| 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 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MACON VALLEY NURSING AND REHABILITATION CENTER | 3195 OLD MURPHY ROAD FRANKLIN, NC 28734 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). | F 580 | | 7/3/19 |

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

Electronically Signed | 06/27/2019

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.

| 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 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MACON VALLEY NURSING AND REHABILITATION CENTER | 3195 OLD MURPHY ROAD FRANKLIN, NC 28734 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 | Continued From page 1<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to notify resident's responsible party of a fracture for 1 of 3 residents reviewed for notification (Resident #1) and failed to notify the resident's responsible party of a follow up appointment for 1 of 3 residents (Resident #1).<br><br>Findings included:<br><br>Resident #1 was admitted to the facility 03/03/17 with diagnoses including heart failure, Alzheimer's disease, non-Alzheimer's dementia, and lack of coordination.<br><br>Review of Resident #1's care plan for transfer last updated 02/22/19 revealed Resident #1 required assistance with transfers.<br><br>Review of the quarterly Minimum Data Set (MDS) dated 04/12/19 revealed Resident #1 was severely cognitively impaired and was completely dependent for transfers.<br><br>Review of Resident #1's medical record revealed she was sent the hospital 04/17/19 after a fall at the facility where she was assisted to the floor on 04/16/19. Resident #1 was diagnosed with an | F 580 | This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provision of federal and state law.<br><br>F580- Notification of Changes<br><br>Residents Affected<br>Resident #1 on 4/1719 was diagnosed with a delayed healing right leg fracture, on 5/13/19 the Director of Nursing notified Resident□s #1 Responsible party of the delayed healing fracture of the right leg.<br><br>Residents with the potential to be affected<br><br>On 6/24/19 the Director of Nursing/Staff Development Coordinator initiated in-service with Nursing Management Staff regarding notifying responsible party with any change of condition, appointments, or | |

| 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 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MACON VALLEY NURSING AND REHABILITATION CENTER | 3195 OLD MURPHY ROAD FRANKLIN, NC 28734 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 | Continued From page 2<br>acute fracture of her right leg tibial tubercle (the top part of the tibia bone which is the larger of the 2 bones in the lower leg), placed in an immobilizer, and returned to the facility. Resident #1 was to follow up with an Orthopedist as an outpatient.<br><br>1a. A telephone interview with Resident #1's responsible party on 06/03/19 at 10:47 AM revealed she was aware Resident #1 had been to the hospital on 04/17/19 after an assisted fall at the facility and had been wearing a knee immobilizer after the hospital visit. When Resident #1's responsible party visited Resident #1 on 05/13/19 she noticed Resident #1 was wearing a different knee immobilizer than she had seen before. She asked Resident #1 why she had a different knee immobilizer and Resident #1 told the responsible party she had a broken leg. The responsible party said she asked the charge nurse if Resident #1 had a broken leg and the charge nurse directed her to the Director of Nursing (DON). The DON told the responsible party Resident #1 was diagnosed with an old fracture of her right leg on 04/17/19. The responsible party stated she was not aware Resident #1 had a fractured leg until 05/13/19.<br><br>An interview with the DON on 06/03/19 at 3:49 PM revealed Resident #1's responsible party came to her 05/13/19 and asked her why Resident #1 had a different knee immobilizer on than she had previously worn. The DON informed the responsible party that Resident #1 had a fracture with delayed healing of her right leg diagnosed on 04/17/19 and saw the Orthopedist 05/10/19. The Orthopedist changed the type of immobilizer Resident #1 wore. The DON stated she skimmed Resident #1's hospital | F 580 | ER visit of transfer to the hospital<br>On 6/24/19 an audit was initiated by the Director of Nursing, Staff Facilitator, and Unit Managers to assure all residents responsible party were notified of any change of condition, appointments, or ER visit of transfer to the hospital encompassing the last 60 days.<br>On 6/24/19 the Staff Facilitator initiated an in-service for all Licensed Nurses and Licensed Agency Staff regarding notification of residents□ responsible party when there is a change of condition, appointment, ER visit or transfer to the hospital, completed by 7/3/19.<br><br>What measures will be put in place or systemic changes to ensure the deficient practice will not occur<br><br>During Orientation Licensed Nurses and Licensed Agency Nurses will be in-serviced regarding proper notification of responsible party with any change of condition, appointment, ER visit or transfer to the hospital.<br>Audit of Appointments, ER Visit/ Hospital Transfer, and change of condition to ensure practice is maintained will be initiated June 28, 2019 using the Change of Condition/Incident audit tool; the Change of Condition audit will be completed 3 days weekly x 4 weeks and then 2 times a week x 4 weeks and then weekly x 4 weeks by the Director of Nursing or Unit Manager.<br><br>Monitoring<br>The Director of Nursing/ designee will | |

