/24	ange halls during the shift at around 7:00 AM. After e medication cart together					
	controlled substance #1, and it consisted o	card belonged to Resident f 30 tablets of oxycodone 5 d the incident to the DON					
	call from Nurse #1 on PM stating she had to immediately due to fa 03/08/24 around 7:20	. She stated she received a 03/07/24 night around 9:00 bleave the facility					
	was unable to talk at 10:30 AM, she receiv Nurse #1 stating that medication cart with N	ediately and realized that she that point. On 03/08/24 at ed a text message from she had counted the Nurse #4 before taking over n 03/07/24 around 7:00 PM.					
	medication cart was 5 admitted she did not continued to docume substance count She	nt 48 cards on the controlled et. In addition, Nurse #1 did					
	staff in the facility beforemergency on 03/07/ screened immediately #1 was tested on 03/1 her family emergency	24 night. Nurse #2 was drug on 03/08/24 while Nurse 18/24 due to the nature of Both Nurse #1 and Nurse					
	after she took the me	ve. Nurse #2 told her that dication cart keys from NA nift without counting the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345263	B. WING _			C <b>4/02/2024</b>		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (	•	4/02/2024		
MACON V	ALLEY NURSING AN	D 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 SHOULD		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 602	any nursing staff. Sworking during the the nurses had recontrolled substant that night. After shincident, she order Nursing (ADON) to immediately by asswho used narcotic Resident #1's famithe incident, and copharmacy to deterwere returned to the reported the incident Department of Headon Department of	ces in the medication cart with She stated Nurse #5 was shift on 03/07/24 but none of quested him to count the ces together for orange halls e was made aware of the red Assistant Director of assist in the investigation sessing pain for all residents medications, notifying ly and the Medical Director of ommunicating with the mine if the missing narcotics he pharmacy accidentally. She ent to the North Carolina alth & Human Services (NC cal Sheriff's office. All the e was replaced and paid for by e incident. She concluded that be avoided if both Nurse #1 updated the controlled heets in a timely manner and eith another nurse during shift we conducted on 04/01/24 at an the state of the missing pain eplaced by the facility and issues to receive her pain ded in a timely manner so far.  The eview conducted on 04/01/24 at a fine placed by the facility and issues to receive her pain ded in a timely manner so far.  The eview conducted on 04/01/24 at a fine placed by the facility and issues to receive her pain ded in a timely manner so far.  The eview conducted on 04/01/24 at a fine placed by the facility and issues to receive her pain ded in a timely manner so far.	F	602				

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		345263	B. WING _			C <b>04/02/2024</b>	
	ROVIDER OR SUPPLIER  ALLEY NURSING AND F	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3195 OLD MURPHY ROAD FRANKLIN, NC 28734	'	0410212024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 602	entering the facility b  During a phone interat 10:35 AM, the MD incident on 03/08/24 of the resident affect was assessed immed consequences noted used "as needed" ba adequate supply of the medication. He adde were replaced and processed was his expectation of follow the facility's principle.	view conducted on 04/02/24 stated he was notified of the and provided with the name ed. He stated Resident #1 diately without any adverse as the missing drugs were sis and the facility had	F 6	02			
F 755 SS=E	on 04/02/24 at 11:33 for all the nursing star protocol to complete and update the balar substance count she medication cart during.  During an interview of Administrator on 04/0 expected all the nursipolicies and procedu substances in the metransition to prevent residents' property. Pharmacy Srvcs/ProcCFR(s): 483.45(a)(b)  §483.45 Pharmacy Structure and the facility must proving the protocol of	conducted with the 02/24 at 11:45 AM, he ing staff to follow facility's res to count all the controlled edication cart during shift misappropriation of cedures/Pharmacist/Records (1)-(3)	F 7	55		4/26/24	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  ALLEY NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3195 OLD MURPHY ROAD FRANKLIN, NC 28734	J 04/02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 755	Continued From pa	_	F 75	5		
	§483.70(g). The factoring personnel to admini	cility may permit unlicensed ster drugs if State law der the general supervision of				
	pharmaceutical servithat assure the accordispensing, and address	res. A facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and the needs of each resident.				
