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 06/20/2018

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F 000	INITIAL COMMENTS A survey team conducted a complaint/follow up survey and entered the facility on 05/15/18 and exited on 05/16/18. Upon review by CMS it was determined the allegation shoud have been cited as immediate jeopardy to resident health or safety. A surveyor returned to the facility on 06/19/18 to obtain additional information and investigate another complaint intake and exited on 06/20/18. Therefore, the survey's exit date was changed to 06/20/18. Event #6VGL11. A complaint investigation was conducted from 05/15/18-05/16/18 and 06/19/18-06/20/18. Immediate Jeopardy was identified at: CFR 483.21 at tag F660 at a scope and severity (J). IJ began on 04/30/18 and was removed 06/13/18. An extended survey was conducted.	F 000		
F 660 SS=J	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be	F 660		6/20/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/03/2018

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updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent

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F 660	Continued From page 2 the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Ombudsman interview, Adult Protective Service Worker interview and former resident interview, the facility failed to provide 1 of 3 sampled residents (Resident #1) with a discharge planning process which included the residents discharge goals and needs, caregiver support and referrals to local contact agencies as appropriate and involvement of the resident and interdisciplinary team in developing the discharge plan. The discharge place had not been assessed prior to Resident #1 being taken there and dropped off by the facility transport driver. Immediate jeopardy began on 04/30/18 when Resident #1 was transported to his residence by a facility transport driver without any assessment, preparation or planning. Resident #1 was assisted out of the facility vehicle in his wheelchair to a utility building with no electricity or running water that could be seen by the facility	F 660	ACKNOWLEDGEMENT DISCLAIMER 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□s 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	

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F 660	Continued From page 3 driver. The facility driver returned to the facility and reported to the Director of Nursing (DON) how the area appeared. On 05/01/18 the facility submitted an Adult Protective Services (APS) report detailing the concerns of the living environment for Resident #1. Immediate Jeopardy was removed on 06/13/18 based on the allegation of compliance that was provided. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to training of facility staff regarding the discharge planning process. The findings included: Resident #1 was admitted to the facility on 12/23/17 after a hospitalization. The admission Minimum Data Set (MDS) dated 12/29/17 indicated Resident #1 had moderately impaired cognitive skills and required assistance with most activities of daily living. The MDS also indicated Resident #1 required assistance with stabilization during transfers. The MDS further indicated Resident #1 had diagnoses which included alcohol abuse, acquired absence of his right leg below the knee, pain, cognitive communication deficit and abnormalities of gait and mobility. The MDS also noted Resident #1 expected to be discharged to the community although no discharge planning had started. The most recent quarterly MDS dated 03/31/18 revealed Resident #1 was cognitively intact with a mini-mental score 14 out of a possible 15. Record review of the hospitalization for Resident #1 indicated he had lived alone in a shack with no	F 660	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. F 660 On 4/3/18, the administrator issued a 30-day discharge to Resident #1. The facility did not contact the ombudsman or adult protective services worker at this time. On 4/3/18, the administrator reviewed the discharge plan with Resident #1. They discussed at length where Resident #1 would go upon discharge. Resident #1 told the administrator he wanted to go to his trailer. The administrator informed Resident #1 that he had enough money for an apartment and he responded "No, I have a trailer and want to go there". At this time a facility representative did not go and look at the trailer. On 4/30/18, Resident #1 was discharged to the community upon agreement with the facility social worker that the resident would go to the hotel where the Resident #1 had friends. After leaving the facility, Resident #1 changed the desired discharge location to Resident #1's home. Resident #1 exercised the right not to go	

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running water or electricity prior to his hospitalization. The record review also revealed the neighbor of Resident #1 found him injured on 11/26/17, emergency services were contacted and he was transported to the hospital. Resident #1 had a right below the knee amputation resulting from this hospitalization. Resident #1 was discharged from the hospital on 12/23/17 to the nursing home.

Record review of the care plan dated 12/27/17 revealed Resident #1 wished to return home after his rehabilitation in the facility. Goals to assist Resident #1 to achieve his wishes included the following: resident will receive adequate preparation and orientation for discharge to home upon completion of rehabilitation therapy.

