Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING:

(X3) DATE SURVEY COMPLETED

PRINTED: 04/03/2018

FORM APPROVED .

HAL031018

B. WING

03/08/2018

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

	BEULAV	ILLE, NC 2851	8	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLE DATE
	Initial Comments  The Adult Care Licensure Section and the Duplin County Department of Social Services conducted an annual and follow-up survey and a complaint investigation on March 07, 2018 and March 08, 2018.	D 000	Responses to the cited deficiency does not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set-forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State Law.	
	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings  10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities.	D 076		
	This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure furniture in the resident's common area and the front entrance lobby were clean and in good repair. The findings are:		All salvagable furnishings in the lobby and day room will be thoroughly cleaned and disposed if unable to clean.  New furnishings have been ordered and	06/15/18
ii CC lk lc	Observations of the front entrance lobby on 03/07/18 at 9:30am revealed:  There was an oval dark stain approximately 5 inches by 3 inches on the headrest of a fabric covered wingback chair in the front entrance obby.  There was a circular dark stain approximately 3 inches in diameter on the right wing of a fabric covered wingback chair in the front entrance obby.  There was a stripped fabric covered sofa with dirty arm rests in the front entrance lobby.  Observations of the front hall common room on 3/07/18 at 03:50pm revealed:		awaiting arrival.	
C	There were large, irregular stains of different olors on fourteen of the fifteen metal framed Service Regulation			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

POC reviewed = addendunces 3)/accepte 6/11/18 20 for OB)

ATEMENT	of Health Service Rec OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION		(X3) DATE	SURVEY	
- FINN C	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:				PLETED	
		HAL031018	B. WING	B. WING		03	R 03/08/2018	
ME OF PF	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE				
JTUMN Y	VILLAGE	235 NOF	RTH NC 41					
			ILLE, NC 28518					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERE	PS PLAN OF CORRECTIVE ACTION SHOUL ENCED TO THE APPROV DEFICIENCY)	DBE	(X5) COMPLE DATE	
D 076	Continued From pag	ge 1	D 076				1	
	chairs with fabric sea	sts and backs						
	-There was a blue f	abric covered Queen Anne						
	chair with dirty arm	rests and a dark stain on the						
	headrest.	oom and a dark stall off the						
	-There was a woode	en straight backed chair with a						
1	pink vinyl seat and b	ackrest; the backrest had slit	1 1					
	the width of the back	crest with padding showing.						
1								
	Interview with house	keeping staff on 03/07/18 at						
	4:07pm revealed:							
	furniture as needed.	staff cleaned the fabric					1	
		was used to clean the		5.50			1	
	furniture.	was used to clean the	1					
		e soiled area and wipe with a						
	cloth.							
	-Sometimes the spot	s would not come out						
	Interview with the Re	esident Care Manager on						
	03/08/18 at 12:20pm	revealed:						
	-He was aware of the	stained furniture.	1					
2	-He had been trying t	to get new furniture ever		2			1	
	since he had started	working at the facility.	1					
	as soon as possible.	have the furniture cleaned						
		e damaged furniture.						
	The straint of the straint of the	damaged furniture.						
D 273	10A NCAC 13F .0902	2(b) Health Care	D 273					
	10A NCAC 13F .0902	Health Care						
		assure referral and follow-up						
1	o meet the routine ar	nd acute health care needs				•		
(	of residents.	,						
T	This Rule is not met a YPE B VIOLATION	as evidenced by:				9		

D PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		HAL031018	B. WING			R 08/2018
ME OF PRO	VIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE ZIP CODE	1 03/	08/2018
ITUMN VII	LLAGE		ORTH NC 41			
		BEULA	VILLE, NC 28518	3 · .		
X4) ID REFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	III D RE	(X5) COMPLETE DATE
D 273	Continued From pag	e 2	D 273			
s	Based on observations, interviews and record reviews, the facility failed to assure 1 of 5 sampled residents (#5) received oxygen with a dehumidifier, scheduled appointments for gynecology and pulmonary, and two follow-up cardiology procedures.  The findings are:  Review of Resident #5's current FL-2 dated 1/31/18 revealed: -Diagnoses included hypertension, post-traumatic stress disorder, hypothyroid, peripheral vascular disease, congestive heart failure, and kidney disease stage IIIThe resident was ambulatory.			A Plan of Protection was submitte Surveyors prior to exit.		3/08/2018
g ca				A intrafacility form has been create communicate between the nursing and facility transporter. This form in the resident's chart once comple appointments are able to be tracker referral to actual attendance of the appointment.	the nursing department. This form will be filed once completed so that to be tracked from	
st di di			1.0	Executive Directory, Resident Care Manager and Director of Nursing v monitor weekly to make sure new being utilized by all staff members residents are not missing appointn	vill form is to assure	
Re	eview of the Reside	nt #5's Assessment & Care realed the resident was		Tc 6/11/18 C/ c Administrato Date come	410	·m.
2/3 at	5/18 revealed Resid	an orders sheet dated lent #5 was ordered oxygen ria nasal cannula with ary care physician.		c Administrato	rected	L
-Si	Interview with Resident #5 on 3/8/18 at 11:39 a.m. revealed: -She now had oxygen as of last night (3/7/18)She used the oxygen last night.	as of last night (3/7/18), last night.		was 4/12	118	
3/7 -He	ing admitted on 2/2/ 7/18. er primary care doci	gen at the facility since /18 prior to receiving it on tor told her last month she		correspond	lance	e
-Th	e.	"in progress" since that		Edmins	nat	a,
Inte	erview with the Med	ication Aide on 3/8/18 at		Supplicate c	WL	un

Div

STATE FORM

R47Q11 POC odoted If continuation sheet 3 of 13

4/12/18

STATEMENT	f Health Service Re				, 0,	RM APPROVE
AND PLAN O	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE O			E SURVEY
			A. BUILDING:		COM	PLETED
		HAL031018	B. WNG	Action to the Control of the Control	0.	R 8/08/2018
NAME OF PR	OVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZID CODE	1 00	0/00/2010
			RTH NC 41	, ZIP CODE		
V MMUTUM	ILLAGE		/ILLE, NC 28518			
(X4) ID PREFIX	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	new .
TAG	REGULATORY (	ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	COMPLETE DATE
D 273	Continued From pa	age 3	D 273			-
	12:10 p.m. reveale	od:				
	-Resident #5 spen	t a lot of time outside smoking.				
- 1	-Resident #5 had r	not had oxygen previously.				
	-She just learned F	Resident #5 had oxygen that				
	day 3/8/18.	The state of the s				
	-It was possible the	ere was an issue with Resident				
	#5's insurance that	t had caused a delay in the				
	resident getting ox	ygen.	1 1			
	Interview with the	Physical Therapy Assistant on				
3	3/8/18 at 3:25 p.m.	revealed.				
	He worked with Re	esident #5 two times weekly.		•		
	-He had not seen to	he resident with oxygen before				
	-Resident #5 occas	sionally complained of being			4	
	short of breath with	strenuous exercise.				
		o issues with shortness of				
	breath when walkin					
	oxygen that day 3/8	Im she would be getting 3/18.				
		ransporter on 3/8/18 at 12:18				
	o.m. revealed:					1
-	He transported Re	sident #5 to appointments.				
-	He had never seer	Resident #5 using oxygen.				
l l	nterview with the R	Resident Care Manager (RCM)				
0	on 3/8/18 at 12:15 p	o.m. revealed:	1			
17	Resident #5 saw h	er primary care provider				
10	PCP) on Monday 3	8/5/18.				
	torage shed on the	oxygen concentrator from the evening of Tuesday 3/6/18.				
-	Resident #5's insu	rance would not cover oxygen				
10	n an as needed ba	isis.				
-	In addition, Reside	nt #5's insurance required a				
f	ace to face visit not	te with the PCP prior to filling		68		
a	n oxygen order.	ye shaapada shaasa €a				
-	Resident #5 continu	ued to smoke heavily.				
-	Resident #5 had re	fused to use oxygen prior to				
	nis week.					
	Service Regulation	ended the order for oxygen in				