| 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 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MACON VALLEY NURSING AND REHABILITATION CENTER | 3195 OLD MURPHY ROAD FRANKLIN, NC 28734 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 | Continued From page 3<br>record and did not see the part of Resident #1's hospital record which stated Resident #1 had an acute fracture of the right leg tibial tubercle from the 04/17/19 hospital visit. The DON stated she told Resident #1's responsible party Resident #1 had a fracture of her right leg with delayed healing from the 04/17/19 hospital visit. The DON stated Resident #1's responsible party should have been notified she was diagnosed with a fractured leg at the time of the hospital visit and was not sure why she was not notified.<br><br>An interview with the Administrator 06/04/19 at 10:21 AM revealed she expected residents' responsible party to be notified of fractures.<br><br>1b. A telephone interview with Resident #1's responsible party on 06/03/19 at 10:47 AM revealed she was aware Resident #1 had been to the hospital on 04/17/19 after an assisted fall at the facility and had been wearing a knee immobilizer after the hospital visit. When Resident #1's responsible party visited Resident #1 on 05/13/19 she noticed Resident #1 was wearing a different knee immobilizer than she had seen before. She asked Resident #1 why she had a different knee immobilizer and Resident #1 told the responsible party she had a broken leg. The responsible party said she asked the charge nurse if Resident #1 had a broken leg and the charge nurse directed her to the Director of Nursing (DON). The DON told the responsible party Resident #1 was diagnosed with an old fracture of her right leg on 04/17/19 and saw an Orthopedist 05/10/19. The responsible party stated she was not aware Resident #1 had a fractured leg or had a follow up appointment with an Orthopedist until 05/13/19. | F 580 | bring the audits to the monthly QAPI meeting for review and discussion for 3 months to identify trends, corrective actions, and to maintain continued compliance. The Quality Improvement nurse will present trends and the QI Committee recommendations to the Quarterly Quality Assurance and Performance Improvement Committee for further recommendations and oversight. | |

| 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 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MACON VALLEY NURSING AND REHABILITATION CENTER | 3195 OLD MURPHY ROAD FRANKLIN, NC 28734 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 580 | Continued From page 4 | F 580 | | |

Review of a nurse's note dated 05/10/19 written by Nurse #4 stated Resident #1 was to follow up with orthopedics on 05/10/19.
An interview with Nurse #4 on 06/03/19 at 2:37 PM revealed she cared for Resident #1 on 05/10/19 and sent Resident #1 to her orthopedic appointment. Nurse #4 stated she thought the responsible party for Resident #1 was aware of the follow up appointment.

An interview with Nurse #3 (a charge nurse) on 06/03/19 at 2:47 PM revealed there was previously no consent required from the responsible party for follow up appointments. Nurse #3 stated when the facility became aware of Resident #1's responsible party not being notified of the follow up appointment the facility developed a system for notifying responsible parties of follow up appointments.

An interview with the DON on 06/03/19 at 3:49 PM revealed Resident #1's responsible party came to her 05/13/19 and asked her why Resident #1 had a different knee immobilizer on than she had previously worn. The DON informed the responsible party that Resident #1 had seen the Orthopedist for a follow up appointment 05/10/19. The Orthopedist changed the type of immobilizer Resident #1 wore. The DON stated Resident #1's responsible party should have been notified of the follow up appointment with the Orthopedist before going to the follow up appointment.

