PRINTED: 06/23/2011 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION (DENTIFICATION NUMBER:		1		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		345263	8. WIN	8. WNG			09/2011	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		2	REET ADDRESS, CITY, STATE, ZIP CODE 46 OLD MURPHY ROAD RANKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
	A resident who is una daily living receives the maintain good nutrition and oral hygiene.  This REQUIREMENT by: Based on observation record reviews, the fact resident's soiled hands of three (3) residents, hair for two (2) of three #109 and #98).  The findings are:  1a. Resident #109 was 12/15/08 with diagnost macular degeneration. Data Set (MDS) dated resident had moderate MDS also revealed the extensive assistance was upervision with eating A review of the resident recently on 05/19/11, required constant supervisions.	ble to carry out activities of e necessary services to n, grooming, and personal is not met as evidenced as, interviews, and medical cility failed to wash a selected before a meal for one (1) and failed to remove facial e (3) residents (Residents admitted to the facility on the selected from the most recent Minimum 05/18/11 revealed the ly impaired cognition. The resident required with personal hygiene and	F	312	Macon Valley Nursing and Rehabilitation Center acknowledges receipt of the statement of deficiencies proposes this plan of correcti the extent that the summary findings is factually correct a in order to maintain complian applicable rules and provision quality of care of residents. The plan of correction is subras a written allegation of com Macon Valley Nursing and Rehabilitation Center respons the statement of deficiencies denote agreement with the stof deficiencies nor does it con admission that any deficiency accurate.  Further, Macon Valley Nursing Rehabilitation Center reserves to refute any of the deficiencies informal dispute resolution or appeals procedure and or any administrative or legal procee.  The identified residents #109 or received activities daily care upon the deficient of the deficiencies informal dispute resolution or appeals procedure and or any administrative or legal procee.	on to  of  nd  ce with  ns of  nitted  pliance.  ee to  does not  atement  astitute an  is  and  s the right  formal  other  ding.	07-07-2011	
	revealed Resident #109 used snuff.  On 06/06/11 at 12:00 noon, Resident #109 was observed in her wheelchair in the dining room feeding herself lunch. She had small pieces of				identification to the nursing st occurring on 06- 09-2011, whi included hand washing on resi #109 & facial hair removal on residents # 109 & 98.	ch dent	X6) DATE	
		1. Bran	٠		Haministrator	- <u>D</u>	4/30/1	

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 regulated to sentimed program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GWQC11

Facility ID: 923019

Julisontinuation sheet Page 1 of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Γ΄.	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
			<del></del> -				С
		345263	B. WING	·		06/0	9/2011
NAME OF PROVIDER OR SUPPLIER  MACON VALLEY NURSING AND REHABILITATION CENTER				24	EET ADDRESS, CITY, STATE, ZIP CODE 6 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.O BE	(X5) COMPLETION DATE
F 312	she used her thumb a trap food onto her for pieces of food with he On 06/07/11 at 12:14 observed in her whee feeding herself lunch a exclusively. The reside pieces of brown matter her forefinger, and the She used her right thuor trap food onto her fup pieces of food with forefinger.  On 06/09/11 at 9:42 a (NA) #1 and #2 were of care to Resident #109 and hygiene, before the activity. The NAs washnot her hands.  On 06/09/11 at 10:16 interviewed. She stated compliant with receiving resident used snuff in "all over her, her bed, stated the resident's his snuff. She stated ever resident up and perfor before sending her out the resident went straiglunch. She stated that hands to eat so they stated the resident was stated t	n her right thumb and ing only her right hand and nd forefinger to scoop or c. Resident #109 picked up r right thumb and forefinger.  