STATEMENT	of Health Service Re T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	Arm = t	nt bit les en c
NO PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			E SURVEY IPLETED
		HAL031018	B. WING		0:	R 3/08/2018
AME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	ZIP CODE		0,00,2010
UTUMN	VILLAGE		RTH NC 41	- LI GODE		
	VILLAGE		ILLE, NC 28518	i.		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	000000000000000000000000000000000000000	
PREFIX TAG	REGULATORY O	NCY MUST BE PRECEDED BY FULL OR LISC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HEAPPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From pa	age 4	D 273			
	mid-February for al	out a week				
	-He would contact t	the PCP to clarify the order for				
- 1	oxygen.	and to claimy the order to	1 1			
	Interview with the R	RCM on 3/8/18 at 2:15 p.m.				
	revealed:					
1	order.	the PCP to clarify the oxygen				
1	-The resident was g	ilven an old margan				
	concentrator from the	ne facility's storage shed.				
	-The resident was s	een by the PCP on 2/12/18				
	but the office note w	vas not generated until	1 1			
	2/24/18.					
	-The PCP did not pr facility until 2/27/18.	rovide the written note to the	=	1		
	-The office note was	s required by the medical				
	equipment company prescription.	/ In order to process the				
	Review of the Enhan	ary and Match 2018				
	Medication Administ	tration Records (MARs)				
	revealed:	saddi Necolds (WARS)				
1.	-Oxygen at 2 liters p	er minute via nasai cannula				
- 1	with humidifier was a	added to the MAR on 2/6/18				
- 1	-The PCP was conta	acted regarding Resident #5				
	not receiving oxyger	n on 2/6/18-2/12/18.				
	2/12/18 to 2/20/18.	n was suspended from				
		cumented as administered				
1	from 2/21/18 to 3/8/1	8.				
	+					
	Interview with the pri	mary care provider (PCP) on				
3	3/8/18 at 3:14 p.m. re	evealed: •				
1	out bolloved the	n he saw Resident #5 last				
"	weeks.	recently in the last two			*	
		eadings on Resident #5's				
0	xygen levels.	sadings on resident #5's		≅		
		Resident #5 down the hall				
а	and took her oxygen	level which resulted at				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION ·		E SURVEY PLETED
		HAL031018	B. WING		03	R 8/08/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E. ZIP CODE		
ALITTURES	WI I 4 AP		RTH NC 41			
AUTUMN	VILLAGE		VILLE, NC 28518			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ma autor		
PRÉFIX TAG	(EACH DEFICIE	INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
D 273	Continued From pa	age 5	D 273			
	95-97%.		1 1			
	On a different day, Resident #5's oxygen level resulted at 86-87% after she returned from smoking.					
	-Resident #5 told him she had oxygen prior to					
	coming to the facility but he was unable to verify					
	that.					
	-It was not an "easy	y process" to get oxygen	1			
	ordered and it was	hard to justify the need for				T G
		ygen levels within normal				
	limits.					1
	-Resident #5 also h	Resident #5 also had no intent to stop smoking				
	and could refuse th	and could refuse the oxygen or stop the oxygen to smoke.				1
				•		1.5
	He did not recall stopping the order for oxygen in February.					
İ		sident #5 did not have the	1 1			
	oxygen as ordered.					
		dent #5 to get the oxygen as				
-	soon as the machin	ne was available.				
	-He had also ordere	ed a pulmonary referral for				
	pulmonary function	tests to be done to speed up				
	the process.	•				
	b. Review of Reside	ent #5's physician orders			1	
	revealed there was	a referral to pulmonary dated				
	2/12/18.					
	Intervious with Deale					
	a.m. revealed:	dent #5 on 3/8/18 at 11:39				8
	-She had not seen a	nulmonany doctor				
	-Her primary care d	octor (PCP) had prescribed				
- 1	her oxygen that she	was given on Wednesday				
	3/7/18.	giron on vigunosuay				
	-She smoked about	a pack a day and had been a				
	smoker since age 1	4.				
	Interview with the Tr	ransporter on 3/8/18 at 12:18				
	p.m. revealed:					
	-He scheduled appo	intments for residents at the				