	§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-					
		des consultation on all sion of pharmacy services in				
		olishes a system of records of ion of all controlled drugs in nable an accurate				
	order and that an action is maintained and p	rmines that drug records are in ecount of all controlled drugs eriodically reconciled. IT is not met as evidenced				
	Based on record re resident, staff, and facility failed to keep controlled medication substance count should cart with at least 2 raccuracy during shi	eview and interviews with the Medical Director (MD), the coan accurate accounting of ons on the controlled eets and failed to conduct e counts in the medication nurses for verification of ft transitions. As a result, a blets of a controlled substance		Macon Valley F755 Pharmacy Services/Procedures/Pharmacist/Reco " The facility administrator will ensu that this plan of correction is initiated a followed as it is written. Problem Statement: " It was alleged that the facility faile ensure that 2 nurses conduct the	ure and	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	(X3) DATE SURVEY COMPLETED		
		345263	B. WING _			C <b>04/02/2024</b>		
NAME OF PR	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP C	CODE	0-11021202-1		
MACONIV	ALLEV NUDCING AND	DELIABILITATION CENTED		3195 OLD MURPHY ROAD				
WACON V	ALLEY NURSING AND	REHABILITATION CENTER		FRANKLIN, NC 28734				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 755	Continued From pa	ge 9	F 7	55				
F 755	was missing from a transition for 1 of 1 misappropriation of #1).  The findings included Resident #1 was ad 02/10/24 with diagnand hip fractures.  A review of the physic revealed Resident #1 tablet of oxycodone analgesic for pain) to once every 3 hours.  A review of the med (MARs) revealed Retablet of oxycodone and 03/07/24.  A review of the cont for orange halls on the cont for orange halls on the cont form Nurse #4, the substance cards in according to the condepleted one card of the cards on the condepleted one card of the cards on the condepleted one card of the cards of t	medication cart during shift resident reviewed for residents' property (Resident ed:  Imitted to the facility on oses including osteoporosis  sician's order dated 02/10/24 et had an order to receive 1 (a semi-synthetic narcotic 5 milligrams (mg) by mouth	F 7	controlled substance count medication cart to verify and the shift-to-shift transfer on one nurse left for a family of around 9:00pm on that dat in missing medication for reactores how the corrective accomplished for those reshave been affected by the practice:  "On 3/8/24, a reconcilia controlled medications was Resident #1 with no additionatified. Resident had meavailable on cart to take peaddress how the facility wiresidents having the potentaffected by the same deficing. On 3/8/24, the Director Nursing/Assistant Director completed an audit of 1000 resident Controlled Subsheets in comparison to the medication blister packs in cart and the order in the Madministration Record to each were no discrepancies in the medications or medication additional areas of concernaddress what measures we place or systemic changes	ccuracy during a 3/7/24 when emergency e. This resulted esident #1. e action will be sidents found to deficient ation of a conducted for onal concerns edication er order. Il identify other tial to be itent practice: r of of Nursing of all stance Count e narcotic the medication nsure there he count of the cards. No in identified. ill be put into			
	03/08/24 at 7:00 AM update the balance 48 cards.  A phone interview w on 04/01/24 at 3:40 first shift on 03/07/2	A. However, Nurse #2 did not and it remained unchanged at was conducted with Nurse #4 PM. She recalled working the 4 and was relieved by Nurse the counted the controlled		place or systemic changes ensure that the deficient pr recur:  " On 3/8/24, the Nurse (conducted education with the leadership team to include Nursing, the Assistant Dire Unit Manager and Staff De Coordinator. This in-service	Consultant the nursing the Director of Coron Nursing, velopment			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	201/1252 02 01/221/52	343263	D. WING _	0.75		04/	02/2024
