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 04/02/2024

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 000	INITIAL COMMENTS A complaint investigation survey was conducted from 04/01/24 to 04/02/24 Event ID# CKCH11. The following intake was investigated: NC00214458. One (1) of the 1 complaint allegation was resulted in deficiency.	F 000		
F 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with resident, staff, and the Medical Director (MD), the facility failed to protect residents' rights to be free from misappropriation of controlled substances for 1 of 1 resident (Resident #1) reviewed for misappropriation of residents' property. The findings included: The facility's Abuse, Neglect, or Misappropriation of Resident property policy, last revised on September 11, 2017, revealed in part the facility would ensure all residents to remain free from abuse or misappropriation of their property. Resident #1 was admitted to the facility on 02/10/24 with diagnoses including osteoporosis and hip fractures.	F 602	Macon Valley -F602 Free from Misappropriation/Exploitation " 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 this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate.	4/26/24

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

Electronically Signed | 04/23/2024

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F 602	Continued From page 1 A review of the physician's order dated 02/10/24 revealed Resident #1 had an order to receive 1 tablet of oxycodone (a semi-synthetic narcotic analgesic for pain) 5 milligrams (mg) by mouth once every 3 hours as needed for pain. The admission Minimum Data Set (MDS) dated 02/16/24 coded Resident #1 with an intact cognition. A review of the medication administration records (MARs) revealed Resident #1 had received 1 tablet of oxycodone 5 mg as needed on 02/19/24 and 03/07/24. A review of the controlled substance count sheet for orange halls on 03/07/24 at 7:00 PM revealed when Nurse #1 took over the medication cart from Nurse #4, the total number of controlled substance cards in the cart was 50 cards according to the count, but it was documented as 48 cards on the count sheet. As Nurse #2 depleted one card during the shift, the balance became 49 cards before the shift transition on 03/08/24 at 7:00 AM. However, Nurse #2 did not update the balance and it remained unchanged at 48 cards. The initial allegation report dated 03/08/24 revealed the facility became aware of the misappropriation of residents' property on 03/08/24 at 7:30 AM when the Director of Nursing (DON) and Administrator were notified that a count of Resident #1's narcotic medication revealed discrepancy. The facility confirmed Resident #1 still had adequate supply of the prescribed narcotic medication and the missing narcotic medications were replaced by the facility. Investigation was initiated by DON immediately.	F 602	Further, Tower 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 proceeding. " The facility administrator will ensure that this plan of correction is initiated and followed as it is written. Problem Statement: " It was alleged that Nurse #1 did not update the count sheet for controlled medication, Oxycodone 5mg, for Resident #1. During an audit by the Assistant Director of Nursing, it was noted that Oxycodone 5mg tablets were missing. An investigation began immediately, and appropriate actions were taken per policy and procedure and to meet regulatory requirements. Resident #1 did not miss any doses of medications and did not have any concerns with pain related to this concern. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: " A pain assessment was conducted by the licensed nurse on duty for Resident #1 on 3/8/24 with no pain reported during the assessment. " On 3/8/24, a reconciliation of controlled medications was conducted for Resident #1 with no additional concerns identified. " All missing medications that were identified as missing were replaced at the	

