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 05/16/2018

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

(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 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 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	{F 812}	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 this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor	6/3/18

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

Electronically Signed | 06/03/2018

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 05/16/2018

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

(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 812}	Continued From page 1 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 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	{F 812}	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 milkshakes in accordance with manufacturer guidelines, failed to discard expired food items, and failed to date open food items- was failure to follow established policy and procedure. 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	

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 05/16/2018

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

(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 812}	Continued From page 2 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 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}	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 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,	

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 05/16/2018

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

(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 812}	Continued From page 3	{F 812}	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. 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.	

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 05/16/2018

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

(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 812}	Continued From page 4	{F 812}	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. 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	F 867	F 867 QAPI/QAA Program/Plan The plan of correcting the specific deficiency	6/3/18

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 05/16/2018

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

(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 867	Continued From page 5 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. 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	F 867	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 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,	

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 05/16/2018

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

(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 867	Continued From page 6 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	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. 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.	

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 05/16/2018

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

(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 867	Continued From page 7	F 867	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. 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.	

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 05/16/2018

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

(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 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide 1 of 3 sampled residents with a safe and orderly discharge. Resident #5 was given a 30 day discharge notice and was discharged 27 days later without any assessments of his home situation, if he needed any durable medical equipment or if he was able to meet his needs at home. The facility failed to develop or implement an interdisciplinary discharge plan for Resident #5. The findings included: Resident #5 was admitted to the facility on 12/23/17 and was his own responsible party with no family involvement. His diagnoses included acquired absence of his right leg below the knee, pain, alcohol abuse, cognitive communication deficit and abnormalities of gait and mobility. Review of the hospital history and physical dated 12/11/17 revealed Resident #5 lived alone in a shack with no reported water or electricity. He was assessed as impulsive. The history and physical revealed Resident #5 had been found by a neighbor on 11/26/17 and noted to be hypothermic, alcohol intoxicated with a non	F 624	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 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.	6/3/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/03/2018

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 05/16/2018

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

(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 624	Continued From page 1 hemorrhagic partially amputated right foot up to the level of the distal leg. This was suspected a probable pedestrian versus motor vehicle accident. He received a right below knee amputation on 11/27/17. The admission Minimum Data Set (MDS) dated 12/29/17 coded Resident #5 as having moderately impaired cognitive skills, requiring extensive assistance with most activities of daily living skills and required staff assistance to stabilize himself during transitions. The MDS noted that he expected to be discharged to the community and the facility had developed no active discharge plans. A care plan was developed on 12/27/17 to address his desire to return home after completion of rehabilitation therapy. The goals included: *the resident will receive adequate preparation and orientation for discharge to home upon completion of rehabilitation therapy. Review of the Physical Therapy (PT) documentation revealed, Resident #5 received therapy services from 12/22/17 through 02/01/18 at which time he met his maximum potential with no further therapy warranted until he needs training for a prosthesis. He was noted with limited ambulation, used a front wheeled walker with care giver assistance for approximately 45 feet before needing rest. His primary mobility was a manual wheelchair. Review of the Occupational Therapy (OT) documentation revealed he received OT services from 12/22/17 through 02/01/18 and again met his maximum potential as he was staying in the nursing facility. Neither the OT or the PT notes indicated any	F 624	F 624 Safe/Orderly Discharge 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 ensuring a safe and orderly discharge. On 4/30/18, Resident # 5 was discharged to the community and the resident changed discharge location to home after leaving facility. On 5/31/18, the Staff Development Coordinator (nurse) spoke with adult protective services who reported once the case is closed they would send a letter to the facility. The facility has not received a letter to report the case is closed. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 5/17/18, the director of nursing (DON) provided an in-service to the social worker (SW) 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.	

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 05/16/2018

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

(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 624	Continued From page 2 plans for discharge back home. Interview with the OT on 05/16/18 at 8:26 AM revealed that she wrote the discharge note for OT. At that time his discharge plans were to stay in the facility. She stated that if they knew he was going back home they could have completed a home evaluation. She stated neither PT or OPT were consulted upon discharge. She stated that even if therapy had quit services the social worker normally asked about any durable medical equipment a resident may need. OT further stated he was as functional as he was going to be at discharge without a prosthesis but was not involved in getting him a prosthesis. In the progress notes dated 01/25/18 at 3:09 PM, the social worker indicated a referral for placement had been sent to another skilled nursing facility. The note dated 01/25/18 at 3:10 PM revealed the social worker found him smoking throughout the day in the parking lot (against the rules). Progress notes dated 01/28/17 at 7:07 AM revealed referrals were sent for smoking facilities for placement for Resident #5 at 4 skilled nursing facilities and 2 assisted living facilities. Review of the resident's financial resident trust fund revealed the facility began to handle his social security checks, including 3 years of back pay on 03/19/18 after the facility applied for and was granted representative payee status. Per the Accounts receivable/bookkeeper on 05/15/18 at 3:53 PM, Resident #5 remained in the facility after Medicare benefits ended and he began private pay status on 02/02/18. The most recent physician's visit was made on 03/28/18 by the nurse practitioner. She noted	F 624	On 5/17/18, the DON initiated an in-service for licensed nurses, including agency on documentation for discharge of a resident. This includes assessment, discharge summary, medication release form, and discharge instructions. This in-service will be complete by 6/4/18. No licensed nurse, including agency, will be allowed to work after 6/4/18, until the in-service is complete. This in-service will be part of the orientation for all newly hired licensed nurses, including agency. On 5/25/18, the DON reviewed all residents discharged in the last 14 days ensuring documentation is present verifying needed equipment, medication, and services were arranged at time of discharge. All discharges had necessary arrangements made prior to discharge. 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. 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	