Division of	of Health Service Re	egulation		*		M APPROVE
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE	SLIDVEN
		IDENTIFICATION NUMBER:	A. BUILDING:		COMP	
		HAL031018	B. WING			R 08/2018
NAME OF PE	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E. ZIP CODE	1 00/	00/2016
AUTUMN	VILLAGE		RTH NC 41			
	000 Med 21 Rep. (	BEULAN	/ILLE, NC 28518			
(X4) ID PREFIX	SUMMARY (FACH DEFICIE	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRESENT (EACH CORRECTIVE ASS		PROVIDER'S PLAN OF C	OPPECTION	
TAG	REGULATORY O	PR LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE	COMPLETE DATE
D 273	Continued From pa	1ge 6	D 273			· · · · · · · · · · · · · · · · · · ·
	facility and also tran	nsported residents to the				
	appointments.					
	-The Resident Care	Manager (RCM) placed				
	referrals in his folder	er after a resident saw the				
	doctor.					
	-He checked the fol	der daily.				
	-rie nad not yet ma	de the appointments with				
	the orders to school	dent #5 due to only receiving ule that appointment this				
	week.	die that appointment this	1 1			
		at day specifically he was				
- 1	given the referral for	r pulmonary but knew it was				
	that week (3/5/18-3/	/9/18).				
	-After making appoin	ntments, the Transporter		3.6		
1.	would give the appo	intment dates to the RCM				
	and they were place	ed on a calendar.				
- 1	Interview with the Re	esident Care Manager (RCM)				
10	on 3/8/18 at 12:45 p	.m. revealed:	1 1		¥.	
1.	vas not sure wr	nen the referrals to pulmonary	1			
		very doctor under the sun	1 1			
1	and if she needed to	go to the pulmonologist she				
	could have just told I	him where she needed to go.				
			1 1			
-	When the PCP saw	a resident he left orders for				
	he RCM.					
1.	The RCM would give	e a copy to the transporter				
1	ne appointment date	he transporter would return es to the RCM to be put onto		59		
a	calendar.	es to the RCM to be put onto				
lr.	terview with the PC	P on 3/8/18 at 3:14 p.m.				
	evealed:	formal to mules a				
	onflicting readings o	ferral to pulmonary due to n Resident #5's oxygen				
le	ivel.	in Nesident #5's oxygen				
	The second secon	onary referral would be				
h	elpful in getting puln	nonary function tests				
CX	ompleted.	,				

Division of	of Health Service Re	egulation			FO	RM APPROVE
STATEMENT AND PLAN (	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DAT	SURVEY
		DEMINIONION NOMBER;	A. BUILDING:			PLETED
		HAL031018	B. WING			R
NAME OF D	ROVIDER OR SUPPLIER				03	/08/2018
WAINE OF F	KOVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
AUTUMN	VILLAGE		RTH NC 41			
			/ILLE, NC 28518			
(X4) ID PREFIX	SUMMARY (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
TAG	REGULATORY	OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE	COMPLETE
				DEFICIE	NCY)	DATE
D 273	Continued From pa	age 7	D 273			
	-He also thought no	ulmonary would clarify whether				
	the resident actual	v needed overen				
	-He was not aware	the appointment had not been				
	made with pulmons	arv				
	-He expected the fa	acility to coordinate				
1	appointments as so	oon as possible.				
	Interview with the F	RCM on 3/8/18 at 3:30 p.m.				
	revealed the pulmo	revealed the pulmonary appointment had been				
	scheduled that day	3/9/18 for 4/16/18 at 10:00	1			
F	a.m.		1 1			
	3 Review of Poside	ent #5's physician orders				
ŀ	revealed there was	a referral made to gynecology	1 1			
	dated 2/16/18.	a relemal made to gynecology				
	Interview with Resid	dent #5 on 3/8/18 at 11:39				
1	a.m. revealed:					
	-She had a growth i	n her vaginal area that was				
.	painful at times.					
	to see another doct	nined the area and wanted her				1
		g gynecologist since last year.				
	THE HALL HOLD GOOM &	gynecologist since last year.				
	Interview with the Ti	ransporter on 3/8/18 at 12:18	1 1			
	p.m. revealed:					
1	-He scheduled appo	intments for residents at the				
100	and the state of t	sported residents to the				
	appointments.					
	- The Resident Care	Manager (RCM) placed				
	doctor.	r after a resident saw the				
	-He checked the fold	der deily				
.	-He had not vet man	le the appointment with				
	gynecology for Resid	dent #5 due to only receiving				
1	the orders to schedu	le that appointment this	1			
1	week.					
1.	He was unsure wha	t day specifically he was				
15	given the referral for	gynecology but knew it was	1			
t	that week (3/5/18-3/9	9/18).				

