STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345102	A. BUILDING _____ B. WING _____	C 10/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGGIE VALLEY NURSING AND REHABILITATION	75 FISHER LOOP MAGGIE VALLEY, NC 28751

(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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		10/19/18

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

Electronically Signed | 10/29/2018

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F 656	Continued From page 1 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to monitor a bed sensor alarm was functioning for 1 of 1 resident reviewed for a bed sensor alarm (Resident #21). Findings included: Resident #21 was admitted to the facility 07/20/18 with diagnoses which included history of falling, restlessness, and agitation. The admission Minimum Data Set (MDS) dated 07/27/18 assessed the cognitive patterns of Resident #21 as severely impaired needing extensive assistance with bed mobility, transfers, toilet use, and personal hygiene. The assessment included bed and chair alarms and indicated they were not used. Review of the physician orders revealed on 07/31/18 the Medical Doctor ordered an alarm to the bed of Resident #21 to alert staff of self attempts to transfer. Review of the care plan last revised 08/06/18 identified a potential risk for falls related to a history of falls, unsteady gait, being impulsive, and not waiting for staff assistance. The goal for Resident #21 was to not sustain serious injuries from a fall through the next review date. The interventions included a silent alarm would be placed on the bed to alert staff of self attempts to transfer without assistance.	F 656	Resident #21 was assessed and did not have any negative outcome from the alarm battery not functioning properly. The Nursing staff will check the silent alarm each shift to ensure it is functioning properly and document on the Treatment Record that the alarm has been checked and working properly. If the batteries are found to be malfunctioning, the nursing staff have access to batteries as well as tools to enable them to change the batteries. The Central Supply Clerk will change the batteries in all silent alarms every Wednesday. All other residents who utilize a silent alarm have been assessed and the alarm batteries checked with no other battery/alarm found to be malfunctioning. To prevent any other resident from being affected by the silent alarm malfunctioning due to battery drainage, The Nursing staff will check the silent alarm each shift to ensure it is functioning properly and document on the Treatment Record that the alarm has been checked and working properly. If the batteries are found to be malfunctioning, the nurses have access to batteries as well as tools to enable them to change the batteries. The Central Supply Clerk will change the batteries in all silent alarms every Wednesday.	

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F 656	Continued From page 2 Observations of Resident #21 throughout the survey revealed the sensor bed alarm had no indicator light showing it was functioning on 10/08/18 at 4:48 PM and 10/11/18 at 5:06 PM, while Resident #21 was resting in the bed. During an interview on 10/11/18 at 5:07 PM, Nurse Aide #1 revealed the bed alarm was in place and acknowledged it wasn't functioning properly. NA #1 confirmed she had assisted Resident #21 to the bed and should have checked the alarm to ensure it was functioning. During an interview on 10/11/18 at 5:21 PM, the Assistant Director of Nursing (ADON) revealed it was her expectation bed alarms were checked every shift to ensure the batteries were working and the alarm functioned. During an interview on 10/12/18 at 4:05 PM, the Director of Nursing revealed it was her expectation sensor alarms be checked by staff when a resident was in the bed. The staff should check the bed alarm to ensure it was properly functioning when they make resident rounds or place a resident in bed.	F 656	The Nursing staff will check the silent alarm each shift to ensure it is functioning properly and document on the Treatment Record that the alarm has been checked and working properly. If the batteries are found to be malfunctioning, the nurses have access to batteries as well as tools to enable them to change the batteries. The Central Supply Clerk will change the batteries in all silent alarms every Wednesday. The Central Supply Clerk will perform a weekly audit and the results of the audit will be given to the Director of Nursing/Designee. This audit will be taken to the monthly QAPI meeting each month for three months for review and the weekly audits will continue as long as the silent alarms are in use. The Treatment Record will be checked by the IDT Team each morning Monday thru Friday for documentation to ensure the alarms are working properly for continued compliance.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary	F 690		10/31/18