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F 602	Continued From page 2 The 5-day investigation report dated 03/13/24 revealed on 03/08/24, a blister card of 30 tablets of oxycodone 5 mg was noted missing from the medication cart for orange halls during shift transition. According to the investigation summary, Nurse #1 had a family emergency on 03/07/24 around 9 PM and needed to leave the facility immediately. She asked Nurse Aide (NA) #1 who happened to be in the parking lot at approximately 9:15 PM to hold the medication cart keys until Nurse #2 arrived to relieve her. Nurse #2 arrived at the facility around 9:45 PM and received the medication cart keys from NA#1 in the parking lot. She went ahead to start her shift without counting the medication cart with any nursing staff in the facility. On 03/08/24 at approximately 7:00 AM, Nurse #3 came on shift to relieve Nurse #2. She noted a blister card of 30 tablets of oxycodone 5 mg went missing when counting the medication cart with Nurse 2. Nurse #1 and Nurse #2 were drug screened with negative results and the allegation of misappropriation of residents' property was unsubstantiated. A phone interview was conducted with Nurse #4 on 04/01/24 at 3:40 PM. She recalled working the first shift on 03/07/24 and was relieved by Nurse #1 in the evening. She counted the controlled substances with Nurse #1 during the shift transition without noticing any discrepancy. She passed the medication cart keys to Nurse #1 after Nurse #1 had signed the controlled substance count sheet. During a phone interview conducted on 04/01/24 at 4:06 PM, Nurse #1 stated when she counted the controlled substances with Nurse #4 on	F 602	expense of the facility and any changes that were billed to the resident were refunded on 4/19/24. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: " On 3/8/24, the Director of Nursing/Assistant Director of Nursing completed a 100% audit of all resident□s Controlled Substance Count sheets in comparison to the narcotic medication blister packs in the medication cart and the order in the Medication Administration Record to ensure there were no discrepancies in the count of the medications or medication cards. No areas of concern identified. " On 3/8/24, the Director of Nursing/Assistant Director of Nursing conducted pain assessments for all residents. Any pain expressed or noted during assessments were addressed immediately. " All assessments and audits were completed by 3/8/24. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: " On 3/8/24, the Director of Nursing/Assistant Director of Nursing/Staff Development Coordinator initiated in-servicing with all licensed nurses and medication aides to include agency staff regarding controlled substance diversion to include: the definition, implications of a diversion and the process for properly receiving and returning medications from the pharmacy. The in-service also	

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F 602	Continued From page 3 03/07/24 at around 7:00 PM, she checked the medication cards while Nurse #4 verified the controlled substance count sheets. She stated she should verify the actual numbers shown in the controlled substance count sheets, but it did not happen. The initial count indicated there were 48 cards of controlled substance in the medication cart. A recount confirmed the actual balance was 50 cards. She signed the controlled substance count sheet but had forgotten to update the total number of cards to 50. She stated she had a family emergency at approximately 9:00 PM that night and had to leave the facility immediately. She did not count the controlled substance in the medication cart with any nursing staff before leaving as she was having a nerve breaking family emergency. While she was talking to her family in the parking lot, she saw NA #1 in the car and decided to pass the medication cart keys to her so that she could leave as soon as possible. She told NA #1 that the controlled substance count was good before passing the keys to her. The DON tried to contact her in the morning on 03/08/24 regarding the incident. However, due to the nature of the family emergency, she was unable to talk to the DON. She contacted DON several days later and was drug screened with a negative result. She denied using any narcotic medication except taking Adderall with a prescription for many years. A phone interview was conducted with NA #1 on 04/01/24 at 2:15 PM. She stated she was a medication aide (MA) and had a habit of coming to the facility's parking lot early to take a nap before her shift. On 03/07/24 at around 9:20 PM, Nurse #1 told her that she had a family emergency and wanted her to hold the medication cart keys for orange halls until Nurse	F 602	included how to appropriately transition a medication cart to the nurse or medication aide. " On 3/8/24, the Nurse Consultant conducted education with the nursing leadership team to include the Director of Nursing, the Assistant Director of Nursing, Unit Manager and Staff Development Coordinator. This in-service included how to appropriately complete a medication cart audit. " Any newly hired, routine facility nursing staff and nursing leadership team members to include agency staff will complete education during orientation and prior to the start of their first shift. " All in-service education was completed by 3/10/24. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: " The Director of Nursing/Assistant Director of Nursing will audit all medication carts to include controlled shift to shift count with cart transition, count sheets and declination sheets to ensure compliance with company policy and procedure. This monitoring will occur 5 times per week for 6 weeks. All areas of concern will be taken to the administrator and the Director of Nursing and addressed immediately, including re-education of nurses or medication aides as appropriate. " The Director of Nursing/Administrator or Director of Nursing will present the findings of the Audit Tools to the Quality Assurance Performance Improvement	