STATEMENT	of Health Service Rec of Deficiencies of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION		E SURVEY
						R
		HAL031018	B. WING		0:	3/08/2018
AME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
UTUMN	VILLAGE		RTH NC 41			
			/ILLE, NC 28518			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE APPROPRIATE	(X5) COMPLET DATE
D 273	Continued From pag	ge 8	D 273			-
	-After making appoin	ntments, the Transporter				
	would give the appo and they were place	intment dates to the RCM				
	Interview with the Re	esident Care Manager (RCM)		(*)		
	on 3/8/18 at 12:45 p	.m. revealed:				
1	-He was not sure when the referral to gynecology					
	was made.					
1	the RCM.	a resident he left orders for				
		e a copy to the transporter				
1	for scheduling then t	he transporter would return				
	the appointment date a calendar.	es to the RCM to be put onto		*		
	interview with the pri	mary care physician (PCP)				
	on 3/8/18 at 3:14 p.n -He did not recall ma	n. revealed:				
	gynecology.	iking the referral to				
		esident had a growth in her				
	vaginal area.			\$6		
	-He did not know the	appointment had not been		(i)		
	scheduled with gyner	cology,				
	-He usually got repor	ts when residents saw d not received one from				
	gynecology.	a flot received one from				
		ility to coordinate the				
1	appointment for gyne	cology as soon as possible.				
- 1	nterview with the RC	M on 3/8/18 at 3:30 p.m.				
	evealed the gynecol	ogy appointment had been		.25		
8	scheduled that day for	or 3/22/18 at 1:15 p.m.				
4	Review of the phys	sician orders for Resident #5				
r	evealed there were o	orders for a repeat overnight				
(	eximetry and mobile of lays dated 3/1/18.	cardiac telemetry for three				
11	nterview with Reside	nt #5 on 3/8/18 at 11:39				

Division o	of Health Service Re				FO	RM APPROVED
STATEMENT AND PLAN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY
			A. BUILDING:		CON	MPLETED
		HAL031018	B. WING			R 3/08/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	770000	1 0	3/00/2018
	COOP - 27 PUBLISHED AND PROPERTY OF A COMPLEMENT OF A COMPLEME		RTH NC 41	e, ZIP GODE		
AUTUMN	VILLAGE		/ILLE, NG 28518	¥0		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	aı	PROVIDER'S PLAN OF C	OPPECTION	
PREFIX TAG	REGULATORY C	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	COMPLETE DATE
D 273	Continued From pa	ige 9	D 273			
	-She saw her cardi	ologist last week				
	-The doctor wanted	her to have some more				
	testing done.					
	-She was not sure	what the tests were.				
1	-She had not had w	orn any heart monitors since				
	moving to the facilit	y on 2/2/18.				
- 1	Interview with staff	at the cardiology office on	1 1			
	3/8/18 at 11:51 a.m	revealed:				
	-Resident #5 was s	een in the office on 3/1/18.				
- 1	-She requested to g	to the hospital at that visit.				
	-Resident #5 was h	aving chest pains on the day		(0)		
	of this visit and was	given a medication to stop				
- 1	the pain while there					
	- The patient still wa	nted to go to the hospital and				
- 1	The dector ordered	ent to the emergency room.				
	done.	an overnight oximetry test be				
1		have to come into the office				
	to pick up the equip	ment and then be sent home				
10	with the equipment	overnight,				
	<ul> <li>The equipment wor</li> </ul>	uld then need to be returned				
	the following day.					
	be worn for three da	order for a cardiac monitor to				
	-The resident would	also need to come to the				
	office to pick up the	equipment and then she				
	would be sent home	to wear the monitor for three		€		
	days.	and the meanter for three	1 1			
	-Any staff could retu	rn the monitor to the office				
1	after the three days.					
	The office usually g	ave facilities flexibility with				
1	scheduling monitor plived out of town.	procedures when residents				
		ed the office to make				
	arrangements for the	ed the office to make e overnight oximetry or the				
6	cardiac telemetry tes	at as of 3/8/18.				
	nterview with the Re	esident Care Manager (RCM)				
	on 3/8/18 at 12:45 p.	m, revealed:				