Record review of progress notes on 01/25/18 revealed the Social Worker (SW) had sent a referral for placement to another skilled nursing facility that was a smoking facility. Resident #1 had been found throughout the day smoking in the parking lot (against facility rules). Additional progress notes dated 01/28/18 revealed referrals had been sent to 6 other facilities that allowed smoking.
Record review of the transfer/discharge notice was issued to the resident on 04/03/18 which indicated he had been non-compliant with the facility's smoking policy. The transfer/discharge notice had been signed by the Administrator. At no time did the resident request an appeal of the discharge notice.

A home visit was made to the residence of Resident #1 with the Adult Protective Services (APS) worker on 06/19/18 at 11:49 AM. An observation of the residence revealed it was a

to his agreed community destination but rather to return directly to his homestead. After discovering the resident did not go to the community motel as agreed, the facility did not do a home visit or have staff do a home visit to evaluate Resident #1's homestead situation. Further at this time, Resident #1 demanded he be taken to his homestead situation and the transportation employee honored the resident's request. Resident #1's home was a tin storage building with no electricity or running water.

What lead tot he deficiency of the resident being discharged to an unsafe situation was the facility did not go and look at Resident #1's trailer or contact the ombudsman, either of which may have helped to identify the potential for discharge to an unsafe location.

On 5/17/18, the DON initiated an in-service for licensed nurses on documentation for discharge of a resident. This includes assessment, discharge summary, medication release form, and discharge instructions. This is-service was completed on 6/4/18. This in-service will be part of the orientation for all newly hired licensed nurses. The in-service will ensure residents are provided with a safe and orderly discharge.

On 5/25/18, the DON reviewed all residents discharged in the last 14 days ensuring documentation is present verifying needed equipment, medication, nursing assessments, and services were

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F 660	Continued From page 5 small utility building with burning trash within a foot of the entranceway. Resident #1 was present, sitting up in his wheelchair, smoking a cigarette. An interview with Resident #1 revealed he had no electricity, no running water, no refrigeration, no toilet or shower, no cell phone or land line, and was unable to close one of the doors of his utility building. He stated he was okay living there and stated there was nothing else he needed as this was where he lived prior to his facility stay. Resident #1 stated the SW at the facility told him he was being discharged but he couldn't remember why. When asked if it was due to his smoking Resident #1 stated he didn't think so. Resident #1 stated he told various staff in the facility that he was coming back to his "little trailer" when he left. Resident #1 also stated that he had 2 checks given to him from the facility, but he had lost one and it was written for over $8,000.00. During an interview on 06/19/18 at 12:12PM with the APS worker, she stated that APS had received a report on Resident #1 on 05/01/18. She also stated the APS report revealed Resident #1 had multiple hazards in the utility building including, but not limited to: being a fire hazard, having inadequate heating and cooling, falling/tripping hazards, no access to transportation, no telephone access, no way to prepare meals, do laundry or housekeeping, and no way to make repairs. The APS worker further stated she made her first visit with Resident #1 at the utility building on 05/03/18 and he told her he didn't have electricity or running water but stated he was fine living there. During repeated meetings with Resident #1 he continued to state the utility building was where he wanted to be. Resident #1 was observed by the APS worker to	F 660	arranged at time of resident's discharge. All discharges had necessary arrangements made prior to discharge to ensure residents are being discharged to a safe location. Beginning 5/25/18 when the facility interdisciplinary team (IDT) determines a resident needs cannot be met or it is necessary for the facility to issue a 30 day discharge notice, the DON and/or Administrator will notify the regional vice president (RVP). The RVP will provide guidance to the facility to ensure the resident is provided with a correct 30 day discharge notice and safe and orderly discharge, including a safe location. The director of Nursing will be responsible for determining the discharge location is safe. On 5/31/18, the facility consultant provided an in-service to the DON to ensuring residents are provided a safe, orderly discharge including when issued a 30 day discharge notice. The in-service included documentation of discharge preparations, barriers, and resident status. On 6/6/18, the DON was in-services by the regional ombudsman on correctly completing a 30 day discharge notice. This in-service included notifying the ombudsman on the same day the 30 day discharge notice is presented to the resident/resident representative. The DON now understands the ombudsman should be involved in the beginning to ensure a resident is discharged to a safe	

