

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345263	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/02/2024
NAME OF PROVIDER OR SUPPLIER  Macon Valley Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36217</p> <p>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.</p> <p>The findings included:</p> <p>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.</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses including osteoporosis and hip fractures.</p> <p>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.</p> <p>The admission Minimum Data Set (MDS) dated [DATE] coded Resident #1 with an intact cognition.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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.</p> <p>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 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.</p> <p>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 #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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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.</p> <p>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 [DATE] 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 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 &amp; 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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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 entering the facility before 10:45 PM on 03/07/24.</p> <p>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.</p> <p>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.</p> <p>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.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36217</p> <p>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 was missing from a medication cart during shift transition for 1 of 1 resident reviewed for misappropriation of residents' property (Resident #1).</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses including osteoporosis and hip fractures.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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 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.</p> <p>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.</p> <p>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.</p> <p>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 entering the facility before 10:45 PM on 03/07/24.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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, 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.</p> <p>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.</p> <p>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.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>36217</p> <p>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.</p> <p>The findings included:</p> <p>This tag is cross referenced to:</p> <p>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.</p> <p>During the recertification and complaint survey on 02/16/24, the facility failed to protect residents' rights to be free from misappropriation of controlled medications for 4 of 4 residents reviewed for misappropriation of residents' property.</p> <p>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.</p>		