STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345263	A. BUILDING _____ B. WING _____	C 06/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACON VALLEY NURSING AND REHABILITATION CENTER	245 OLD MURPHY ROAD FRANKLIN, NC 28734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and medical record reviews, the facility failed to wash a resident's soiled hands before a meal for one (1) of three (3) residents, and failed to remove facial hair for two (2) of three (3) residents (Residents #109 and #98). The findings are: 1a. Resident #109 was admitted to the facility on 12/15/08 with diagnoses of hip fracture and macular degeneration. The most recent Minimum Data Set (MDS) dated 05/18/11 revealed the resident had moderately impaired cognition. The MDS also revealed the resident required extensive assistance with personal hygiene and supervision with eating. A review of the resident's care plan, revised most recently on 05/19/11, revealed that the resident required constant supervision and physical assist with hygiene. Review of the medical record also 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	F 312	**Macon Valley Nursing and Rehabilitation Center acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance.** **Macon Valley Nursing and Rehabilitation Center response to the statement of deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate.** **Further, Macon Valley Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this statement of deficiencies through informal dispute resolution or formal appeals procedure and or any other administrative or legal proceeding.** **The identified residents #109 & #98 received activities daily care upon identification to the nursing staff, occurring on 06- 09-2011, which included hand washing on resident #109 & facial hair removal on residents # 109 & 98.**	07-07-2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 06/30/11

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.

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F 312	Continued From page 1 brown matter caked on her right thumb and forefinger. She ate using only her right hand and she used her thumb and forefinger to scoop or trap food onto her fork. Resident #109 picked up pieces of food with her right thumb and forefinger. On 06/07/11 at 12:14 p.m., Resident #109 was observed in her wheelchair in the dining room feeding herself lunch using her right hand exclusively. The resident's right hand had small pieces of brown matter caked on her right thumb, her forefinger, and the palm of her right hand. She used her right thumb and forefinger to scoop or trap food onto her fork. Resident #109 picked up pieces of food with her right thumb and forefinger. On 06/09/11 at 9:42 a.m., Nursing Assistants (NA) #1 and #2 were observed providing morning care to Resident #109, which included grooming and hygiene, before they sent her off to an activity. The NAs washed the resident's face but not her hands. On 06/09/11 at 10:16 a.m. NA #1 was interviewed. She stated Resident # 109 was very compliant with receiving care. She stated the resident used snuff in her room and often got it "all over her, her bed, and her wheelchair." She stated the resident's hands were often soiled with snuff. She stated every weekday the NAs got the resident up and performed morning care for her before sending her out to an activity. She stated the resident went straight from the activity to lunch. She stated that the resident used her hands to eat so they should be clean. NA #1 stated the resident was visually impaired so she could not see if her hands were soiled with snuff.	F 312	**All residents have the potential to be affected by this practice.** **In-services were conducted by the Director of Nursing to the nursing staff which included the topic of proper activities of daily living care to include washing hands before and after meals, facial hair removal and or if the resident refuses to permit facial hair removal that it is documented as a resident preference or care planned as applicable.** **An audit tool has been developed to include monitoring of these (2) areas identified.** **Monitoring will be completed daily by a Licensed Nurse/Designee to review min of 4 max 6 different residents from each hall/area daily.** **In addition the QI rounds committee members that monitors assigned halls, their QI tool was revised to include monitoring of facial hair and hand washing.**	

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F 312	Continued From page 2 On 06/09/11 at 10:37 Licensed Nurse (LN) #1 was interviewed. She stated Resident #109 went to activities first thing in the morning and from there straight to lunch. She stated she would expect NAs to wash the resident's hands before leaving for activities because the resident was visually impaired and needed assistance with hand washing. She stated she would expect dining room staff to wash the resident's hands if they were visibly soiled with snuff. On 06/09/11 at 11:02 a.m. the Director of Nursing (DON) was interviewed. She stated that NAs are supposed to wash residents' hands before all meals and use wet wipes to wash the hands of the residents who ate in the dining room. She stated this should be done at the time the tray was delivered to and set up for the resident. She stated dining room staff should have noticed if the resident had snuff on her hands. The DON further stated she would not expect Resident #109 to have to eat her meal with snuff on her hands. 1b. Resident #109 was admitted to the facility on 12/15/08 with diagnoses of hip fracture and macular degeneration. The most recent Minimum Data Set (MDS) dated 05/18/11 revealed the resident had moderately impaired cognition. The MDS also revealed the resident required extensive assistance with personal hygiene. A review of the resident's care plan, revised most recently on 05/19/11, revealed that the resident required constant supervision and physical assist with hygiene and grooming.	F 312	Audits will be completed by the Licensed Nurses daily and turned into the Director of Nursing/Designee weekly. Audits will occur weekly for one month, then monthly x3 months, and then quarterly. The DON/Designee will report the audit results to the QA&A-QI Committee. The QA&A-QI Committee will review the audit results and make recommendations as appropriate to the Administrator or Designee.	

