STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078082	A. BUILDING: _____ B. WING _____	R 03/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROMARTIE SPRING VILLAGE REST HOME	508 WORTH STREET SAINT PAULS, NC 28384

(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) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow up survey on 03/22/16-03/23/16.	{D 000}		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure referral and follow up to meet the routine and acute health care needs of 1 of 3 residents sampled (#3) by failing to schedule a modified barium swallow test and chest x-ray. The findings are: Review of Resident #3's current FL-2 dated 11/29/15 revealed diagnoses included late effects of cerebrovascular disease, muscle weakness, type 2 diabetes, and esophageal reflux. Review of the Resident Register revealed Resident #3 was admitted to the facility on 11/01/14. Review of the "Report of Health Services to Residents" form for Resident #3 dated 02/22/16 and signed by the Adult Nurse Practitioner (ANP) revealed: -Resident #3 had "coughing spells" when eating. -There was an order for a modified barium swallow (MBS) test. (A MBS is a test used to evaluate the swallowing process in individuals	D 273		

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D 273	Continued From page 1	D 273		

who have difficulty speaking or swallowing food. MBS helps determine if food and liquids are inhaled or aspirated into the lungs).
-There was an order for a chest x-ray.

Observation of Resident #3 on 03/23/16 at 09:50am revealed:
-Resident #3 was alert and oriented.
-Resident #3 was sitting in a wheelchair in his room.
-Resident #3's respirations were normal and he did not exhibit symptoms of shortness of breath.
-Resident #3 had trace edema in his left lower extremity around the ankle.

Interview with Resident #3 on 03/23/16 at 09:50am revealed:
-Resident #3 had a history a "stroke on my left side."
-Resident #3 coughed "a good little bit" when he ate food and drank liquids for "6 months."
-"It feels like food sticks where my flap is at my windpipe."
-Resident #3's swallowing problems had not worsened over the 6 month period.
-Resident #3 told the ANP about his swallowing difficulty.
-Resident #3 "might" have told facility staff about his swallowing difficulty.
-Resident #3 had a swallowing test performed a year and a half ago when he was hospitalized.
-"They said it was alright. "
-Resident #3 had not had a swallowing test performed since he moved into the facility.
-Resident #3 had no knowledge of the ANP order dated 02/22/16 for MBS.
-Resident #3 took Lasix and elevated his left leg at night to decrease the swelling.
-Resident #3 denied any shortness of breath or breathing problems.

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D 273	Continued From page 2 -Resident #3 did not recall having a recent chest x-ray. Telephone Interview with Resident #3's family member on 03/23/16 at 10:35am revealed: -The family member visited Resident #3 two to three times weekly. -Resident #3 "gets strangled" when eating and using a straw to drink liquids. -"He tries to eat too fast." -The condition had been present for "8-10 months" and had not changed since then "as far as I know." -The family member did not know if the medical provider had been notified about Resident #'3's swallowing difficulty. -Facility staff was aware of Resident #3's swallowing difficulty. -"The lady [staff member's name] was there a couple of times and saw it and patted him on the back." -When Resident #3 was in the hospital "about a year ago" he had a test performed "to check his throat." -The family member did not know if Resident #3 had a more recent swallow test. -Resident #3 had not had any complaints about any breathing problems. -The family member did not know if Resident #3 had a recent chest x-ray. Interview with a Medication Aide/Supervisor in Charge (MA/SIC) on 03/23/16 at 10:00am revealed: -Resident #3 did not have full range of motion in his neck therefore "he coughs when he eats too fast." -Resident #3 coughed when eating "every once in a while, not all the time." -The condition had been present since Resident	D 273		

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#3 was admitted into the facility.
-Staff observed Resident #3 closely when he ate.
-Resident #3 told the MA/SIC that he had a test performed previously to check his swallowing.
-"They didn't find anything wrong."
-The MA/SIC did not know if Resident #3 was supposed to have another swallowing test.

Observation of Resident #3 during the lunch meal on 03/23/16 from 11:45am-11:57am revealed:
-Resident #3 was sitting in his wheelchair in the dining room.
-Resident #3 was able to feed himself and drink independently.
-Resident #3 was served stew beef, greens, cooked apples, roll, iced tea, and water.
-Resident #3 ate all of his meal and drank the tea and water.
-Resident #3 did not cough or exhibit any swallowing problems during the meal.
-Resident #3 did not complain of any swallowing difficulty during the meal.
-Resident #3 did not complain of shortness of breath or exhibit signs of breathing difficulty.

