Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
HAL093010		B. WING		08/28/2024		
	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
ALPHA N	IAGNOLIA GARDEN	WARRENT	TON, NC 27	589		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 000	Initial Comments		D 000			
D 273	10A NCAC 13F .09	02(b) Health Care	D 273			
		02 Health Care I assure referral and follow-up and acute health care needs				
	reviews, the facility follow-up to meet the	et as evidenced by: ons, interviews, and record failed to ensure referral and the health care needs for 1 of 5 (#1) related to a referral for				
	The findings are:					
	05/24/24 revealed of	#1's current FL2 dated diagnoses included type II hronic kidney disease stage 3,				
	06/03/24 revealed: -There was an orde therapy concerning -The order included Resident #1's ability changes in his diet to swallow and mini -Speech therapy wa Resident #1's cogni	cian's after-visit report dated or for a referral to speech swallowing with liquids. I evaluation and treatment of to swallow and to prescribe which could improve his ability mize aspiration. As also ordered to evaluate itive status and proved to recommendations based on				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation								
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
HAL093010		B. WING		08/28/2024				
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE				
AL DUA I	AA ONOLIA GADDEN	930 HWY	158 BUS E					
ALPHA	MAGNOLIA GARDEN	WARREN <sup>*</sup>	TON, NC 27	589				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE		
D 273	Continued From pa	ge 1	D 273					
	Review of Resident #1's record revealed there was no documentation of a completed evaluation for swallowing by a speech therapist.  Telephone interview with a registered nurse from resident #1's PCP office on 08/27/24 at 2:21pm revealed:  -There was nothing documented in Resident #1's record of an incident of choking while eating.  -The facility was responsible for scheduling the appointments for the referrals the PCP ordered.  -The PCP provided the order for the referral and there was no other involvement after that.							
	have been schedule referral being order	vith a speech therapist should ed within a few days of the ed on 06/03/24. dent #1 on 08/27/24 at						
	-He had trouble with cancer treatments of the had not seen a know he had an ord therapistHe had not choked with swallowing; he	n swallowing since he had over three years ago. speech therapist and did not der for a referral to a speech don his food or had a problem did not know why he was a speech therapist.						
	08/28/24 at 7:54am -She had not witnes clearing his throat v -She would have no was coughing or ch	ssed Resident #1 coughing or while eating. oticed if resident number one oking while eating. dining room with the residents						
	Interview with the m 08/27/24 at 3:18pm	nedication aide (MA) on revealed:						

6899

Division of Health Service Regulation STATE FORM

-She would help in the dining room after

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED	
HAL093010		B. WING		08/28/2024		
NAME OF PROVIDER OR SUPPLIER		DRESS. CITY. S	STATE, ZIP CODE	1 00/2	0/2024	
		158 BUS E				
ALPHA MAGNOLIA GARDEN	WARREN <sup>-</sup>	TON, NC 27	589			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE	
eating his mealsShe had last witner couple of weeks ag throat himself when the coughed a couple had not choked. He was served a pliquidsShe did not know a therapyStaff had not report while eating his mean literviews with the (RCC) on 08/27/24 revealed: -The facility staff has appointments for real a speech therapist therapist available it resided inThe primary care put to get an appointment for reade by the RCC are or within a week of the she was going to colosest major city the she could schedule #1The PCP had told ordered a referral for a seferral for a referral for a	d Resident #1 cough while  ssed him cough while eating a po; he was able to clear his in he coughed. ple of times during the meal. d or aspirated while eating. bureed meal and thickened  about a referral for speech rted any issues for Resident #1 als.  Resident Care Coordinator at 10:19am and 3:02pm  ad attempted to schedule esidents who had referrals for but there were no speech in the county the facility  provider (PCP) was attempting ent for Resident #1 through his referrals to specialist were and were made the same day the referral by the PCP. call a speech therapist in the nat morning, 08/27/24, to see if e an appointment for Resident ther months ago that he had or Resident #1. why Resident #1 had an order speech therapist. ssed Resident #1 choking or	D 273				

Division of Health Service Regulation STATE FORM

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	
	HAL093010	B. WING		08/2	28/2024
NAME OF PROVIDER OR SUPPLIER  ALPHA MAGNOLIA GARDEN	930 HWY	DDRESS, CITY, ST 158 BUS E ITON, NC 275			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
-Resident #1 said he due to a stroke, but anymoreResident #1 was me the top and only one interview with the Arro 8/28/24 at 9:18am - The RCC ensured a were scheduledShe reviewed all aff PCP and signed off -No one had signed after-visit summary - The RCC had attent appointment with a separate the facility had not the property appointment with a separate to the property and the property appointment with a separate to the property and the property appointment with a separate to the property and the property appointment with a separate to the property and the property appointment with a separate to the property and the property and the property appointment with a separate to the property and	g or coughing while eating. e used to choke while eating he did not have problems issing teeth; he had one on e on the bottom.  rea Clinical Director on revealed: appointments for referrals  ter-visit summaries from the on them. off on Resident #1's dated 06/03/24. inpted to schedule an speech therapist for Resident rea but had not been able to bist. attempted to find a speech the local area or the county. keep the residents from e than an hour to a speech int. re the facility had difficulty erapist and the PCP was also in therapist for Resident #1 to when an appointment should and for Resident #1 because attempting to find a speech orted incidents of choking or was eating. ritten the order for the referral				

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI/		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		HAL093010	B. WING		08/2	8/2024		
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
ALPHA I	ALPHA MAGNOLIA GARDEN 930 HWY 158 BUS E WARRENTON, NC 27589							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE		
D 273	Attempted interview	ge 4 v with the Administrator on m was unsuccessful.	D 273					

6899

Division of Health Service Regulation STATE FORM