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F 312	Continued From page 3 On 06/07/11 at 11:04 a.m. Resident #109 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 #109 was observed in her wheelchair in her 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 nursing assistants trimmed facial hair of female residents on shower days or when they needed to be trimmed. 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. On 06/09/11 at 11:02 a.m. the Director of Nursing (DON) was interviewed. She stated that facial hair on female residents was usually trimmed on shower days but she expected NAs to monitor facial hair daily. She stated she would not expect to see facial hair ½ inch long on female residents. The DON went to observe the facial hair on Resident #109. She stated the facial hair should have been trimmed on Resident #109, and the DON went to tell staff to trim it. 2. Resident #98 was admitted to the facility on 09/01/10 with Alzheimer's Disease, diabetes, difficulty walking, and congestive heart failure. The most recent Minimum Data Set (MDS) dated 04/07/11 revealed the resident had short and long	F 312		

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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 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 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 06/09/11 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. NA #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 hair on any residents with diabetes. On 06/09/11 at 11:02 a.m. the Director of Nursing (DON) was interviewed. She stated that facial	F 312		

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F 312	Continued From page 5 hair on female residents was usually trimmed on shower days but she expected NAs to monitor facial hair daily. She stated she would not expect to see facial hair ½ inch long on female residents. She stated she expected NAs to notify the nurse for a resident with diabetes who needed facial hair trimmed. The DON went to observe the facial hair on Resident #98. She stated the facial hair should have been trimmed on Resident #98, and the DON went to tell staff to trim it.	F 312		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure food was stored at the proper temperature in the freezer in one (1) of three (3) refrigerators, failed to remove dented cans from three (3) of three (3) nourishment rooms, and failed to ensure one (1) of three (3) microwaves was clean. The findings are: 1. On 06/06/11 at 12:46 p.m. the refrigerator in the nourishment room on the 100 Hall was	F 371	**No particular resident was identified in the findings.** **All residents have the potential to be affected by this practice.**	07-07-2011

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F 371	Continued From page 6 observed. In the freezer were nine 4-ounce cups of ice cream which all felt soft to the touch and two popsicles which felt mushy and broke in half when handled. On 06/06/11 at 3:20 p.m. the Dietary Manager (DM) was interviewed. She examined the ice cream and popsicles in the 100 Hall refrigerator freezer and stated that the ice cream was soft and the popsicles crumbled when handled. The DM stated that the ice cream and popsicles were not frozen but were thawing. She noted that the thermometer in the freezer read 6 degrees above zero but that it should read 0 degrees or below and all items should be frozen hard. The DM stated that nursing staff were expected to monitor the temperatures of nourishment room refrigerators twice a day, including the freezer portion. She noted that the form on the refrigerator door used to document temperatures had a column for documenting the refrigerator temperatures but did not have a column for documenting the freezer temperatures. The DM removed all the ice cream and popsicles and discarded them. She stated that she would tell the Maintenance Director that the freezer was not holding proper temperature. On 06/06/11 at 4:04 p.m. the Director of Nursing (DON) was interviewed. She stated that the charge nurses were responsible for checking nourishment room refrigerators twice daily which included checking the freezer temperature. The DON noted that the form on the refrigerator door used to document temperatures had a column for documenting the refrigerator temperatures but did not have a column for documenting the freezer temperatures. She stated the form needed to be	F 371	**In-services were conducted with the facility staff on proper temperature ranges for refrigerators/freezers, dented cans are to be thrown out, and microwave sanitation was reviewed. Staff members were reminded of the need to monitor the refrigerator /freezer temperatures and to be aware of the required temperature ranges and to notify maint when not within acceptable ranges. Maint serviced the refrigerator and the temp became within proper temp range, also new refrigerator was purchased during survey on 06-07-2011 at and survey team member was advised of the replacement. Dented cans were removed upon identification. The contracted therapy staff also was in serviced on prevention of dented cans and on the process to eliminate dented cans when found. The microwave was removed from use related to the discoloration of the ceiling of the microwave and replaced with a new microwave on 06-07-2011 and the survey team member was advised of the replacement. An audit tool has been developed to include monitoring of the nourishment rooms to include the identified areas monitoring by the Dietary Manager/ Designee.**	

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F 371	Continued From page 7 revised to include monitoring of the freezer temperature to ensure items in the freezer remained frozen. 2. On a tour of nourishment rooms on 06/06/11 at 12.41 p.m. the following was observed: Sub-acute Hall nourishment room - four 7 and ¼ ounce cans of soup, one cream of mushroom, one chicken noodle, and two vegetable beef, with dents on the sides near or on the rims, stored and ready for use. 100 Hall nourishment room - one 7 and ¼ ounce can of cream of mushroom soup with a dent on the side near the rim, stored and ready for use. Secured Unit - two 7 and ¼ ounce cans of soup, one cream of chicken and one tomato, with dents on the sides near or on the rims, stored and ready for use; one 8 fluid ounce can of protein supplement with a dent on the rim, stored and ready for use. On 06/06/11 at 3:20 p.m. the Dietary Manager (DM) was interviewed. She stated that cans of soup and protein supplements were stocked in the nourishment rooms by her staff after they were examined for dents. She stated dented cans were returned to the food vendor and that any dented cans in the nourishment rooms should have been returned to the kitchen by nursing staff. The DM toured the nourishment rooms at this time and examined the dented cans. She stated she expected that they should have been pulled out of use by staff and returned to the kitchen. The DM discarded the dented cans.	F 371	**Audits will be completed by the Dietary Manager/Designee daily and turned into the Administrator weekly. Audits will occur weekly for one month, then monthly x3 months and then quarterly. The Dietary Manager will report the audits results to the QA&A-QI Committee. The QA&A-QI Committee will review the audit results and make recommendations as appropriate to the Administrator or Designee.**	

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F 371	Continued From page 8 3. On 06/06/11 at 12:41 p.m. the microwave oven in the sub-acute hall nourishment room was observed to have splashes on the inside walls of the unit and particulate matter splattered on the inside ceiling of the unit. On 06/06/11 at 4:25 p.m. the Housekeeping Supervisor was interviewed. He examined the inside walls and ceiling of the unit and noted the splashes and particulate matter. He stated the housekeeper had missed cleaning the microwave which should be cleaned daily. He stated he expected the microwave would have been cleaned, with no build-up of particulate matter on the ceiling.	F 371		