p.m., Resident #109 was ichair in the dining room using her right hand ent's right hand had small or caked on her right thumb, e palm of her right hand. Imb and forefinger to scoop ork. Resident #109 picked her right thumb and her sident's face but her room and often got it and her wheelchair." She ands were often solled with y weekday the NAs got the med morning care for her to an activity. She stated ght from the activity to the resident used her	F	312	All residents have the potential to be affected by this practice. In-services were conducted by Director of Nursing to the nurs staff which included the topic of proper activities of daily living to include washing hands befor after meals, facial hair removal or if the resident refuses to perfacial hair removal that it is documented as a resident prefer or care planned as applicable.  An audit tool has been develop include monitoring of these (2) identified.  Monitoring will be completed of by a Licensed Nurse/Designee for review min of 4 max 6 different residents from each hall/area defined in addition the QI rounds commembers that monitors assigned halls, their QI tool was revised include monitoring of facial halr and hand washing.	sing of care re and l and mit erence ed to areas laily t aily. mittee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER  MACON VALLEY NURSING AND RE	EHABILITATION CENTER	<b>,</b>	20	EET ADDRESS, CITY, STATE, ZIP CODE 45 OLD MURPHY ROAD RANKLIN, NC 28734		
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to activities first thing in there straight to lunch. expect NAs to wash the leaving for activities bervisually impaired and not hand washing. She stated dining room staff to was they were visibly soiled.  On 06/09/11 at 11:02 a. (DON) was interviewed supposed to wash residents and use wet wiped the residents who ate in stated this should be downed was delivered to and se stated dining room staff resident had snuff on he further stated she would #109 to have to eat her hands.  1b. Resident #109 was a 12/15/08 with diagnoses macular degeneration. The Data Set (MDS) dated the resident had moderately MDS also revealed the rextensive assistance with the resident recently on 05/19/11, revently on 05/	stated Resident #109 went of the morning and from She stated she would be resident's hands before cause the resident was eeded assistance with ated she would expect she the resident's hands if with snuff.  I.m. the Director of Nursing She stated that NAs are dents' hands before all less to wash the hands of in the dining room. She one at the time the tray of the time the tray of the resident. She is should have noticed if the first hands. The DON of not expect Resident meal with snuff on her admitted to the facility on so of hip fracture and of the most recent Minimum 15/18/11 revealed the resident required the personal hygiene.	F	312	Audits will be completed by the Licensed Nurses daily and turn into the Director of Nursing/E weekly. Audits will occur weekly. Audits will occur weekly and then quarterly.  The DON/Designee will report audit results to the QA&A-QI Committee.  The QA&A-QI Committee with review the audit results and in recommendations as appropriate Administrator or Designee.	rned Designee kly for nonths, t the H nake ate to	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A, BUILI	JLTIPLE CONSTRUCTION	• • •	(X3) DATE SURVEY COMPLETED		
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	observed in her whee She had multiple chin approximately ½ inch. On 06/08/11 at 4:15 p observed in her whee multiple chin and facia inch long.  On 06/09/11 at 10:16 #1 was interviewed. Sassistants trimmed facon shower days or what trimmed.  On 06/09/11 at 10:37 at #1 was interviewed. Shas to address facial and if there was a profession of the polymer of the polymer of the polymer of the polymer on the polymer on po	a.m. Resident #109 was Ichair in the dining room. and facial hairs Iong.  I.m. Resident #109 was Ichair in her room. She had all hairs approximately ½  a.m. Nursing Assistant (NA) She stated that nursing sial hair of female residents en they needed to be  a.m. Licensed Nurse (LN) She stated she expected hair on female residents olem to come to her.  a.m. the Director of Nursing d. She stated that facial ts was usually trimmed on expected NAs to monitor tated she would not expect the long on female residents. The reve the facial hair on tated the facial hair on tated the facial hair should Resident #109, and the otrim it.	F3	312				

