STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345263	A. BUILDING _____ B. WING _____	03/12/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to clarify the code status for 1 of 1 resident reviewed for advanced directives (Resident #37). Findings included: Resident #37 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. Resident #37's Electronic Medical Record (EMR) revealed a physician's orders [REDACTED]. Resident #37's advanced directive care plan, last revised on [DATE], revealed a focus of end of life/planning directives: Full Code/Hospice with the goal his wishes would be honored. Interventions included Full Code and for staff to review code status quarterly and at care plan meetings. The significant Minimum Data Set ((MDS) dated [DATE] assessed Resident #37 with severe impairment in cognition. The MDS noted Resident #37 had a prognosis of a life expectancy of less than 6 months and received hospice services. Resident #37's paper medical record revealed a Resident Request Do Not Resuscitate (DNR) Form signed by Resident #37's guardian on [DATE] authorizing facility staff to withhold CPR in the event of an emergency situation. Further review revealed a DNR form signed by the Nurse Practitioner (NP) with an effective date of [DATE] and no expiration date. During an interview on [DATE] at 9:16 AM, Nurse #1 stated she referred to the advanced directive information documented in the resident's EMR when determining code status. Nurse #1 reviewed Resident #37's EMR and confirmed his code status was listed as Full Code. During an interview on [DATE] at 2:30 PM, the Social Worker (SW) explained he reviewed a resident's code status quarterly and/or during care plan meetings and initiated code status changes when hospice services were elected if the resident was a Full Code or requested by the resident or their family. He added once the DNR form was signed, he gave the form to the Nurse to write the order and update code status in the resident's EMR. He confirmed Resident #37 was listed as a Full Code in his EMR and reported he was working on getting a DNR form signed by the facility's physician. The SW was unaware a DNR form, signed by the NP with an effective date of [DATE], was in Resident #37's paper medical record. During an interview on [DATE] at 3:12 PM, the Director of Nursing (DON) stated the SW typically reviewed a resident's code status during quarterly care plan meetings or as needed and nurses were responsible for getting a signed physician's orders [REDACTED]. The DON was unsure who had placed the DNR form dated [DATE], which was signed by the NP, in Resident #37's paper medical record without updating the physician's orders [REDACTED]. The DON added she reviewed physician orders [REDACTED].#37's code status from a full code to a DNR was missed.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) in the areas of Hospice (Resident #79) and Falls (Resident #60) for 2 of 5 residents whose MDS assessments were reviewed. The findings included: Resident #79 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. She was re-admitted on [DATE] with a [DIAGNOSES REDACTED]. A physician's orders [REDACTED].#79's significant change MDS dated [DATE] revealed the resident was not coded as having received Hospice care. An interview with the MDS nurse on 03/11/2020 at 8:52 AM revealed that a significant change MDS would occur for major injury, Hospice, decline in health, or at least 2 declines with activities of daily living and must be done within 14 days after acknowledgement of change. She reported that Hospice should have been coded on any MDS and that it was a mistake that Hospice was not coded on the resident's 02/12/20 significant change MDS. An interview with the Director of Nursing (DON) on 03/11/20 at 11:22 AM revealed that there was a process for significant change MDS that included change in status, doctor decision, change in family dynamics, Hospice, other health related changes that would impact the resident. She reported that Hospice should have been coded in Section O of the significant change MDS and thereafter and in the case of Resident #79, it was an error that it was not coded. An interview with the Administrator on 03/12/2020 at 3:24 PM revealed that clearly the 02/12/20 significant change MDS for Resident #79 was because of the order for Hospice and believed it was a clerical error. Her expectation was for the MDS staff to follow the Clinical Guidelines for MDS. 2. Resident #60 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. Review of the nurse progress notes for Resident #60 revealed the following entries: 12/22/19 read in part, Resident #60 was found in her room, sitting on the floor between the wall and bed. Resident #60 was assessed with [REDACTED]. 