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F 660	Continued From page 6 be wearing the same clothes at this visit and he had been wearing when she first met him on 05/03/18 and each time she has seen him since. The Department of Social Service APS Department did substantiate self-neglect on 05/31/18 and Resident #1 had agreed to protective services and signed a contract on 06/04/18 allowing them to 1) be his payee 2) set up transportation services for him and 3) find him a new play to live. It had taken the APS worker a month to convince Resident #1 to agree to the protective service contract which allowed them to assist with his social security check, assist with transportation and attempt to locate him a place to live. During an interview on 06/19/18 at 3:52 PM with the Transport Driver (TD) who assisted Resident #1 to his residence on 04/30/18, the TD stated the plan was to take Resident #1 to the bank to cash his checks and then to a hotel. The total amount of the 2 checks was quite substantial. The TD also stated the first bank would not cash the checks for Resident #1 because he had no identification so he drove back to the facility, got a copy of the face sheet for Resident #1 and then drove to the second bank, who was the issuer of the checks to Resident #1. At the second bank, the bank teller stated she knew Resident #1 and was uncomfortable giving him this amount of money. Resident #1 told the TD to forget it and just take him home. After calling the facility for guidance, the Director of Nursing (DON) told the TD that Resident #1 was of sound mind and body and could make that decision independently. Resident #1 was taken to an area off the road that had no mailbox and no driveway up to a small shack with 2 windows, no toilet, no	F 660	location. The DON is responsible for reviewing 30 day discharge notices. This in-service will ensure any future 30 day discharge notices are completely accurately and completely. This in-service will ensure the resident is provided with a safe and orderly discharge, including safe discharge location. The DON, quality assurance nurse (QI), and/or staff facilitator will review discharges occurring during the last 7 days weekly X 12 weeks to ensure the discharge was safe and orderly, including medications, equipment, and services were arranged and documented prior to discharge. This audit will be documented on the Day of Discharge Item Checklist/Audit. The audit will include verifying contact of the ombudsman. The DON, and/or QI nurse will review all 30 day discharge notices weekly X 6 months. The review will include ensuring the documentation is complete and accurate, including ensuring a safe discharge location. This will be documented on the discharge audit tool. The monthly QI committee will review the results of the discharge audit tool for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly	

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F 660	Continued From page 7 refrigerator and phone that he could see. Realizing that Resident #1 had no way to be mobile, the TD left the facility wheelchair with him. Upon his arrival back to the facility, the TD stated he reported the place looked horrible to the DON and the Quality Improvement (QI) nurse. The next morning, the TD was concerned that Resident #1 may not have anything to eat and went to a local restaurant to buy breakfast for him. While he was driving back to the shack of Resident #1, the TD saw him on the highway and stopped to let him know he had brought him some food. Resident #1 asked the TD if he would take the food up to his trailer because he was on his way to meet someone to take him into town to cash his check. Per his request, the TD took his food up to the shack and left it and when he drove back down to the road, Resident #1 was no longer on the road. The facility Social Worker (SW) (who no longer works in the facility) was given the information about the condition of the shack by the TD and he stated she called in an APS report and told the TD that was all they could do for Resident #1. During an interview with the current Rehabilitation Director (RD) on 06/19/18 at 4:31 PM, the RD stated when Resident #1 first came to them he was very disoriented, confused, impulsive and having pain, but was able to progress quickly with therapy and was eventually able to transfer and walk several hundred feet with a wheeled walker. Resident #1 had said he was going home after his therapy and they had offered a home assessment for him but he denied wanting this. The RD also stated they became aware he would not be going home at that time but would be staying in the facility. He was discharged from speech therapy on 01/19/18 for noncompliance	F 660	executive QA committee for further recommendations and oversight. The QI committee met on 6/13/18 and reviewed discharges to ensure documentation supports a safe and orderly discharge. The administrator and DON will be responsible for the implementation of correctly issuing a 30 day discharge notice and ensuring a resident has a safe and orderly discharge. Corporate oversight will be provided by the corporate RVP to ensure the administrator and DON implements and monitors the plan of correction.	