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F 602	Continued From page 4 #2 arrived at the facility to relieve her. Nurse #1 told her that she had counted the controlled substances, and the count was good. At approximately 9:45 PM, Nurse #2 picked up the keys from her in the parking lot. However, Nurse #2 did not ask her to count the controlled substances in the medication cart together before started her shift. NA #1 stated she did not enter the facility until approximately 10:42 PM that night. The timecard dated 03/07/24 revealed NA#1 started her shift at 10:42 PM and clocked out on 03/08/24 at 7:05 AM. A phone interview was conducted with Nurse #2 on 04/01/24 at 2:47 PM. She stated when she arrived at the facility's parking lot on 03/07/24 at around 9:45 PM, she found that NA #1 was parked next to her car and told her that she had the medication cart keys for her. She asked NA #1 if she had counted the medication cart with Nurse #1 and was told it had not been done. NA #1 stated Nurse #1 told her that the medication cart was counted, and it was fine. As she assumed the medication cart was counted by Nurse #1 without any discrepancies, she stated she made a big mistake to start the shift without counting the controlled substances in the medication cart with any nursing staff. She denied seeing anything unusual with her medication cart during the shift and stated she had the medication cart keys throughout the shift. She completed a drug screening on 03/08/24, and the result was negative. She was later disciplined for not following the facility protocol to count the controlled substances during shift transition. During a phone interview conducted on 04/01/24	F 602	(QAPI) Committee monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the Audit Tools to determine trends and/or issues that may need further interventions and the need for additional monitoring. Date of Compliance: 4/26/24	

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F 602	Continued From page 5	F 602		

at 3:06 PM, Nurse #3 stated she noticed there were 49 controlled substance count sheets but only 48 controlled substance cards in the medication cart for orange halls during the shift transition on 03/08/24 at around 7:00 AM. After she had recounted the medication cart together with Nurse #2, she found that the missing controlled substance card belonged to Resident #1, and it consisted of 30 tablets of oxycodone 5 mg. Nurse #2 reported the incident to the DON immediately.

An interview was conducted with DON on 04/01/24 at 12:15 PM. She stated she received a call from Nurse #1 on 03/07/24 night around 9:00 PM stating she had to leave the facility immediately due to family emergency. On 03/08/24 around 7:20 AM, Nurse #2 called to notify her about the narcotic medication loss. She called Nurse #1 immediately and realized that she was unable to talk at that point. On 03/08/24 at 10:30 AM, she received a text message from Nurse #1 stating that she had counted the medication cart with Nurse #4 before taking over the medication cart on 03/07/24 around 7:00 PM. The total number of controlled medications in the medication cart was 50 cards. However, Nurse #1 admitted she did not update the count and continued to document 48 cards on the controlled substance count Sheet. In addition, Nurse #1 did not count the medication cart with any nursing staff in the facility before leaving for family emergency on 03/07/24 night. Nurse #2 was drug screened immediately on 03/08/24 while Nurse #1 was tested on 03/18/24 due to the nature of her family emergency. Both Nurse #1 and Nurse #2 were tested negative. Nurse #2 told her that after she took the medication cart keys from NA #1, she started her shift without counting the

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F 602	Continued From page 6	F 602		

controlled substances in the medication cart with any nursing staff. She stated Nurse #5 was working during the shift on 03/07/24 but none of the nurses had requested him to count the controlled substances together for orange halls that night. After she was made aware of the incident, she ordered Assistant Director of Nursing (ADON) to assist in the investigation immediately by assessing pain for all residents who used narcotic medications, notifying Resident #1's family and the Medical Director of the incident, and communicating with the pharmacy to determine if the missing narcotics were returned to the pharmacy accidentally. She reported the incident to the North Carolina Department of Health & Human Services (NC DHHS) and the local Sheriff's office. All the missing oxycodone was replaced and paid for by the facility after the incident. She concluded that the incident could be avoided if both Nurse #1 and Nurse #2 had updated the controlled substance count sheets in a timely manner and counted the controlled substances in the medication cart with another nurse during shift transition.

During an interview conducted on 04/01/24 at 12:49 PM, Resident #1 stated she was notified of the incident and being assessed for pain on 03/08/24. She added all the missing pain medication were replaced by the facility and denied having any issues to receive her pain medication as needed in a timely manner so far.