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER			95 OLD MURPHY ROAD		
11.5 (00)			FRANKLIN, NC 28734		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 755	755 Continued From page 10		F 7	755			
	transition without noting passed the medication Nurse #1 had signed count sheet.  During a phone intervat 4:06 PM, Nurse #1 the controlled substant 03/07/24 at around 7: medication cards whit controlled substance she should verify the the controlled substant not happen. The initiated 48 cards of controlled medication cart. A recommedication cart. A recommedication cart and substance count sheet update the total numbers attended to the facility immediate the facility immediate the controlled substant with any nursing staff.	rances with Nurse #1 during the shift ition without noticing any discrepancy. She ed the medication cart keys to Nurse #1 after e #1 had signed the controlled substance			to appropriately complete a medication cart audit.  " On 3/8/24, the Director of Nursing/Assistant Director of Nursing/S Development Coordinator initiated in-servicing with all licensed nurses and medication aides to include agency staregarding controlled substance diversion to include: the definition, implications of diversion and the process for properly receiving and returning medications from the pharmacy. The in-service also included how to appropriately transition medication cart to the nurse or medication.  " Any newly hired, routine facility nursing staff and nursing leadership teamembers to include agency staff will complete education during orientation apprior to the start of their first shift.  Date of Compliance:  " All in-service education was completed by 4/24/24.	Staff d ff, on f a m a tion	
	she was talking to he she saw NA #1 in the medication cart keys leave as soon as pos the controlled substan passing the keys to h	ing family emergency. While r family in the parking lot, car and decided to pass the to her so that she could sible. She told NA #1 that noce count was good before er.  s conducted with NA #1 on She stated she had a habit			Indicate how the facility plans to monitorits performance to make sure that solutions are sustained:  "The Director of Nursing/Assistant Director of Nursing will audit all medication carts to include controlled sto shift count sheets and declination sheets to ensure compliance with	shift	
	of coming to the facili a nap before her shift	ty's parking lot early to take On 03/07/24 at around ld her that she had a family			company policy and procedure 5 times per week for 6 weeks. All areas of concern will be taken to the administrati and the Director of Nursing and addressed immediately, including		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE		
MACON V	ALLEY NURSING AND	REHABILITATION CENTER		3195 OLD MURPHY ROAD			
	, 1222 1 110 110 110 7 1112	KEIDABIELIKIIGI GERTEK		FRANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE TO THE APPROPRIATIENCY)		(X5) COMPLETION DATE
F 755	Continued From page 11		F 7	755			
F 755	medication cart key #2 arrived at the fact told her that she has substances, and the approximately 9:45 keys from her in the #2 did not ask her to substances in the m started her shift. NA the facility until appr night.  The timecard dated started her shift at 1 03/08/24 at 7:05 AN A phone interview w on 04/01/24 at 2:47 arrived at the facility around 9:45 PM, sh parked next to her of the medication cart #1 if she had counte Nurse #1 and was t #1 stated Nurse #1 cart was counted, a assumed the medic Nurse #1 without ar she made a big mis without counting the medication cart with seeing anything und during the shift and medication cart key #2 stated she was is following the facility	s for orange halls until Nurse cility to relieve her. Nurse #1 docunted the controlled ecount was good. At PM, Nurse #2 picked up the parking