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with following his plan of care and discharged from physical therapy and occupational therapy on 02/01/18 after his goals had been met. Resident #1 had refused to consider a prosthesis for his amputation. The amputation area of his right leg was also noted to be healed by 01/16/18.

During an interview on 06/20/18 at 11:35 AM, the Ombudsman stated he had not been made aware of the discharge for Resident #1 until about 04/15/18 and there was no documentation about discharge planning, where he was discharging to, or any type of home assessment on the notice to determine if it was a safe discharge for him. The transfer/discharge notice did indicate the reason for his discharge was "non-compliant with safety procedures, smoking in non-designated areas."

During an interview on 06/20/18 at 12:03PM, the Administrator stated Resident #1 had indicated from his arrival in the facility that after his therapy was done he would be leaving. Resident #1 had received a 30-day discharge notice on 04/03/18 as he would not comply with the facility smoking policy. The Director of Nursing and the Administrator had tried to discuss with Resident #1 an option of moving to a disability apartment but Resident #1 stated he wanted to go home. The Administrator stated she had also discussed purchasing a small travel trailer with his Social Security back pay, but he continued to state that he had a little trailer on the property that he was returning to. Resident #1 had previously advised the Administrator that he would not use his back pay of over $8,000.00 dollars from social security to pay for a prosthetic leg because he was fine in a wheelchair. During morning stand up meetings starting on 04/04/18, they had started talking about him going home and the Physical Therapy

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Supervisor was present and aware that Resident #1 would be returning home. The Administrator stated she was out on leave at the time of the discharge for Resident #1 and is unsure what the SW did to help with his discharge.

During an interview on 06/20/18 at 12:32 PM with the previous RD during the time of the discharge for Resident #1, the RD stated he did not recall any discussions of the upcoming discharge for Resident #1 during morning meetings. During the facility stay for Resident #1, the RD stated he only had either one or two meetings with Resident #1 and he had never mentioned wanting to go home to him. The RD also stated he had been on vacation the first week of May and when he came back the following week was when he found out that Resident #1 was gone and assumed he had been discharged home. The RD further stated the purpose of the home visit was to see what barriers exist for the resident at the home. He indicated Resident #1 was not on the therapy caseload at the time of his discharge so a home assessment would not have been done.

During an interview on 06/20/18 at 6:42 PM with the DON, she stated Resident #1 had indicated from the time he came into the facility that he was going to go home after his therapy. On the afternoon of 04/30/18, the DON was contacted by the TD and he had explained about the banks not cashing the checks for Resident #1 and he was requesting to return to his home. The DON stated she looked up his BIMS and told the TD Resident #1 was his own Responsible Party (RP) and was of sound mind and body and could make that decision for himself. The DON stated she had talked to the doctor and he agreed with the discharge for Resident #1 and did not feel any

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other services were needed except the discharge. She also stated there was nothing else they could do for Resident #1 as he was competent, had no medical needs and he refused other options. As the Administrator was out of the facility, the DON contacted the Vice President of Operations for validation it was okay to let Resident #1 discharge to his residence.

The DON was notified of immediate jeopardy on 06/19/18 at 10:02 AM.

The facility provided a credible allegation of compliance on 06/20/18 at 3:13 PM as follows:

·Plan of correcting the specific deficiency

On 12/25/18, the social worker history reflects Resident #1's prior level of living, lived alone, and discharge plan was short term rehab (STR).

On 12/27/18, Resident #1's care plan reflected the resident's desire to return home upon completion of rehabilitation therapy.

On 1/25/18, the social worker sent a referral to Valley View Nursing (a smoking facility) to review for placement.