During a phone interview conducted on 04/01/24 at 2:32 PM, Nurse #5 could not recall any nurses had asked him to count the medication cart for orange halls together during his shift from 3 PM to 11 PM on 03/07/24. He denied seeing NA #1

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F 602	Continued From page 7 entering the facility before 10:45 PM on 03/07/24. During a phone interview conducted on 04/02/24 at 10:35 AM, the MD stated he was notified of the incident on 03/08/24 and provided with the name of the resident affected. He stated Resident #1 was assessed immediately without any adverse consequences noted as the missing drugs were used "as needed" basis and the facility had adequate supply of the missing narcotic medication. He added all the missing medications were replaced and paid for by the facility later. It was his expectation for all the nursing staff to follow the facility's protocol to count the controlled substance in the medication cart during shift transition. A subsequent interview was conducted with DON on 04/02/24 at 11:33 AM. It was her expectation for all the nursing staff to follow the facility's protocol to complete controlled substance count and update the balance of cards in the controlled substance count sheets before taking over a medication cart during shift transition. During an interview conducted with the Administrator on 04/02/24 at 11:45 AM, he expected all the nursing staff to follow facility's policies and procedures to count all the controlled substances in the medication cart during shift transition to prevent misappropriation of residents' property.	F 602		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 755		4/26/24

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F 755	Continued From page 8 them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with resident, staff, and the Medical Director (MD), the facility failed to keep an accurate accounting of controlled medications on the controlled substance count sheets and failed to conduct controlled substance counts in the medication cart with at least 2 nurses for verification of accuracy during shift transitions. As a result, a blister card of 30 tablets of a controlled substance	F 755	Macon Valley F755 Pharmacy Services/Procedures/Pharmacist/Records " The facility administrator will ensure that this plan of correction is initiated and followed as it is written. Problem Statement: " It was alleged that the facility failed to ensure that 2 nurses conduct the	

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F 755	Continued From page 9	F 755		

was missing from a medication cart during shift transition for 1 of 1 resident reviewed for misappropriation of residents' property (Resident #1).

The findings included:

Resident #1 was admitted to the facility on 02/10/24 with diagnoses including osteoporosis and hip fractures.

A review of the physician's order dated 02/10/24 revealed Resident #1 had an order to receive 1 tablet of oxycodone (a semi-synthetic narcotic analgesic for pain) 5 milligrams (mg) by mouth once every 3 hours as needed for pain.

A review of the medication administration records (MARs) revealed Resident #1 had received 1 tablet of oxycodone 5 mg as needed on 02/19/24 and 03/07/24.

A review of the controlled substance count sheet for orange halls on 03/07/24 at 7:00 PM revealed when Nurse #1 took over the medication cart from Nurse #4, the total number of controlled substance cards in the cart was 50 cards according to the count, but it was documented as 48 cards on the count sheet. As Nurse #2 depleted one card during the shift, the balance became 49 cards before the shift transition on 03/08/24 at 7:00 AM. However, Nurse #2 did not update the balance and it remained unchanged at 48 cards.

A phone interview was conducted with Nurse #4 on 04/01/24 at 3:40 PM. She recalled working the first shift on 03/07/24 and was relieved by Nurse #1 in the evening. She counted the controlled

controlled substance count of the medication cart to verify accuracy during the shift-to-shift transfer on 3/7/24 when one nurse left for a family emergency around 9:00pm on that date. This resulted in missing medication for resident #1.
Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice:
" On 3/8/24, a reconciliation of controlled medications was conducted for Resident #1 with no additional concerns identified. Resident had medication available on cart to take per order.
Address how the facility will identify other residents having the potential to be affected by the same deficient practice:
" On 3/8/24, the Director of Nursing/Assistant Director of Nursing completed an audit of 100% of all resident□s Controlled Substance Count sheets in comparison to the narcotic medication blister packs in the medication cart and the order in the Medication Administration Record to ensure there were no discrepancies in the count of the medications or medication cards. No additional areas of concern identified.
Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
" On 3/8/24, the Nurse Consultant conducted education with the nursing leadership team to include the Director of Nursing, the Assistant Director of Nursing, Unit Manager and Staff Development Coordinator. This in-service included how