lot. However, Nurse count the controlled hedication cart together before with stated she did not enter roximately 10:42 PM that  03/07/24 revealed NA#1 0:42 PM and clocked out on M.  vas conducted with Nurse #2 PM. She stated when she of sparking lot on 03/07/24 at the found that NA #1 was that and told her that she had keys for her. She asked NA and the medication cart with hold it had not been done. NA told her that the medication and it was fine. As she atton cart was counted by any discrepancies, she stated take and started the shift the controlled substances in the any nursing staff. She denied usual with her medication cart stated she had the sthroughout the shift. Nurse atter disciplined for not protocol to count the		re-education of nurses aides as appropriate.  "The Director of Nursing with findings of the Audit Too Assurance Performance (QAPI) Committee with for 2 months and review determine trends and/oneed further intervention for additional monitoring Date of Compliance: 4/2	rsing/Administrativill present the ols to the Quality e Improvement of the Improvement of the Audit Tools or issues that mains and the need g.	s. s to y	
		es during shift transition. rview conducted on 04/01/24					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345263	B. WING _	B. WING		C <b>04/02/2024</b>		
NAME OF PROVIDER OR SUPPLIER  MACON VALLEY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP C 3195 OLD MURPHY ROAD FRANKLIN, NC 28734	ODE	1 0-11	V2/2027	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE	
F 755	had asked him to colorange halls togethe to 11 PM on 03/07/24 entering the facility be buring a phone inter at 3:06 PM, Nurse #3 were 49 controlled su medication cart for o transition on 03/08/2 she had recounted the with Nurse #2, she for controlled substance #1, and it consisted of mg. Nurse #2 reporte immediately.  During a phone inter at 10:35 AM, the MD for all the nursing star protocol to count the medication cart during the medication cart during the medication cart during the medication cart in the parking lot at appear to the parking lot at appear to the medication cart with	ocould not recall any nurses and the medication cart for r during his shift from 3 PM 4. He denied seeing NA #1 efore 10:45 PM on 03/07/24.  View conducted on 04/01/24 3 stated she noticed there abstance count sheets but betance cards in the range halls during the shift 4 at around 7:00 AM. After the medication cart together bund that the missing card belonged to Resident of 30 tablets of oxycodone 5 ed the incident to the DON  View conducted on 04/02/24 a stated it was his expectation off to follow the facility's controlled substance in the ang shift transition.  A. She stated she received a m 03/07/24 night around 9:00	F7	755				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345263	B. WING				02/2024	
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	02/2024	
				] 3	8195 OLD MURPHY ROAD			
MACON V	ALLEY NURSING AND F	REHABILITATION CENTER		F	FRANKLIN, NC 28734			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
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F 755	Continued From page	e 13	F	755				
	Nurse #3 came on sh	nift to relieve Nurse #2. She						
	noted a blister card o	f 30 tablets of oxycodone 5						
	mg went missing whe	en counting the medication						
	cart with Nurse 2. On	03/08/24 around 7:20 AM,						
	Nurse #2 called to no	tify her about the narcotic						
		called Nurse #1 immediately						
		was unable to talk at that						
	l ·	10:30 AM, she received a						
		urse #1 stating that she had						
	counted the medication cart with Nurse #4 before taking over the medication cart on 03/07/24							
		e total number of controlled						
		edication cart was 50 cards.						
		idmitted she did not update						
	· ·	ued to document 48 cards on						
		nce count Sheet. In addition,						
		did not count the medication						
	cart with any nursing	staff in the facility before						
	leaving for family em	ergency on 03/07/24 night.						