On 1/28/18, the social worker sent referrals to the following to review for placement (smoking facilities): Hayesville House, Blue Ridge on Mountain, Clay County Care Center, Valley View skilled nursing facility, Franklin House Assisted Living, Grandview Assisted Living.

On 2/1/18, Resident #1 was discharged from rehabilitation therapy, all goals met. By the end of January 2018, after Resident #1 received

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wound therapy treatment by the facility, the resident's amputation area had healed.

On 3/31/18, Resident #1 was assessed with a BIM score to be level of 14 out of 15.

On 4/3/18, the administrator issued a 30-day discharge to Resident #1. The facility did not contact the ombudsman or the adult protective services worker that this time.

On 4/3/18, the administrator reviewed the discharge plan with Resident #1. They discussed at length where Resident #1 would go upon discharge. Resident #1 told the administrator he wanted to go to his trailer. The administrator informed Resident #1 that he had enough money for an apartment and he responded "No, I have a trailer and want to go there". At this time a facility representative did not go and look at the trailer.

On 4/30/18, Resident #1 was discharged to the community upon agreement with the facility social worker that the resident would go to the hotel where Resident #1 had friends. After leaving the facility, Resident #1 changed the desired discharge location to Resident #1's home. Resident #1 exercised the right not to go to his agreed community destination but rather to return directly to his homestead. After discovering the resident did not go to the community motel as agreed, the facility did not do a home visit or have staff do a home visit to evaluate Resident #1's homestead situation. Further at this time, Resident #1 demanded he be taken to his homestead situation and the transportation employee honored the residents request. Resident #1's home was a tin storage building with no electricity or running water.

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What lead to the deficiency of the resident being discharged to an unsafe situation was the facility did not go and look at Resident #1's trailer or contact the ombudsman, either of which may have helped to identify the potential for discharge to an unsafe location.

·The procedure for implementing the acceptable plan of correction for the specific deficiency cited

On 5/17/18, the DON initiated an in-service for licensed nurses on documentation for discharge of a resident. This includes assessment, discharge summary, medication release form, and discharge instructions. This in-service was completed on 6/4/18. This in-service will be part of the orientation for all newly hired licensed nurses. The in-service will ensure residents are provided with a safe and orderly discharge.

On 5/25/18, the DON reviewed all residents discharged in the last 14 days ensuring documentation is present verifying needed equipment, medication, nursing assessments, and services were arranged at time of a resident's discharge. All discharges had necessary arrangements made prior to discharge to ensure residents are being discharged to a safe location.

Beginning 5/25/18 when the facility interdisciplinary team (IDT) determines resident needs cannot be met or it is necessary for the facility to issue a 30-day discharge notice, the DON and/or administrator will notify the regional vice president (RVP). The RVP will provide guidance to the facility to ensure the resident is provided with a correct 30-day discharge notice

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and safe and orderly discharge, including a safe location. The director of nursing will be responsible for determining the discharge location is safe.

On 5/31/18, the facility consultant provided an in-service to the DON on ensuring residents are provided a safe, orderly discharge including when issued a 30-day discharge notice. The in-service included documentation of discharge preparations, barriers, and resident status.

On 6/6/18, the DON was in-serviced by the regional ombudsman on correctly completing a 30- day discharge notice. This in-service included notifying the ombudsman on the same day the 30-day discharge notice is presented to the resident/resident representative. The DON now understands the ombudsman should be involved in the beginning to ensure a resident is discharged to a safe location. The DON is responsible for reviewing 30-day discharge notices. This in-service will ensure any future 30-day discharge notices are completed accurately and completely. This in-service will ensure the resident is provided with a safe and orderly discharge, including safe discharge location.

·The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements

The DON, quality assurance nurse(QI), and/or staff facilitator will review discharges occurring during the last 7 days weekly x 12 weeks to ensure the discharge was safe and orderly, including medications, equipment, and services

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were arranged and documented prior to discharge. This audit will be documented on the Day of Discharge Item Checklist/Audit. The audit will include verifying contact of the ombudsman.