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NAME OF PROVIDER OR SUPPLIFE  MACON VALLEY NURSING AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCES (GARD DEFICIENCY MUST BE PRECEDED BY FILL) PRIENT TAG  SUMMARY STATEMENT OF DEFICIENCES (GEARD DEFICIENCY MUST BE PRECEDED BY FILL) PRIENT TAG  REGULATORY OR I.S. DEFICIENCY MUST BE PRECEDED BY FILL REGULATORY OR I.S. DEFICIENCY MUST BE PRECEDED BY FILL TAG  F 312  Continued From page 4 term memory problems and was severely impaired in cognitive skills for daily decision making. The MDS also revealed the resident required extensive assistance with personal hygiene.  A review of the resident's care plan, revised most recently on 03/31/11, revealed that the resident required total assist with hygiene and grooming  On 06/07/11 at 12:55 p.m. Resident #98 was observed in her wheelchair in the dining room. She had multiple chin and facial hairs approximately ½ inch long.  On 06/08/11 at 10:16 a.m. Nursing Assistant (NA) #1 was interviewed. She stated that fire residents on shower days or when they needed to be trimmed. NA #1 stated that if the resident was diabelic like Realdent #98, the NA notified the nurse that the facial hair needed trimming and the nurse did it.  On 06/09/11 at 10:37 a.m. Licensed Nurse (LIN) #1 was interviewed. She stated she expected NAs to address facial hair on female residents and if there was a problem to come to hor. She stated no NA head sked her recently to trim facial	STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA			LE CONSTRUCTION	1, ,	(X3) DATE SURVEY COMPLETED	
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F 312  Continued From page 4 term memory problems and was severely impaired in cognitive skills for daily decision making. The MDS also revealed the resident required extensive assistance with personal hygione.  A review of the resident's care plan, revised most recently on 03/31/11, revealed that the resident required total assist with hygiene and grooming  On 06/07/11 at 12.55 p.m. Resident #98 was observed in her wheelchair in the dining room. She had multiple chin and facial hairs approximately ½ inch long.  On 06/09/11 at 10:16 a.m. Nursing Assistant (NA) #1 was interviewed. She stated that rurning assistants trimmed facial hair of female resident so n shower days or when they needed to be trimmed. NA #1 stated that if the resident was diabetic like Resklent #98 who had used the female residents on shower days or when they needed to be trimmed. NA #1 stated that if the resident was diabetic like Resklent #98 the NA notified the nurse that the facial hair needed trimming and the nurse did it.  On 06/09/11 at 10:37 a.m. Licensed Nurse (LN) #1 was interviewed. She stated she expected NAs to address facial hair on female residents and if there was a problem to come to her. She stated no NA had asked her reconity to trim facial	NAME OF PROVIDER OR SUPPLIER			<u>l</u>	24	15 OLD MURPHY ROAD			
term memory problems and was severely impaired in cognitive skills for daily decision making. The MDS also reveated the resident required extensive assistance with personal hyglene.  A review of the resident's care plan, revised most recently on 03/31/11, reveated that the resident required total assist with hyglene and grooming  On 06/07/11 at 12:55 p.m. Resident #98 was observed in her wheelchair in the dining room.  She had multiple chin and facial hairs approximately ½ inch long.  On 06/08/11 at 4:15 p.m. Resident #98 was observed in her wheelchair in the television room on her hall. She had multiple chin and facial hairs approximately ½ inch long.  On 06/08/11 at 10:16 a.m. Nursing Assistant (NA) #1 was interviewed. She stated that nursing assistants trimmed facial hair of female residents on shower days or when they needed to be trimmed. Nat #1 stated that if the resident was diabetic like Resident #98, the NA notified the nurse that the facial hair needed trimming and the nurse did it.  On 06/09/11 at 10:37 a.m. Licensed Nurse (LN) #1 was interviewed. She stated she expected NAs to address facial hair on female residents and if there was a problem to come to her. She stated no NA had asked her recently to trim facial	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE	COMPLETION	