	Nurse #2 told her tha	t after she took the						
		from NA #1, she started her						
	_	the controlled substances in						
		vith any nursing staff. She						
		working during the shift on						
		the nurses had requested						
		rolled substances together						
	_	night. She concluded that the pided if both Nurse #1 and						
		ed the controlled substance						
		ely manner and counted the						
		s in the medication cart with						
	another nurse during							
	A subsequent intervie	ew was conducted with DON						
	•	AM. It was her expectation						
		ff to follow the facility's						
	1 -	controlled substance count						
		ice of cards in the controlled						
	substance count she	ets before taking over a						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER  MACON VALLEY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 3195 OLD MURPHY ROAD FRANKLIN, NC 28734	I )E	04/02/2024	
(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 APPROPRIAT	(X5) COMPLETION DATE	
F 755 F 867 SS=E	expected all the nursipolicies and procedure substances in the metransition to prevent residents' property. QAPI/QAA Improvem CFR(s): 483.75(c)(d) §483.75(c) Program for monitoring. A facility must establipolicies and procedure collections systems, adverse event monitor procedures must inclifollowing: §483.75(c)(1) Facility systems to obtain and from direct care staff, resident representativinformation will be usare high risk, high volopportunities for impression systems to identify, conformation from all donot limited to the facility systems to identify, conformation from all donot limited to the facility systems to identify, conformation from all donot limited to the facility systems to identify, conformation from all donot limited to the facility systems to identify, conformation from all donot limited to the facility systems to identify, conformation from all donot limited to the facility systems to identify, conformation from all donot limited to the facility systems to identify, conformation from all donot limited to the facility systems to identify, conformation from all donot limited to the facility systems to identify, conformation from all donot limited to the facility systems to identify, conformation from all donot limited to the facility systems to identify, conformation from all donot limited to the facility systems to identify, conformation from all donot limited to the facility systems to identify, conformation from all donot limited to the facility systems to identify, conformation from all donot limited to the facility systems to identify.	g shift transition.  onducted with the 12/24 at 11:45 AM, he ing staff to follow facility's res to count all the controlled idication cart during shift misappropriation of tent Activities (e)(g)(2)(i)(ii)  feedback, data systems and sh and implement written res for feedback, data and monitoring, including oring. The policies and ude, at a minimum, the remaintenance of effective duse of feedback and input other staff, residents, and res, including how such ed to identify problems that lume, or problem-prone, and	F 7			4/26/24	
	0 ( )(-)	,					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	IPLE CONSTE		(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER  MACON VALLEY NURSING AND REHABILITATION CENTER				3195 OLD	DDRESS, CITY, STATE, ZIP CODE  MURPHY ROAD  IN, NC 28734	1 04/	02/2024	
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F 867	development, monito §483.75(c)(4) Facility	formance indicators, blogy and frequency for such ring, and evaluation. adverse event monitoring,	F	867				
	systematically identify analyze and use data adverse events in the	s by which the facility will y, report, track, investigate, and information relating to facility, including how the ta to develop activities to its.						
	systemic action.  §483.75(d)(1) The factorized at performance implementing those as	cility must take actions improvement and, after actions, measure its success, at a ensure that						
	determine underlying impacting larger syste (ii) How they will deve will be designed to ef level to prevent qualit safety problems; and (iii) How the facility w of its performance im ensure that improven	alized and sustained.  cility will develop and dressing: a systematic approach to causes of problems ems; elop corrective actions that fect change at the systems y of care, quality of life, or all monitor the effectiveness provement activities to nents are sustained.						
	\ '\ '	activities.  cility must set priorities for its ment activities that focus on						

DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	EHABILITATION CENTER		3195 OLD MURPHY RO	DAD				
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG				(X5) COMPLETION DATE		
Continued From page	e 16	F 8	367					
consider the incidence of problems in those outcomes, resident so resident so resident choice, and of \$483.75(e)(2) Performactivities must track in resident events, analytimplement preventive that include feedback facility.  §483.75(e)(3) As partimprovement activitied distinct performance number and frequency conducted by the faci and complexity of the available resources, a assessment required Improvement projects annually a project that problem-prone areas collection and analys (c) and (d) of this section and solve the governing body, or defunctioning as a governing body, or defunctioning as a governing body including in program required under the governing body. The quasurance committee governing including in program required under the governing body. The quasurance committee governing body.	e, prevalence, and severity areas; and affect health afety, resident autonomy, quality of care.  mance improvement medical errors and adverse yze their causes, and actions and mechanisms and learning throughout the stof their performance s, the facility must conduct improvement projects. The ey of improvement projects and as reflected in the facility at §483.70(e). It is must include at least at focuses on high risk or identified through the data is described in paragraphs tion.  Seessment and assurance.  Callity assessment and a reports to the facility's esignated person(s) arining body regarding its implementation of the QAPI der paragraphs (a) through the committee must:							