An interview with the Administrator on 06/04/19 at 10:21 AM revealed she expected residents' responsible parties to be notified of follow up appointments.

| 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 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MACON VALLEY NURSING AND REHABILITATION CENTER | 3195 OLD MURPHY ROAD FRANKLIN, NC 28734 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 5 | F 689 | | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff and Physician interviews the facility failed to use a mechanical lift to safely transfer a resident for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1). Two staff were in the process of manually transferring Resident #1 and had to lower her to the floor. Resident #1 complained of knee pain and the following day was diagnosed at the hospital with a fractured right leg.<br><br>Findings included:<br><br>Resident #1 was admitted to the facility 03/03/17 with diagnoses including Alzheimer's disease and lack of coordination.<br>Resident #1's Resident Care Guide last updated 02/07/19 revealed she was to be transferred via a mechanical lift.<br><br>Resident #1's care plan for transfer last updated 02/22/19 revealed Resident #1 required assistance with transfers related to a fracture of her right hip, lack of strength, physical limitations, and unsteady gait. The goal was for Resident #1 to receive the necessary physical assistance to transfer daily. Interventions included transferring | F 689 | This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provision of federal and state law.<br><br>Resident Affected<br>Resident #1 care guide was validated for accuracy; the care guide was accurate.<br><br>Residents with the potential to be affected Therapy Director reviewed 100% of residents care guide for accuracy with mode of transfers. Nurse Consultant updated care guides as appropriate.<br>On 6/25/19 the Staff Facilitator initiated in-service for 100% of Certified Nursing Assistants and agency staff using the in-service titled, Resident Care Guide. In-service was completed on June 28, 2019. | 7/3/19 |

| 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 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MACON VALLEY NURSING AND REHABILITATION CENTER | 3195 OLD MURPHY ROAD FRANKLIN, NC 28734 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 6<br>Resident #1 with a mechanical lift, showing her how to position her body parts when transferring, and monitoring her for safety awareness.<br><br>Resident #1's quarterly Minimum Data Set (MDS) dated 04/12/19 revealed she was severely cognitively impaired and was completely dependent for transfers.<br><br>Resident #1's medical record revealed a nurse's note dated 04/16/19 at 10:53 PM written by Nurse #1 which stated she received a report from another nurse that Resident #1 was in the floor in the shower room. When Nurse #1 entered the shower room Resident #1 was sitting on her buttocks with a nurse aide (NA) supporting her from behind. Staff reported they were transferring Resident #1 from her chair to the shower chair and could not hold her up so they lowered her to the floor. Resident #1 was assessed and no apparent injury was noted but Resident #1 did complain of right knee pain. No edema (swelling) or discoloration was noted to Resident #1's knee. Resident #1 was assisted with using the mechanical lift. The Physician was notified and gave a new order to obtain a mobile x-ray and have the clinician follow-up with a knee assessment when in the building the following day.<br><br>Nurse #1 was unavailable for interview during the survey.<br><br>The incident report dated 04/16/19 revealed staff lowered Resident #1 to the floor during transfer. Interventions put into place post incident included reviewing care guide access, in-servicing staff to use the mechanical lift, and obtaining a mobile x-ray of Resident #1's right knee. | F 689 | What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur<br>The Staff Facilitator will audit 100% of the C.N.A.□s by return demonstration using the Appropriate Transfer of Resident Audit Tool post in-service to be completed June 28th, 2019; C.N.A. staff will not be allowed to work until staff education provided and audit completed.<br>The Staff Facilitator or designee will initiate an audit July 1, 2019 to ensure practice is maintained. The audit will include 5 C.N.A.□s 2 times a week to include all shifts x 12 weeks using the Appropriate Transfer of Resident Audit Tool.<br>The Resident Care Guide in-service will be added to the new C.N.A. orientation and agency staff.<br><br>Monitoring<br>The Director of Nursing will review the results of the audits with the monthly Quality Improvement committee for 3 months to identify trends, corrective actions, and to determine the need for frequency of continued monitoring to maintain compliance. The Quality Improvement nurse will present trends and QI committee recommendations to the quarterly quality assurance and performance improvement (QAPI) committee for further recommendations and oversight. | |

| 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 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MACON VALLEY NURSING AND REHABILITATION CENTER | 3195 OLD MURPHY ROAD FRANKLIN, NC 28734 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 7 | F 689 | | |

A review of the Resident Incident Witness Statement dated 04/16/19 and written by NA #1 revealed Resident #1 was lowered to the floor during transfer. The statement revealed Resident #1 reported her knee was hurting but asked to go ahead with her shower.