On 06/09/11 at 11:02 a.m. the Director of Nursing (DON) was interviewed. She stated that facial		term memory problem impaired in cognitive smaking. The MDS als required extensive as hygiene.  A review of the reside recently on 03/31/11, required total assist wow On 06/07/11 at 12:55 observed in her wheels he had multiple chin approximately ½ inch On 06/08/11 at 4:15 pobserved in her wheel on her hall. She had approximately ½ inch On 06/09/11 at 10:16 assistants trimmed assistants trimmed assistants trimmed factors who wer days or who trimmed. NA #1 stated diabetic like Resident and the facial had nurse did it.  On 06/09/11 at 10:37 af was interviewed. Since the small residents in the facial had assisted in NA had aske hair on any residents woon 06/09/11 at 11:02 af the marked in the facial had aske hair on any residents woon 06/09/11 at 11:02 af the marked in the facial had aske hair on any residents woon 06/09/11 at 11:02 af the facial had aske hair on any residents woon 06/09/11 at 11:02 af the facial had aske hair on any residents woon 06/09/11 at 11:02 af the facial had aske hair on any residents woon 06/09/11 at 11:02 af the facial had aske hair on any residents woon 06/09/11 at 11:02 af the facial had aske hair on any residents woon 06/09/11 at 11:02 af the facial had aske hair on any residents woon 06/09/11 at 11:02 af the facial had aske hair on any residents woon 06/09/11 at 11:02 af the facial had aske hair on any residents woon 06/09/11 at 11:02 af the facial had aske hair on any residents woon 06/09/11 at 11:02 af the facial had aske hair on any residents who 06/09/11 at 11:02 af the facial had aske hair on any residents who 06/09/11 at 11:02 af the facial had aske hair on any residents who 06/09/11 at 11:02 af the facial had aske hair on any residents who 06/09/11 at 11:02 af the facial had aske hair on any residents who 06/09/11 at 11:02 af the facial had aske hair on any residents who 06/09/11 at 11:02 af the facial had aske hair on any residents who 06/09/11 at 11:02 af the facial had aske hair on any residents who 06/09/11 at 11:02 af the facial had aske hair on any residents who 06/09/11	is and was severely skills for daily decision so revealed the resident sistance with personal int's care plan, revised most revealed that the resident inth hygiene and grooming.  p.m. Resident #98 was lehair in the dining room, and facial hairs long.  im. Resident #98 was lehair in the television room multiple chin and facial hairs long.  a.m. Nursing Assistant (NA) she stated that nursing stal hair of female residents en they needed to be do that if the resident was #98, the NA notified the air needed trimming and the sa.m. Licensed Nurse (LN) the stated she expected thair on female residents olem to come to her. She ed her recently to trim facial with diabetes.  a.m. the Director of Nursing	F	312				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		CONSTRUCTION	COMPI		
		345263	B. WIN	3 <u></u>		0	6/09/2011	
NAME OF PROVIDER OR SUPPLIER  MACON VALLEY NURSING AND REHABILITATION CENTER			•	245 (	T ADDRESS, CITY, STATE, ZIP CODE OLD MURPHY ROAD NKLIN, NC 28734			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	shower days but she facial hair daily. She to see facial hair ½ it She stated she expetor a resident with diahair trimmed. The D facial hair on Reside hair should have been and the DON went to 483.35(i) FOOD PROSTORE/PREPARE/STHE facility must - (1) Procure food from considered satisfactor authorities; and	ents was usually trimmed on expected NAs to monitor estated she would not expect inch long on female residents. It is cled NAs to notify the nurse abetes who needed facial ON went to observe the int #98. She stated the facial en trimmed on Resident #98, to tell staff to trim it.  DCURE, SERVE - SANITARY  In sources approved or any by Federal, State or local.		312	No particular resident wa identified in the findings.  All residents have the pote be affected by this practic	ential to	07-07-2011	
	by: Based on observation facility failed to ensure proper temperature in three (3) refrigerators cans from three (3) or rooms, and failed to emicrowaves was clear.  The findings are:  1. On 06/06/11 at 12	r is not met as evidenced ons and staff interviews the e food was stored at the on the freezer in one (1) of one failed to remove dented of three (3) nourishment ensure one (1) of three (3) on.						