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F 755	Continued From page 10 substances with Nurse #1 during the shift transition without noticing any discrepancy. She passed the medication cart keys to Nurse #1 after Nurse #1 had signed the controlled substance count sheet. During a phone interview conducted on 04/01/24 at 4:06 PM, Nurse #1 stated when she counted the controlled substances with Nurse #4 on 03/07/24 at around 7:00 PM, she checked the medication cards while Nurse #4 verified the controlled substance count sheets. She stated she should verify the actual numbers shown in the controlled substance count sheets, but it did not happen. The initial count indicated there were 48 cards of controlled substance in the medication cart. A recounted confirmed the actual balance was 50 cards. She signed the controlled substance count sheet but had forgotten to update the total number of cards to 50. She stated she had a family emergency at approximately 9:00 PM that night and had to leave the facility immediately. She did not count the controlled substance in the medication cart with any nursing staff before leaving as she was having a nerve breaking family emergency. While she was talking to her family in the parking lot, she saw NA #1 in the car and decided to pass the medication cart keys to her so that she could leave as soon as possible. She told NA #1 that the controlled substance count was good before passing the keys to her. A phone interview was conducted with NA #1 on 04/01/24 at 2:15 PM. She stated she had a habit of coming to the facility's parking lot early to take a nap before her shift. On 03/07/24 at around 9:20 PM, Nurse #1 told her that she had a family emergency and wanted her to hold the	F 755	to appropriately complete a medication cart audit. " On 3/8/24, the Director of Nursing/Assistant Director of Nursing/Staff Development Coordinator initiated in-servicing with all licensed nurses and medication aides to include agency staff, regarding controlled substance diversion to include: the definition, implications of a diversion and the process for properly receiving and returning medications from the pharmacy. The in-service also included how to appropriately transition a medication cart to the nurse or medication aide. " Any newly hired, routine facility nursing staff and nursing leadership team members to include agency staff will complete education during orientation and prior to the start of their first shift. Date of Compliance: " All in-service education was completed by 4/24/24. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: " The Director of Nursing/Assistant Director of Nursing will audit all medication carts to include controlled shift to shift count sheets and declination sheets to ensure compliance with company policy and procedure 5 times per week for 6 weeks. All areas of concern will be taken to the administrator and the Director of Nursing and addressed immediately, including	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345263	A. BUILDING _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 755	Continued From page 11 medication cart keys for orange halls until Nurse #2 arrived at the facility to relieve her. Nurse #1 told her that she had counted the controlled substances, and the count was good. At approximately 9:45 PM, Nurse #2 picked up the keys from her in the parking lot. However, Nurse #2 did not ask her to count the controlled substances in the medication cart together before started her shift. NA #1 stated she did not enter the facility until approximately 10:42 PM that night. The timecard dated 03/07/24 revealed NA#1 started her shift at 10:42 PM and clocked out on 03/08/24 at 7:05 AM. A phone interview was conducted with Nurse #2 on 04/01/24 at 2:47 PM. She stated when she arrived at the facility's parking lot on 03/07/24 at around 9:45 PM, she found that NA #1 was parked next to her car and told her that she had the medication cart keys for her. She asked NA #1 if she had counted the medication cart with Nurse #1 and was told it had not been done. NA #1 stated Nurse #1 told her that the medication cart was counted, and it was fine. As she assumed the medication cart was counted by Nurse #1 without any discrepancies, she stated she made a big mistake and started the shift without counting the controlled substances in the medication cart with any nursing staff. She denied seeing anything unusual with her medication cart during the shift and stated she had the medication cart keys throughout the shift. Nurse #2 stated she was later disciplined for not following the facility protocol to count the controlled substances during shift transition. During a phone interview conducted on 04/01/24	F 755	re-education of nurses or medication aides as appropriate. " The Director of Nursing/Administrator or Director of Nursing will present the findings of the Audit Tools to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the Audit Tools to determine trends and/or issues that may need further interventions and the need for additional monitoring. Date of Compliance: 4/26/24	

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 04/02/2024

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F 755	Continued From page 12	F 755		

at 2:32 PM, Nurse #5 could not recall any nurses had asked him to count the medication cart for orange halls together during his shift from 3 PM to 11 PM on 03/07/24. He denied seeing NA #1 entering the facility before 10:45 PM on 03/07/24.