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F 690	Continued From page 3 incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews the facility failed to properly place a catheter by placing it under the wheelchair with the tubing touching the floor while the resident propelled throughout the facility for 1 of 1 resident reviewed for urinary catheter (Resident #19). Findings included: Resident #19 was admitted to the facility 09/28/15 with diagnoses which included neurogenic	F 690	Resident #19 was accessed for negative outcome from the catheter tubing touching the floor with no negative outcome noted. The facility has purchased and will continue to purchase catheter bags with the enclosed bottom instead of catheter bag sleeves. All catheter bag sleeves have been discarded. Staff will continue to monitor this resident to ensure the catheter tubing does not touch the floor.	

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F 690	Continued From page 4 bladder and paraplegia. The quarterly Minimum Data Set (MDS) dated 07/17/18 assessed cognitive patterns were intact for daily decision making with no identified behaviors or rejection of care. The assessment included the functional status for activities of daily and extensive assistance was needed for bed mobility, toilet use, and personal hygiene, and total assistance for transfers. The MDS reviewed bowel and bladder with an indwelling catheter and colostomy with incontinence not rated. The Care Area Assessment (CAA) evaluated Resident #19 as being in long-term care since 2003 with the most recent hospitalization 11/15/17which was related to a fever and found to have urosepsis secondary to chronic catheter placement and hyperglycemia. The care plan identified potential complications related to the indwelling catheter and risk for urinary tract infections (UTI) with a history of UTI's. The goal was to remain free of a UTI over the next 90 days. Nursing interventions included observe for clinical signs and symptoms of UTI such as fever, hematuria, chills, and abdominal pain. Observations of Resident #19 throughout the survey revealed when in the wheelchair the catheter bag was placed under the seat with tubing touching the floor on 10/10/18 at 12:51 PM while the resident sat in front of the main dining room entrance door, 10/10/18 at 2:05 PM while sitting in the hallway in front of the room entrance door after Resident #19 self-propelled to the area, and 10/11/18 at 12:23 PM while sitting in the hallway after assisted out of bed by 2 Nurse Aides	F 690	Other residents who have a catheter have been assessed and no negative outcome noted for those residents. The facility has purchased and will continue to purchase catheter bags with the enclosed bottom instead of catheter bag sleeves. All catheter bag sleeves have been discarded. Staff will continue to monitor these residents to ensure the catheter tubing does not touch the floor. The facility has purchased and will continue to purchase catheter bags with the enclosed bottom instead of catheter bag sleeves. All catheter bag sleeves have been discarded. The Nursing staff will be educated to be aware that the excess tubing for the catheters will be inside the new catheter bags to ensure no tubing is touching the floor. The Nursing staff will monitor that the excess Catheter tubing is in the bag and not touching the floor each shift and document on the Treatment Record. The treatment record will be reviewed in IDT each morning Monday through Friday for continued compliance. The Director of Nursing Services or ADON will ensure that the treatment record is accurate and the results will be brought to the monthly QAPI Meeting for 3 months.	

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F 690	Continued From page 5	F 690		

(NA).

During an interview on 10/11/18 at 12:23 PM, Resident #19 explained he was able to move about the facility in the wheelchair after staff helped him into the wheelchair.

During an interview on 10/11/18 at 12:27 PM, NA #2 explains she placed the catheter bag in a privacy bag and hung it underneath the wheelchair seat. She confirmed the catheter tubing was touching the floor and explained the tubing should not touch the floor because the floor is dirty.

During an interview on 10/11/18 at 12:31 PM, NA #3 explained she assisted getting Resident #19 out of bed and confirmed the catheter tubing was touching the floor. She explained catheter tubing shouldn't touch the floor because it could get caught in the wheelchair wheels and be pulled out causing trauma and the floor was dirty and could cause an infection.

During an interview on 10/12/18 at 4:12 PM, the Director of Nursing revealed it was her expectation the catheter tubing to be off the floor at all times and if noted on the floor to be correctly placed to prevent contamination, breakage, leakage, or accidental removal.