The DON, and/or QI nurse will review all 30-day discharge notices weekly x 6 months. The review will include ensuring the documentation is complete and accurate, including ensuring a safe discharge location. This will be documented on the discharge audit tool.

The monthly QI committee will review the results of the discharge audit tool for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.

The QI Committee met on 6/13/18 and reviewed discharges to ensure documentation supports a safe and orderly discharge.

·The title of the person responsible for implementing the acceptable plan of correction.

The Administrator and DON will be responsible for the implementation of correctly issuing a 30-day discharge notice and ensuring a resident has a safe and orderly discharge. Corporate oversight will be provided by the corporate RVP to ensure the administrator and DON implements and monitors the plan of correction.

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F 660	Continued From page 15 The credible allegation was verified on 06/20/18 and as evidenced by the following: verification of re-education for licensed nurses of documentation for discharge of a resident including assessment, discharge summary, medication release from and discharge instructions, validating the DON was reviewing resident discharges daily to verify needed equipment, medication, nursing assessment, documentation and services were arranged at the time of discharge, education to the DON by the facility consultant regarding safe and orderly discharges for residents being given a 30-day discharge notice including documentation of discharge preparations, barriers, and resident status, and education to the DON by the Ombudsman of correctly completing 30-day discharge notices.	F 660		

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F 000	INITIAL COMMENTS A survey team conducted a complaint/follow up survey and entered the facility on 05/15/18 and exited on 05/16/18. Upon review by CMS it was determined the allegation shoud have been cited as immediate jeopardy to resident health or safety. A surveyor returned to the facility on 06/19/18 to obtain additional information and investigate another complaint intake and exited on 06/20/18. Therefore, the survey's exit date was changed to 06/20/18. Event #6VGL11.	F 000		
{F 812} SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to store 2 sheet pans of milkshakes in the kitchen walk in cooler to ensure use in	{F 812}	ACKNOWLEDGEMENT DISCLAIMER Macon Valley Nursing and Rehabilitation	7/13/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/03/2018

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{F 812}	Continued From page 1 accordance with manufacturer guidelines, failed to discard expired food items for 2 of 3 nourishment rooms (Sparks and Brown units), and failed to date opened food items for 3 of 3 nourishment rooms (Sparks, Brown, and sub-acute units). The findings included: 1. An initial tour of the kitchen on 5/15/18 at 10:40 am revealed 2 sheet pans of milkshakes thawing in the walk in cooler. None of the milkshakes were labeled to indicate the day they were thawed or their expiration date. Each milkshake had a manufacturer stamped date which indicated the expiration of the product in a frozen state. The manufacturer's label on each carton indicated the milkshakes were good for 14 days after being thawed. An interview with the dietary manager on 5/15/18 at 10:43 am revealed when the milkshakes were taken from the freezer to the walk in cooler for thawing a label should have been placed on the milkshakes to indicate when they were thawed. The dietary manager further stated the milkshakes were good for 14 days after being thawed. An interview with dietary aide #1 on 5/15/18 at 1:40 pm revealed when milkshakes were taken from the freezer to the walk in cooler for thawing they should be labeled with that date. The dietary aide stated the thawed milkshakes were good for 5 days. A telephone interview with the Administrator on 5/16/18 at 10:16 am revealed it was her expectation that milkshakes be labeled with a date when they were thawed and discarded after	{F 812}	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'□s response to this 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, formal appeal procedure and/or any other administrative or legal proceedings. F812 The plan of correcting the specific deficiency The position of Macon Valley Nursing and Rehabilitation center regarding the process that lead to this deficiency-facility failed to Store, prepare, distribute and serve food in accordance with professional standards for food service safety by failing to store 2 sheet pans of milkshakes in the kitchen walk in cooler to ensure use in accordance with manufacturer guidelines. The facility failed	