STATEMEN	of Health Service Red T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	Dem Francisco			
	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION		E SURVEY MPLETED
		HAL031018	B. WING		0	R 3/08/2018
AME OF P	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE		0,00,2010
LITTEMAN	VILLAGE		RTH NC 41	-, LR OODE	**	
O TOMIN	VILLAGE		/ILLE, NC 28518			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC (DENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X6) COMPLET DATE
D 273	Continued From pag	ge 10	D 273			
	-No arrangements h	ist seen cardiology last week. and been made as of yet to ken back to the office for				
	5:25 p.m. revealed: -They were waiting or resident's hospital vi what testing was do	ardiology office on 3/8/18 at on the report from the list on 3/1/18 to determine there.		*		
	on the same day, 3/ -The oximetry test w -The doctor wanted oximetry and the car	as not done at the hospital. to have the overnight diac monitor testing done as				
	soon as possible prio scheduled on 3/26/1 -She had not receive	or to the stress test 8. ad any calls from the facility to				
	schedule the testing.	the facility to arrange the				
	reviews, no appointing scheduled for the over	ns, interviews, and record nent dates had been ernight oximetry or cardiac rr to exiting the survey.				
	for oxygen, two referr gynecology, and two procedures for a resid congestive heart failu	dent with a history of are and chest pain. This		я		i
	failure was detrimenta	al to the health, safety, and at which constitutes a Type B				
	03/08/18 revealed: The Resident Care N	s plan of protection dated  Manager would review				
-	The Resident Care N	lanager would review are follow-up appointments				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A BUILDING: HAL031018 B. WING 03/08/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 235 NORTH NC 41 **AUTUMN VILLAGE** BEULAVILLE, NC 28518 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 273 Continued From page 11 D 273 had been made. -The Resident Care Manager would prioritze appointments prior to giving them to Transportation to schedule. -The Resident Care Manager would increase communication with providers and have daily meeetings with his Assistant Care Manager and Transportation to discuss the appointment schedule. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 22, 2018. D912 G.\$. 131D-21(2) Declaration of Residents' Rights D912 G.\$. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to assure residents received care and services that were adequate, appropriate and in compliance with federal and state laws and rules and regulations related to health care referral and follow-up. The findings are: Based on observations, interviews and record reviews, the facility failed to assure 1 of 5 sampled residents (#5) received oxygen with a dehumidifier, scheduled appointments for gynecology and pulmonary, and two follow-up Division of Health Service Regulation

STATE FORM

TATEMENT	of Health Service F	(X1) PROVIDER/SUPPLIER/CLIA				RM APPROV
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE C	(X3) DATE	(X3) DATE SURVEY COMPLETED	
			A BOLDING.		COM	LETEU
		HAL031018	B. WING	0.0	R	
AME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, GITY, STATE	ZIP CODE	1 03	/08/2018
UTUMN	VILLAGE		RTH NC 41	, AIT GODE		
		BEULA	VILLE, NC 28518			
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
D912	Continued From p	page 12	D912			-
	cardiology proced NCAC 13F .0902 Violation)].	lures. [Refer to Tag 0273, 10A (b) Health Care (Type B				
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