01/17/20 read in part, Resident #60 was found on the floor of her room in a seated position with no visible injuries noted upon nurse assessment. The quarterly MDS assessment dated [DATE] assessed Resident #60 with no memory impairment and independent with making decisions regarding tasks of daily life. The MDS noted Resident #60 displayed no behaviors and required extensive staff assistance with bed mobility and transfers. It was further noted she had no falls during the MDS assessment period. During an interview on 03/11/20 at 4:47 PM, the MDS Coordinator confirmed Resident #60 had 2 documented falls that occurred after the MDS assessment dated [DATE] that should have been coded on the MDS assessment dated [DATE]. The MDS Coordinator stated when reviewing Resident #60's medical record to code the MDS assessment, they had overlooked the falls documented in the nurse progress notes. She added a modification of the MDS assessment dated [DATE] would be submitted to accurately reflect Resident #60 had 2 falls with no injuries since the previous MDS assessment. During an interview on 03/12/20 at 3:39 PM, the Director of Nursing (DON) confirmed she was aware of the issues identified with MDS accuracy and felt it was an honest mistake on the part of the MDS Coordinator who simply overlooked the documented falls for Resident #60 when completing the MDS assessment. The DON stated she would expect for MDS assessments to be accuracy coded. During an interview on 03/12/20 at 4:24 PM, the Administrator stated resident falls were reviewed during daily meetings and felt the missed opportunity for coding Resident #60's falls on the MDS assessment dated [DATE] were due to human error. The Administrator stated she would expect for MDS assessments to be accurately coded.
F 0814 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Dispose of garbage and refuse properly.** Based on observations and staff interview, the facility failed to keep the trash compactor free of holes to prevent leaks, the compactor's door closed and area around the compactor free of accumulated medical waste and debris for 1 of 2 dumpsters observed. The findings include: Observations were conducted on [DATE] at 10:30 AM, on 3/10/20 at 10:30 AM, and on 3/11/20 at 10:30 AM, of the facility's automatic trash compactor. During each of these observations of the trash compactor an opaque fluid was leaking from the following three rusted areas; the front lower outer edge where the compactor's winch hook was located, the right back lower corner and an inaccessible area underneath the compactor. The fluid leaking from the trash compactor dripped onto the concrete pad the compactor was positioned on, drained down the pad's edges and onto the

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0814 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) asphalt parking lot, where it collected and drained into the ground and into a depression in the parking lot. Here, the fluid had pooled to an area measuring approximately 2 feet wide and 4 feet in length. These observations also revealed the compactor's door was open and not securely fastened. The area around the trash compactor contained accumulated debris including; medical blue and white examination gloves, tinfoil, cleaning wipes, white and brown colored paper, hospital masks, assorted metal cans and plastic containers, alcohol pads, foam cups and containers, plastic wear, cardboard containers, smoking paraphernalia, medicine ointment tube, and a plastic syringe. An Interview conducted on 3/10/20 at 11:45 AM with the Director of Maintenance revealed that two months ago he had contacted the refuse contractor and complained the compactor was leaking and that the contractor told the Maintenance Director they would try to fix the leak as soon as possible, as the contractor only had one compactor and could not replace it with another compactor. An Interview and observations were conducted on 3/11/20 at 11:30 AM of facility's trash compactor and surrounding area with the facility's Administrator and Director of Maintenance. The Administrator stated the Director of Maintenance was responsible for managing the refuse for the facility and monitoring the disposable units, which included leaks, trash found around the compactor and on the grounds. During the observation the facility's Administrator expressed concerned regarding the amount of trash that was on the ground and the fluid leaking from the trash compactor. The Administrator requested the Director of Maintenance to immediately have his staff pick up and dispose of all the trash that was on the ground. The Administrator then contacted the refuse contractor to have the compactor immediately removed from the premises and have four additional refuse bins placed with daily refuse removal by the contractor until the compactor could be repaired and/or replaced.