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{F 812}	Continued From page 2 14 days. 2. An observation of the nourishment refrigerator on the Sparks unit on 5/15/18 at 10:59 am revealed an opened bottle of milk labeled with a resident's name and an opened date of 4/16/18. The printed expiration date on the bottle was 4/25/18. An observation of the nourishment refrigerator on the Brown unit on 5/15/18 at 11:00 am revealed an opened bottle of orange juice, 2 opened cups of chocolate pudding, and 2 opened cups of applesauce with no date stating when they were opened. There was an opened container of Resource 2.0 (a liquid nutritional supplement) with no date stating when it was opened and a manufacturer's use by date of 4/17/18. There was also another opened container of Resource 2.0 dated as being opened 3/11/18 and having a manufacturer's use by date of 4/17/18. An observation of the nourishment refrigerator on the sub-acute unit on 5/15/18 at 11:15 am revealed an opened container of Resource 2.0, an opened bottle of cranberry juice, an opened bottle of apple juice with no dates indicating when they were opened. An interview with the dietary manager on 5/15/18 at 3:44 pm revealed any opened food or drink was expected to be labeled the day it was opened. All opened pudding was to be discarded 5 days from the open date and fruit and juices were to be discarded 7 days after being opened per the facility's policy. The dietary manager also stated it was the dietary department's responsibility to monitor the nourishment rooms to ensure opened food and drinks were dated and	{F 812}	to discard expired food items for 2 of 3 nourishment rooms and staff failed to date opened food items for 3 of 3 nourishment rooms. Staff failed to follow established policy and procedure by not dating milkshakes and pudding in refrigeration, not throwing out open containers of juice, and resource that were undated. Staff failed to monitor the nourishment rooms for open food item, drinks not dated, and out of date food and liquids. On May 15, 2018, the milkshakes in the walk in cooler in dietary were discarded by the dietary manager. On May 15, 2018, the nursing staff discarded the open milk bottle marked with a resident name in the refrigerator on the sparks unit. On May 15, 2018, the nursing staff discarded from the nourishment refrigerator on the brown unit: an open bottle of orange juice, 2 open cups of cholate pudding, 2 opened cups of applesauce, and 1 open container of Resource 2.0 all without date of opening. On May 15, 2018, the dietary manager discarded from the nourishment refrigerator on the brown unit an open, expired bottle of Resource 2.0. On May 15, 2018, the dietary manager discarded from the nourishment refrigerator on the sub-acute unit: 1 open, undated Resource 2.0, 1 open, undated cranberry juice, and 1 open, undated	

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{F 812}	Continued From page 3 out of date food and liquids were discarded. A telephone interview with the Administrator on 5/16/18 at 10:16 am revealed the dietary manager was to train all dietary staff on labeling and discarding items but the Administrator had gone on medical leave prior to ensuring the training was completed. The Administrator also stated it was her expectation that expired items be discarded from the kitchen and nourishment rooms and all food and drinks be dated when they were opened.	{F 812}	bottle of apple juice. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On May 15, 2018, the dietary manager in-serviced all dietary staff that it is their responsibility to to monitor the nourishment rooms to ensure open food and drinks are dated and out of date food and drinks are discarded. The dietary manager also in-serviced the dietary staff on the monitoring tool used, and frequency of monitoring. This in-service will be complete by June 4, 2018. After June 4, 2018, no dietary staff will be allowed to work until the in-service is complete. This in-service will be part of the orientation process for all newly hired dietary employees. On May 16, 2018, the director of nursing (DON) audited all nourishment rooms, including sub-acute, and brown unit, to ensure no items were present that were open without dates, and/or expired. No open and unlabeled or expired items were discovered. On May 16, 2018, the dietary manager audited all nourishment rooms, and the walk in cooler in dietary to ensure any thawed milkshakes were labeled per manufacturer□s guidelines, and were not expired. No open and unlabeled or expired items were discovered.	