(ii) Develop and imple	этын арргорнасе ріань от							
	ROVIDER OR SUPPLIER  SUMMARY ST.  (EACH DEFICIENC REGULATORY OR I  Continued From page high-risk, high-volume consider the incidence of problems in those outcomes, resident stresident choice, and of stresident events, analytimplement preventive that include feedback facility.  §483.75(e)(2) Perform activities must track in resident events, analytimplement preventive that include feedback facility.  §483.75(e)(3) As partimprovement activitied distinct performance number and frequency conducted by the faciliant performance number and frequency conducted by the faciliant performance number and frequency conducted by the faciliant complexity of the available resources, a assessment required Improvement projects annually a project that problem-prone areas collection and analys (c) and (d) of this section and analys (c) and (d) of this section are quired under the governing body, or defunctioning as a governing body, or defunctioning as a governing body activities, including in program required under the governing body. The quasurance committee governing body activities, including in program required under the governing body. The quasurance committee governing body activities, including in program required under the governing body. The quasurance committee governing body activities, including in program required under the governing body. The quasurance committee governing body activities, including in program required under the governing body.	ALLEY NURSING AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 16 high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.  §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the	A BUILDIN  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 16 high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.  §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.  §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility is services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.  §483.75(g) Quality assessment and assurance.  §483.75(g) Quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:	A BUILDING  345263  B. WING  SOURIDER 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 16 high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.  \$483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.  \$483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.  \$483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:	A BUILDING  345263  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  3199 OLD MURPHY ROAD  FRANKLIN, NO. 28734  SUMMARY STATEMENT OF DEPTICENCIES  (EACH DESTICIENCY MUST BE PRECEDED BY PILL REGULATORY OR LSC. DEMITTING INFORMATION)  Continued From page 16 high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.  \$483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.  \$483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at \$483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.  \$483.75(g) Quality assessment and assurance.  \$483.75(g) Quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:	A BUILDING  345263  B. WING  345263  B. WING  3195 OLD MURPHY ROAD  FRANKLIN, NC 28734  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES (EACH DEFICIENCIES) EPRECEDE DBY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 16 high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.  \$483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.  \$483.75(e)(3) As part of their performance improvement projects. The number and frequency of improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility services and available resources, as reflected in the facility assessment required at \$483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.  \$483.75(g) Quality assessment and assurance committee reports to the facility's governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		LETED
345263		B. WING			C 04/02/2024	
NAME OF PROVIDER OR SUPPLIER		_	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1	<u></u>
			31	95 OLD MURPHY ROAD		
MACON VALLEY NURSING AND RE	HABILITATION CENTER		FI	RANKLIN, NC 28734		
PREFIX (EACH DEFICIENCY N	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 867 Continued From page 1	17	F 8	367			