An interview with NA #1 on 06/04/19 at 5:56 PM revealed she and NA #2 were caring for Resident #1 the evening of 04/16/19. NA #1 stated she and NA #2 wheeled Resident #1 to the shower room in her wheelchair. NA #1 stated she and NA #2 were supporting Resident #1 under each arm to move Resident #1 from the wheelchair to the shower chair. The NA stated Resident #1 began to slip during the transfer and was lowered to the floor. During the process of Resident #1 being lowered to the floor her right leg ended up underneath her. NA #1 stated she was not sure who straightened out Resident #1's leg from underneath her. The NA stated she sent NA #2 to notify the nurse of the fall while she stayed with Resident #1 and supported her back. NA #1 stated she and NA #2 did not look at the Resident Care Guide before transferring Resident #1. NA #1 stated she should have looked at the Resident Care Guide before transferring Resident #1 and she was not sure why she did not. The NA stated she had cared for Resident #1 previously and was not aware she needed to be transferred with a mechanical lift.

A Resident Incident Witness Statement was not completed by NA #2 for Resident #1's 04/16/19 incident.

NA #2 was not available for interview during the survey.

| 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 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MACON VALLEY NURSING AND REHABILITATION CENTER | 3195 OLD MURPHY ROAD FRANKLIN, NC 28734 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 8 | F 689 | | |

An interview with Nurse #2 on 06/03/19 at 12:50 PM revealed she was called to the shower room when Resident #1 fell because Nurse #1 (the nurse assigned to Resident #1) was busy. She stated when she entered the shower room on 04/16/19 Resident #1 was sitting on the floor. Nurse #2 stated Resident #1 complained of pain in her right knee but asked to complete her shower. Nurse #2 stated after Resident #1 was assessed she was transferred to the shower chair with a mechanical lift. She stated there was no mechanical lift in the shower room when she responded to the shower room and the NAs caring for Resident #1 stated they attempted to transfer Resident #1 from her chair to the shower chair without using the mechanical lift.

An interview with Nurse #3 (charge nurse for the gray unit) on 06/03/19 at 2:47 PM revealed she was working the evening of 04/16/19 and was getting ready to leave when she was notified Resident #1 had a fall in the shower room. Nurse #3 stated she asked the 2 NAs caring for Resident #1 the evening of 04/16/19 what happened when Resident #1 fell and they both stated they transferred Resident #1 without using the mechanical lift.

A nurse's note dated 04/17/19 at 8:22 AM written by Nurse #3 stated Resident #1 reported right knee pain after a fall during transfer on 04/16/19. Resident #1's right knee was bruised and swollen. New Physician's orders were received to send Resident #1 to the hospital.

Resident #1's medical record revealed she was seen in the Emergency Department on 04/17/19 because she fell at the facility and was assisted

| 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 06/04/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MACON VALLEY NURSING AND REHABILITATION CENTER | 3195 OLD MURPHY ROAD FRANKLIN, NC 28734 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 9 | F 689 | | |

to the ground. Resident #1 was diagnosed with an acute fracture of the right leg tibial tubercle. Orthopedics was consulted and recommended a knee immobilizer and follow up as an outpatient. Resident #1 was discharged back to the facility. An interview with the Director of Nursing (DON) on 06/03/19 at 3:49 PM revealed she expected staff to review the Resident Care Guide prior to transferring residents and to follow the Resident Care Guide for transfers.

An interview with the interim Administrator on 06/03/19 at 5:10 PM revealed she completed the fall investigation after Resident #1's fall on 04/16/19. The interim Administrator stated NA #1 confirmed she and NA #2 transferred Resident #1 without using the mechanical lift. NA #1 stated she and NA #2 did not look at the Resident Care Guide to determine how Resident #1 transferred before transferring Resident #1. The Interim Administrator stated she did not talk to Nurse #1 after Resident #1's fall. She also stated NA #2 was not available for interview during the fall investigation because she never returned to the facility after 04/16/19. The interim Administrator specified she expected staff to review the Resident Care Guide prior to transfers and to follow the Resident Care Guide when transferring residents.

An interview with the Physician on 06/03/19 at 6:04 PM revealed he expected staff to follow the Resident Care Guide for transfers.