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMO NO. 0930-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X2) MULTIPLE CONSTRUCTION  A. BUILDING			URVEY ETED
		B. WIN	IG		c		
		345263	l			06	09/2011
NAME OF PE	ROVIDER OR SUPPLIER			ŞTR	EET ADDRESS, CITY, STATE, ZIP CODE		
MACONIN	ALLEY MUDGING AND D	EHABILITATION CENTER		2.	45 OLD MURPHY ROAD		
MACON	ALCET NUNSING AND N	ENABLITATION OF THE		F	RANKLIN, NC 28734		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
F 371	Continued From page observed. In the freezof ice cream which all two popsicles which for when handled.  On 06/06/11 at 3:20 p (DM) was interviewed cream and popsicles in freezer and stated that and the popsicles crur DM stated that the ice not frozen but were that thermometer in the freezer but that it should and all items should be stated that nursing stated that nursing stated that nursing stated the temperatures of no refrigerators twice a daportion. She noted that refrigerator door used had a column for documenting the freezer moved all the ice crediscarded them. She stee Maintenance Direct holding proper temperatures on 06/06/11 at 4:04 p.m. (DON) was interviewed charge nurses were resourishment room refrigincluded checking the firead that the firead course for the firead cour	cer were nine 4-ounce cups felt soft to the touch and elt mushy and broke in half  m. the Dietary Manager She examined the ice in the 100 Hall refrigerator it the ice cream was soft inbled when handled. The cream and popsicles were awing. She noted that the ezer read 6 degrees above read 0 degrees or below is frozen hard. The DM iff were expected to monitor furishment room introducing the freezer it the form on the ito document temperatures menting the refrigerator out have a column for ier temperatures. The DM am and popsicles and itated that she would tell itor that the freezer was not alture.  m. the Director of Nursing is She stated that the	<u> </u>	371	In-services were conducted the facility staff on proper temperature ranges for refrigerators/freezers, dente cans are to be thrown out, a microwave sanitation was reviewed. Staff members we reminded of the need to more the refrigerator /freezer temperatures and to be awa the required temperature ra and to notify maint when no within acceptable ranges. Meany became within proper range, also new refrigerator purchased during survey on 07-2011 at and survey team member was advised of the replacement. Dented cans we removed upon identification contracted therapy staff also in serviced on prevention of dented cans and on the proceediminate dented cans when found. The microwave was removed from use related to discoloration of the ceiling of microwave and replaced with new microwave on 06-07-201 and the survey team member advised of the replacement. audit tool has been developed	with  d  nd  ere nitor  re of nges t laint i the temp was 06-  ere . The was ess to  the i the i a i a i was An	
	used to document temp documenting the refrige not have a column for o	peratures had a column for erator temperatures but did locumenting the freezer ed the form needed to be			include monitoring of the nourishment rooms to includ identified areas monitoring b Dietary Manager/ Designee.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
345263 B. WNG		06/0	C 06/09/2011			
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	24	EET ADDRESS, CITY, STATE, ZIP CODE 5 OLD MURPHY ROAD RANKLIN, NC 28734		· · · · · · · · · · · · · · · · · · ·
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F 371	revised to include m temperature to ensuremained frozen.  2. On a tour of nour at 12.41 p.m. the foll Sub-acute Hall nouriounce cans of soup, one chicken noodle, dents on the sides mand ready for use.  100 Hall nourishment can of cream of must the side near the rim Secured Unit - two 7 one cream of chicker on the sides near or ready for use; one 8 supplement with a deready for use.  On 06/06/11 at 3:20 (DM) was interviewed soup and protein sup the nourishment roor were examined for decans were returned to any dented cans in the should have been returned stans. She stated she have been pulled out	onitoring of the freezer re items in the freezer re items on 06/06/11 lowing was observed:  Shment room - four 7 and ½ once cream of mushroom, and two vegetable beef, with ear or on the rims, stored  It room - one 7 and ½ ounce throom soup with a dent on, stored and ready for use.  and ½ ounce cans of soup, and one tomato, with dents on the rims, stored and fluid ounce can of protein ent on the rim, stored and p.m. the Dietary Manager d. She stated that cans of optements were stocked in ms by her staff after they ents. She stated dented to the food vendor and that he nourishment rooms turned to the kitchen by the toured the nourishment dexamined the dented of use by staff and returned to the food the dented of use by staff and returned to the dented of use by staff and returned to the dented of use by staff and returned the dented of the dented of the dented the dented of the dented the dented of the dented the dented the dented of the dented the dent	F 371	Audits will be completed be Dietary Manager/Designed and turned into the Administrator weekly. Audition will occur weekly for one month, then monthly x3 mand then quarterly. The Dimanager will report the auresults to the QA&A-QI Committee. The QA&A-Q Committee will review the results and make recommendations as appropriate to the Administrator or Designee.	daily lits onths ietary idits I audit	

Event ID: GWQC11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A BUII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED  C	
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F 371	oven in the sub-acute observed to have spla	41 p.m. the microwave hall nourishment room was ashes on the inside walls of e matter splattered on the	F	371			
	On 06/06/11 at 4:25 p Supervisor was intervi inside walls and cellin splashes and particula housekeeper had miss which should be clean expected the microwa	.m. the Housekeeping lewed. He examined the g of the unit and noted the late matter. He stated the sed cleaning the microwave led daily. He stated he					