action to correct identification (iii) Regularly review and data collected under the resulting from drug reging available data to make This REQUIREMENT is by:  Based on observations interview, the facility's (Assurance (QAA) Commimplemented procedure interventions the commimplemented procedure interventions the commifollowing the recertification conducted on 02/16/24 investigation survey conwas for a repeat deficient misappropriation/exploid property that was origined during the recertification and subsequently recited investigation survey concontinued failure of the surveys of record show inability to sustain an experience of the surveys of record show inability to sustain an experience of the surveys of record show in the findings included:  This tag is cross reference of the following the facility failed to be free from misappropriate of the surveys of the surveys of record show in the findings included:  The findings included:  The findings included:  The findings included:  This tag is cross reference of the following the facility failed to be free from misappropriate of the findings included:  The findings included:	Continued From page 17 action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.  This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint survey conducted on 02/16/24 and the complaint investigation survey conducted on 04/02/24. This was for a repeat deficiency in the area of misappropriation/exploitation of resident's property that was originally cited on 02/16/24 during the recertification and complaint survey, and subsequently recited during the complaint investigation survey completed on 04/02/24. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program.  The findings included:  This tag is cross referenced to:  F 602 - Based on record review and interviews with resident, staff, and the Medical Director (MD), the facility failed to protect residents' rights to be free from misappropriation of controlled substances for 1 of 1 resident (Resident #1) reviewed for misappropriation of residents'		307	Macon Valley F867 QAPI/QAA Improvement Activitie "The facility administrator will ensu that this plan of correction is initiated a followed as written. Problem Statement: "It was alleged that the facility failed maintain implemented procedures and monitor interventions the Quality Assurance Performance Improvement Committee put into place following the recertification and complaint survey in area of misappropriation/exploitation or resident's property. Address how the corrective action will accomplished for those residents found have been affected by the deficient practice: "On 4/21/2024, The Administrator initiated an audit of the previous citatio and action plans outlined in the annual survey and re-visit survey to ensure the Quality Assurance committee has maintained and monitored intervention that were put into place. Any areas of concern were updated and presented the Quality Assurance Committee by th Administrator. The audit was complete by 4/22/24 with no concerns identified. Address how the facility will identify oth residents having the potential to be affected by the same deficient practice	re nd d to the f be d to ns e s ne d	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345263		B. WING	B. WING		C 04/02/2024	
NAME OF PROVIDER OR SUPPLIER  MACON VALLEY NURSING AND REHABILITATION CENTER				3	TREET ADDRESS, CITY, STATE, ZIP CODE 195 OLD MURPHY ROAD RANKLIN, NC 28734	1 04/	<u> </u>
(X4) ID PREFIX TAG			ID PREFI TAG				(X5) COMPLETION DATE
F 867	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 867  " On 4/21/24 the Administrator and Director of Nursing conducted an and the previous 2 months of Quality Assurance Performance Improvement (QAPI) committee meeting minutes ensure all areas of improvement has appropriately been documented as compared to facility Performance Improvement Plans with appropriate follow-up completed. The Director of Nursing and the Administrator will eall Performance Improvement Plans brought to QAPI monthly going forwing and the Administrator will eall Performance Improvement Plans brought to QAPI monthly going forwing and the Administrator will eall Performance Improvement Plans brought to QAPI monthly going forwing and the Administrator will be put place or systemic changes made to ensure that the deficient practice werecur:  " On 4/22/24, the Facility Nurse Consultant completed an in-service the Administrator, and Director of Niregarding the Quality Assurance protoinclude implementation of Action Monitoring Tools, the Evaluation of Quality Assurance process, modificand correction if needed, to preven reoccurrence of deficient practice to include grievances, care plan timing revision, and medication storage. In-service also included identifying that warrant development and estal a system to monitor the corrections implement changes when the expension of Nursing will be educated during of Nursing will be educated during		of  Ire e I o ot h ing ss ns, e ing d d d g g i.		
					of Nursing will be educated during orientation regarding the Quality Assurance Process.		

		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  IG	' '	(X3) DATE SURVEY COMPLETED	
	<b>345263</b> B. WING			C <b>04/02/2024</b>			
NAME OF P	ROVIDER OR SUPPLIER		<del>_</del>	STREET ADDRESS, CITY, STATE, ZIP CODE		J4/02/2024	
				3195 OLD MURPHY ROAD			
MACON V	ALLEY NURSING AND R	EHABILITATION CENTER		FRANKLIN, NC 28734			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG				
F 867	Continued From page	e 19	F 8	· ·	ied areas priation of v services urance 2 months. ee will f plans of if changes o improve cion is pring is commented  ant will g an gram by rance nd ensure conitoring ns, to ming and e. The w d for vices. The mediately rector of of  Quality ented by		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
245262		B. WING _		С			
345263			B. WING _			04/02/2024	
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	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
F 867	Continued From page	20	F8	Performance Improvement (QA Committee monthly x 2 months and the identification of trends, development of action plans as to determine the need and/or fr continued monitoring. The Direct Nursing is responsible for the coplan and the Administrator for scompliance.  Date of Compliance: 4/26/24	for review indicated equency of ctor of orrection		