Interview with the Resident Care Coordinator (RCC) on 03/23/16 at 09:40am revealed:
-The RCC called the Ear, Nose, and Throat (ENT) physician's office and left a message about scheduling Resident #3's MBS when the ANP wrote the order "on 02/26" (2016).
-The RCC was out of work due to illness and was unsure if the ENT physician's office had called the facility back to schedule Resident #3's MBS.
-The RCC did not know when or if Resident #3 had an appointment scheduled for the MBS.
-The RCC would call the ENT physician's office that day (03/23/16) to schedule Resident #3's MBS if it had not already been scheduled.
-The RCC acknowledged if the MBS was not yet

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D 273	Continued From page 4 scheduled, there was a delay in scheduling the appointment for the test. Telephone interview with the front office staff/scheduler at the ENT physician's office on 03/23/16 at 10:12am revealed: -The ENT office had never evaluated Resident #3. -The ENT office did not have any orders or referrals on file for Resident #3. -The facility had contacted the ENT office that day (03/23/16) "about 15 minutes ago" to schedule an appointment for Resident #3's MBS. -The ENT office did not have any record on file of being contacted by the facility prior to 03/23/16 for scheduling Resident #3's MBS. -Resident #3 had an appointment scheduled at the ENT office on 04/07/16 at 2:00pm. Interview with the RCC on 03/23/16 at 10:20am revealed: -The RCC was responsible for transcribing provider orders and scheduling appointments for residents if he was on duity when the order was received. -If the RCC was not working, whoever was scheduled to work on first shift was responsible for transcribing physician orders. -The first shift staff and the Owner/Administrator were responsible for scheduling appointments when the RCC was not there. -Staff were supposed to communicate with the RCC by putting provider orders or "anything else" the RCC needed to follow up on in the envelope kept on the board above the medication cart. -The RCC followed up as needed on the items in the envelope. Telephone interview with a dispatcher with the x-ray provider on 03/23/16 at 10:27am revealed:	D 273		

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D 273	Continued From page 5 -The x-ray provider did not have a provider order dated 02/22/16 on file for a chest x-ray for Resident #3. -The x-ray provider had last performed an x-ray on Resident #3 on 10/21/15. -The facility was responsible for notifying the x-ray provider of any provider orders for x-rays. Interview with the RCC on 03/23/16 at 11:00am revealed: -Resident #3 "occasionally" had trouble swallowing "mostly when he eats fast." -Staff monitored Resident #3 whenever he was eating. -Staff reminded Resident #3 to slow down and take small bites. -The facility utilized an outside x-ray provider for x-rays services; the x-ray provider came to the facility to perform x-rays as needed. -The ANP had ordered x-rays for four different residents on 02/22/16. -The facility was supposed to notify the x-ray provider when an x-ray was needed. -The facility notified the x-ray provider of the need for the four residents on the same day that the ANP wrote the orders (02/22/16) for the four residents to receive x-rays. -The RCC thought Resident #3's chest x-ray had been completed on the same day as the other resident's x-rays. -The RCC was not there when the x-ray provider came to the facility to perform the x-rays for the ANP's orders written on 02/22/16. -The MA/SIC had just notified the RCC that day (03/23/16) that Resident #3's chest x-ray had not been performed on the day when the other three resident's x-rays were completed because the x-ray provider told the MA/SIC that Resident #3 did not have an x-ray scheduled with the provider. -The RCC was "unsure" what happened or why	D 273		

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the x-ray provider did not have the order dated to perform Resident #3' chest x-ray.

Telephone interview with the ANP on 03/23/16 at 10:50am revealed:
-The ANP expected orders to be implemented when written.
-The ANP did not know Resident #3's chest x-ray had not been completed.
-The ANP expected Resident #3's chest x-ray to be completed "more timely than one month."
-"Somebody let the ball drop on that."
-The ANP had not been notified by the facility that Resident #3's MBS had not been scheduled and the chest x-ray had not been performed.
-The ANP expected the facility to schedule the MBS "more timely"; the MBS should have been scheduled before that day (03/23/16) because the order had been written over a month ago.

Interview with the Owner/Administrator (O/A) and RCC on 03/23/16 at 11:10am revealed:
-The RCC recalled calling the ENT physician's office "around lunch time" on 02/26/16; the RCC left a message about scheduling Resident #3's appointment for the MBS.
-The RCC recalled asking staff the next day if the ENT office had returned his message and was told the message was not returned.
-The RCC was out of work due to illness after that and the MBS had not been scheduled.
-The O/A expected the first shift staff member who was scheduled to work from 10:00am -2:00pm on Tuesday through Friday to transcribe provider orders and schedule x-rays and physician appointments.
-The RCC was usually scheduled to work 10:00am -2:00pm Tuesday-Friday and normally transcribed orders and scheduled appointments.
-When the RCC was not there, the staff member

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D 273	Continued From page 7 on duty from 10:00am-2:00pm was responsible for transcribing orders and scheduling appointments. -The O/A expected residents to receive care and services per the provider orders. -The RCC would contact the x-ray provider that day (03/23/16) to schedule Resident #3's chest x-ray. Interview the O/A on 03/23/16 at 10:08am revealed: -The RCC had "confirmed" the appointment for Resident #3' MBS "today" (03/23/16). -Resident #3's appointment for the MBS test was scheduled for 04/07/16 at 2:00pm.	D 273		
{D9999}	Final Observation Type A2 Violation in Resident Rights was changed to a Type B Violation by IDR on 3/7/16.	{D9999}		