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 05/16/2018

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

(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 624	Continued From page 3 she had assessed the course of the resident's debility and he demonstrated significant debility that warranted frequent monitoring by staff as well as preventative measures for complications such as skin breakdown, infections, falls with potential for injury or fractures. The facility would continue to prove a safe environment , preventative measures and support to optimize this resident's safety, function and quality of life. The quarterly MDS dated 03/31/18 coded Resident #5 with intact cognitive skills, having some behavior issues 1-3 times per week, requiring limited assistance with bed mobility, transfers, and toileting with extensive assistance with dressing and hygiene. It was noted that he had one fall since the previous assessment, and the facility had no discharge plans. There were no additional social work or nursing notes related to any discharge discussions with the resident. Nursing progress notes indicated he was suspected of smoking in nondesignated areas, including in his room on 03/01/18 at 10:48 PM, on 03/12/18 at 9:03 PM, on 04/01/18 at 10:37 PM, and on 04/02/18 at 12:50 AM. A Notice of Transfer/Discharge dated 04/03/18 was provided to the resident. This notice stated the reason for discharge was Resident #5's noncompliance with safety procedures, smoking in non-designated areas. There was no other family listed as being provided this notification. The form was blank where the discharge location was to be included on the form. Appeal rights to the ombudsman were included on this form and the form was signed by the Administrator. There was no documentation provided by the physician which indicated the reason he needed to be discharged from the facility.	F 624	The DON, SW, quality assurance (QI) nurse, 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 discharge audit tool. The monthly QI committee will review the results of the discharge audit tool 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 quality assurance (QA) committee for further recommendations and oversight The title of the person responsible for implementing the acceptable plan of correction The DON is responsible for implementation of the acceptable plan of correction.	

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 05/16/2018

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

(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 624	Continued From page 4	F 624		

Review of nursing and or social work progress notes revealed no discussions related to discharge planning were documented as occurring between the facility and the resident after the discharge notice dated 04/03/18 and the actual discharge on 04/30/18. A nursing progress note dated 04/30/18 at 4:00 PM stated the resident was discharged home, no acute distress noted at this time. In addition, there was no documentation in the medical record to reflect any home assessment, any assessment related to durable medical equipment, or any assessment or discussion as to how he would receive further social security checks or any Adult Protective Services to follow him. Review of the Checklist for Transfer/Discharge for Resident #5 found in the paper chart was blank.

The Social Worker (SW) was interviewed on 05/15/18 at 3:39 PM. She stated that the facility had changed from a smoke free facility to a smoking facility since she began employment in February 2018. Resident #5 was noncompliant with the smoking rules even though she discussed it with him several times. She stated the Administrator issued him a 30 day discharge on 04/03/18. SW stated she made several referrals to other smoking facilities but they would not accept him due to his noncompliance. She stated he was Medicaid pending and had no payment source. She stated she talked to him during the week prior to discharge and he kept saying he had a place to live. She stated she had informed him that according to Medicaid he owned no property. She stated that she learned he stayed in a lot of hotels and so she called hotels for vacancies due to her not knowing what his living situation was prior to admission to the

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 05/16/2018

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

(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 624	Continued From page 5	F 624		

facility. He agreed to stay at a hotel for one week. SW then talked to the business office after discovering he had monies and asked the office to write two checks, one for the hotel stay and the other for the larger sum of money left in his personal fund account. She stated she set up transport through the transporter and did not find out until the following day that Resident #5 did not go to the hotel. She then made an Adult Protective Services (APS) referral.

On 05/15/18 at 3:53 PM, the Accounts Receivable/Bookkeeper (ARB) was interviewed. ARB stated that on 04/30/18 she was instructed to write two checks from his personal fund account to Resident #5. One for $350.00 for the week stay in the hotel and one for the remainder of his monies for $8224.13. She stated that his Medicaid application was never pursued. She learned the next day 05/01/18 that he was not dropped off at the hotel and returned home.