During a phone interview conducted on 04/01/24 at 3:06 PM, Nurse #3 stated she noticed there were 49 controlled substance count sheets but only 48 controlled substance cards in the medication cart for orange halls during the shift transition on 03/08/24 at around 7:00 AM. After she had recounted the medication cart together with Nurse #2, she found that the missing controlled substance card belonged to Resident #1, and it consisted of 30 tablets of oxycodone 5 mg. Nurse #2 reported the incident to the DON immediately.

During a phone interview conducted on 04/02/24 at 10:35 AM, the MD stated it was his expectation for all the nursing staff to follow the facility's protocol to count the controlled substance in the medication cart during shift transition.

An interview was conducted with DON on 04/01/24 at 12:15 PM. She stated she received a call from Nurse #1 on 03/07/24 night around 9:00 PM stating she had to leave the facility immediately due to family emergency. Nurse #1 asked Nurse Aide (NA) #1 who happened to be in the parking lot at approximately 9:15 PM to hold the medication cart keys until Nurse #2 arrived to relieve her. Nurse #2 arrived at the facility around 9:45 PM and received the medication cart keys from NA#1 in the parking lot. Nurse #2 went ahead to start her shift without counting the medication cart with any nursing staff in the facility. On 03/08/24 at approximately 7:00 AM,

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 04/02/2024

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MACON VALLEY NURSING AND REHABILITATION CENTER	3195 OLD MURPHY ROAD FRANKLIN, NC 28734

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F 755	Continued From page 13	F 755		

Nurse #3 came on shift to relieve Nurse #2. She noted a blister card of 30 tablets of oxycodone 5 mg went missing when counting the medication cart with Nurse 2. On 03/08/24 around 7:20 AM, Nurse #2 called to notify her about the narcotic medication loss. She called Nurse #1 immediately and realized that she was unable to talk at that point. On 03/08/24 at 10:30 AM, she received a text message from Nurse #1 stating that she had counted the medication cart with Nurse #4 before taking over the medication cart on 03/07/24 around 7:00 PM. The total number of controlled medications in the medication cart was 50 cards. However, Nurse #1 admitted she did not update the count and continued to document 48 cards on the controlled substance count Sheet. In addition, Nurse #1 stated she did not count the medication cart with any nursing staff in the facility before leaving for family emergency on 03/07/24 night. Nurse #2 told her that after she took the medication cart keys from NA #1, she started her shift without counting the controlled substances in the medication cart with any nursing staff. She stated Nurse #5 was working during the shift on 03/07/24 but none of the nurses had requested him to count the controlled substances together for orange halls that night. She concluded that the incident could be avoided if both Nurse #1 and Nurse #2 had updated the controlled substance count sheets in a timely manner and counted the controlled substances in the medication cart with another nurse during shift transition.

A subsequent interview was conducted with DON on 04/02/24 at 11:33 AM. It was her expectation for all the nursing staff to follow the facility's protocol to complete controlled substance count and update the balance of cards in the controlled substance count sheets before taking over a

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 04/02/2024

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F 755	Continued From page 14 medication cart during shift transition. During an interview conducted with the Administrator on 04/02/24 at 11:45 AM, he expected all the nursing staff to follow facility's policies and procedures to count all the controlled substances in the medication cart during shift transition to prevent misappropriation of residents' property.	F 755		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring,	F 867		4/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 867	Continued From page 15	F 867		

and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on

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 04/02/2024

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F 867	Continued From page 16	F 867		

high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of

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 04/02/2024

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MACON VALLEY NURSING AND REHABILITATION CENTER	3195 OLD MURPHY ROAD FRANKLIN, NC 28734