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{F 812}	Continued From page 4	{F 812}	As of May 25, 2018, the facility no longer uses milkshakes, and all milkshakes were discarded by the dietary manager. The facility has begun using a nutritional supplement stable at room temperature until opened. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The administrator, DON, dietary manager DM, and/or quality assurance (QA) nurse will audit 50% of nourishment rooms 3 times weekly x 12 weeks to ensure open food and/or drinks are dated and are not expired, including milkshakes. This audit will be documented on the nourishment room audit tool. The monthly quality improvement (QI) committee will review the results of the nourishment room audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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{F 812}	Continued From page 5	{F 812}	The title of the person responsible for implementing the acceptable plan of correction. The administrator is responsible for implementing the acceptable plan of correction.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee put into place. This failure resulted in one recited deficiency that was originally cited following the 01/27/17 recertification and complaint survey, then recited on the 04/13/18 recertification and complaint survey, and recited on the current 05/16/18 followup survey. The recited deficiency was in the area of store, prepare, distribute and serve food in accordance with professional standards for food service safety. The continued failure during 3 federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program.	F 867	F 867 QAPI/QAA Program/Plan The plan of correcting the specific deficiency The position of Macon Valley Nursing and Rehabilitation Center regarding the process that lead to this deficiency was- failure to follow established facility policy related to quality assurance (QAPI). The procedure for implementing the acceptable plan of correction for the specific deficiency cited	6/3/18

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F 867	Continued From page 6 The findings included: This tag is cross referred to: 483.60 Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observations and interviews the facility failed to store 2 sheet pans of milkshakes in the kitchen walk in cooler to ensure use in accordance with manufacturer guidelines, failed to discard expired food items for 2 of 3 nourishment rooms (Sparks and Brown units), and failed to date opened food items for 3 of 3 nourishment rooms (Sparks, Brown, and sub-acute units). During the recertification and complaint survey of 01/27/17, the facility was cited for failure to remove 1 container of expired chocolate pudding for resident use in 1 of 3 nourishment room refrigerators and failed to date or label 3 bags of sliced cheese for resident use in 3 of 3 nourishment room refrigerators. During the recertification and complaint survey of 04/13/18, the facility failed to provide a barrier between bare hands and ice ready for distribution and failed to store 13 milkshakes in a nourishment pantry to ensure use within guidance provided by the manufacturer. During an interview with the Director of Nursing (DON) on 05/16/18 at 1:01 PM, the DON stated that even though staff were completing audits per the plan of correction to ensure items were labeled, dated and within appropriate dates for use, the facility lacked an oversite or checks and balance system to ensure findings were accurate.	F 867	By May 23, 2018, the facility quality assurance (QA) Committee held two meetings to review the purpose and function of the Quality Assurance Performance Improvement (QAPI) committee and review on-going compliance issues. The director of nursing (DON), minimum data set (MDS) nurse, dietary manager, maintenance director, medical records, and housekeeping supervisor will attend QAPI Committee Meetings on an ongoing basis and will assign additional team members as appropriate. On June 1, 2018 the DON provided updates regarding POC to the Medical Director. On May 31, 2018, the corporate facility consultant in-serviced the DON related to the appropriate functioning of the QAPI Committee and the purpose of the committee to include identify issues and correct repeat deficiencies related F812. As of May 31, 2018 after the corporate facility consultant in-serviced the DON, the facility QAPI Committee will begin identifying other areas of quality concern through the quality improvement (QI) review process, for example: review of rounds tools, review of work orders, review of Point Click Care (PCC - electronic health record), review of resident council minutes, review of resident concern logs, review of pharmacy reports, review of audits related to the plan of correction, and review of regional facility consultant recommendations.	

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F 867	Continued From page 7	F 867	The QAPI committee will meet at a minimum of monthly and the Executive QAPI committee will meet a minimum of quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implementing appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to repeat deficiency. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The Executive QAPI committee will continue to meet at a minimum of quarterly, and QAPI committee monthly with oversight by a corporate staff member. The Executive QAPI committee, including the medical director, will review quarterly compiled QAPI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QAPI committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring QAPI committee concerns are addressed through further training or other interventions.	

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 _____	R-C 06/20/2018

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

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F 867	Continued From page 8	F 867	The title of the person responsible for implementing the acceptable plan of correction The administrator is responsible for implementation of the acceptable plan of correction.	