An interview was conducted with the transporter of the facility on 05/15/18 at 11:27 AM. The transporter stated he was instructed on 04/30/18 to take Resident #5 to the bank to cash a check and then onto a specific hotel. Once at the bank, the bank would not cash the check since Resident #5 had no identification. The transporter then brought him back to the facility where they obtained a copy of his facility face sheet and information on it for identification and proceeded to another bank, the bank noted on the checks. The second bank would not cash either check because the teller was familiar with this resident and did not think it was safe for him to walk around with all this money. Because Resident #5 had no way to now pay for the hotel, the resident told the transporter to take him back

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 05/16/2018

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

(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 624	Continued From page 6	F 624		

to where he used to live. The transporter stated he called the facility and the Director of Nursing told him that if that was where he wanted to go it was ok to take him there. The transporter stated the address was a shack. He left the wheelchair which belonged to the facility with him so he could be mobile. The transporter stated that was a decision made between him and the social worker. He did not know anything about additional equipment. The transporter stated that he returned to address the following day and brought the resident food.

The DON was interviewed on 05/15/18 at 5:03 PM. The DON stated the Administrator and the SW were involved in the 30 day discharge notice. DON stated that on 04/30/18 during morning meeting she was made aware the 30 days of discharge was up and he had to be discharged. She stated she was not involved in the discharge planning but heard the SW found him a hotel. She stated that the facility's Vice President of Operations was notified and he stated to give the resident his money, take him to the bank to cash it and then to the hotel. When the Transporter called when the bank would not cash the check because he had no identification, the Transporter returned for a copy of the face sheet. The Transporter called again after the bank did not cash the check with the face sheet and told the DON Resident #5 wanted to go home. DON stated Resident #5 was taken home and the VP of Operations was informed. The DON stated there was no offer made for him to return to the facility to ensure home was a safe discharge.

An interview with Nurse #1 who worked second shift on 04/30/18 was interviewed on 05/15/18 at 3:32 PM. She stated normally that for 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 05/16/2018

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

(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 624	Continued From page 7	F 624		

discharge, the discharge orders were written. She further stated the nurse on first shift did all the discharge paperwork/preparation and all Nurse #1 did was write the discharge progress note. She stated she had no involvement in any discharge discussions with the resident and 04/30/18 was the first she heard he was leaving the facility.

Nurse #2 , who worked first shift on 04/30/18, was interviewed on 05/15/18 at 6:01 PM via phone. She stated she was in the facility but was off her shift when the order for the discharge for Resident #5 was received. She stated she had no discussion or involvement in Resident #5's discharge that day.

On 05/16/18 at 8:20 AM, a voice message was left for the physician who wrote the discharge order on 04/30/18 and he did not return the call. There was no documentation in the medical record which indicted the physician was consulted on this resident's discharge prior to 04/30/18.

On 05/16/18 at 8:41 AM the APS worker was contacted by phone. APS was in the process of evaluating Resident #5's situation. She stated he resided in a shack that had windows and a door, no water or electricity and Resident #5 was sleeping on blankets.

Follow up interview with the SW on 05/16/18 at 8:49 AM revealed that she did not document any conversations about discharge with Resident #5. SW stated that on 04/30/18 in morning meeting the team discussed the 30 discharge was approaching. When she talked to the resident that day he stated he was ready to leave that day and asked for boxes to pack his items. She

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 05/16/2018

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

(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 624	Continued From page 8	F 624		

stated she asked about him going to a hotel because she was unaware of his home situation to which he agreed. She did not investigate homeless shelters in the area. SW stated she had no idea what his home looked like, but was aware Medicaid stated he did not own property. She stated she did not talk to therapy about any home assessment, had no idea he had no form of identification. She further stated she did not discuss discharge with the physician. She stated that she and the Transporter decided to leave the facility wheelchair with him so he could be mobile. She stated that he probably would not have wanted to pay for a wheelchair. She stated she did not make any assessments of his home situation or assessed any needs for food, banking, transportation, medical equipment needed, or Medicaid information. She called APS on 05/01/18 when she learned he was not dropped off at the hotel when the bank would not cash his checks.

Interview with the VP of Operations on 05/16/18 at 10:00 AM revealed the DON never told him about the details only asked if Resident #5 could go home per his request. Because Resident #5 was alert and oriented he had that right to make that decision.

During follow up interview with the DON on 05/16/18 at 10:57 AM, the DON stated that during discharge, a red folder was provided to nursing with all the necessary information needed for discharge and discussion with the resident. Nursing never received this folder. She denied knowing anything about his prior living conditions. She further stated she never thought to have him return to the facility to ensure he had cash for the hotel as he had told the transporter to take him

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 05/16/2018

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

(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 624	Continued From page 9 home. She stated he often mentioned his desire to go home or find friends to take him to the liquor store.	F 624		