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F 867	Continued From page 17 action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint survey conducted on 02/16/24 and the complaint investigation survey conducted on 04/02/24. This was for a repeat deficiency in the area of misappropriation/exploitation of resident's property that was originally cited on 02/16/24 during the recertification and complaint survey, and subsequently recited during the complaint investigation survey completed on 04/02/24. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross referenced to: F 602 - Based on record review and interviews with resident, staff, and the Medical Director (MD), the facility failed to protect residents' rights to be free from misappropriation of controlled substances for 1 of 1 resident (Resident #1) reviewed for misappropriation of residents' property. During the recertification and complaint survey on 02/16/24, the facility failed to protect residents'	F 867	Macon Valley F867 QAPI/QAA Improvement Activities " The facility administrator will ensure that this plan of correction is initiated and followed as written. Problem Statement: " It was alleged that the facility failed to maintain implemented procedures and monitor interventions the Quality Assurance Performance Improvement Committee put into place following the recertification and complaint survey in the area of misappropriation/exploitation of resident's property. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: " On 4/21/2024, The Administrator initiated an audit of the previous citations and action plans outlined in the annual survey and re-visit survey to ensure the Quality Assurance committee has maintained and monitored interventions that were put into place. Any areas of concern were updated and presented to the Quality Assurance Committee by the Administrator. The audit was completed by 4/22/24 with no concerns identified. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:	

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F 867	Continued From page 18 rights to be free from misappropriation of controlled medications for 4 of 4 residents reviewed for misappropriation of residents' property. During an interview conducted with the Administrator on 04/02/24 at 11:45 AM, he stated the facility conducted QAA meeting at least once monthly to discuss areas of previously and/or newly identified concerns in the facility. It also included deficiencies from the surveys. The areas of concern were tracked from month to month for progression toward the goals. The Administrator attributed the failure of facility during the recent federal surveys to failure of nursing staff to follow the policies and procedures to count, verify, and confirm the quantity of controlled substances in the medication cart during shift transition. He stated the recited deficiency was different in nature from the previous citation and added all the plan of corrections were properly implemented and monitored as planned since the last survey.	F 867	" On 4/21/24 the Administrator and the Director of Nursing conducted an audit of the previous 2 months of Quality Assurance Performance Improvement (QAPI) committee meeting minutes to ensure all areas of improvement had appropriately been documented as compared to facility Performance Improvement Plans with appropriate follow-up completed. The Director of Nursing and the Administrator will ensure all Performance Improvement Plans are brought to QAPI monthly going forward. The audit will be completed by 4/24/24. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: " On 4/22/24, the Facility Nurse Consultant completed an in-service with the Administrator, and Director of Nursing regarding the Quality Assurance process to include implementation of Action Plans, Monitoring Tools, the Evaluation of the Quality Assurance process, modification, and correction if needed, to prevent the reoccurrence of deficient practice to include grievances, care plan timing, revision, and medication storage. In-service also included identifying issues that warrant development and establishing a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective Quality Assurance process. All newly hired Administrator, and Director of Nursing will be educated during orientation regarding the Quality Assurance Process.	

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 04/02/2024

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F 867	Continued From page 19	F 867		

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

" All data collected for identified areas of concern to include misappropriation of resident property and pharmacy services will be taken to the Quality Assurance committee for review monthly x 2 months. The Quality Assurance committee will review the data and determine if plans of corrections are being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the Administrator.

" The Facility Nurse Consultant will ensure the facility is maintaining an effective Quality Assurance program by attending Monthly Quality Assurance meetings monthly x 2 months and ensure implemented procedures and monitoring practices to address interventions, to include Grievances, care plan timing and revision and medication storage. The facility consultant will also review interventions/plans implemented for misappropriation/pharmacy services. The Facility Nurse Consultant will immediately retrain the Administrator and Director of Nursing for any identified areas of concern.

" The results of the Monthly Quality Assurance meeting will be presented by Administrator to the Quality Assurance

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 04/02/2024

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F 867	Continued From page 20	F 867	Performance Improvement (QAPI) Committee monthly x 2 months for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring. The Director of Nursing is responsible for the correction plan and the Administrator for sustained compliance. Date of Compliance: 4/26/24	