

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL036018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/30/2019
NAME OF PROVIDER OR SUPPLIER COUNTRY TIME INN		STREET ADDRESS, CITY, STATE, ZIP CODE 602 BREVARD ROAD KINGS MOUNTAIN, NC 28086		
(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 an Annual survey on January 29-30, 2019.	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 for 2 of 5 sampled residents (Resident #2 and #1) regarding physician notification for Resident #2 related to a missed appointment with cardiac rehabilitation after a hospital discharge and not setting up an appointment related to a orthopedic referral for Resident #1 following a fall. 1. Review of Resident #2's current FL2 dated revealed diagnoses included bipolar and diabetes. Review of Resident #2's Resident Registry revealed an admission date of 09/24/18. Review of a discharge summary from a local hospital for Resident #2 dated 01/18/19 revealed: -Resident #2 was admitted to the hospital on 01/14/19 and discharged back to the facility on 01/18/19. -Resident #2 was admitted with a diagnosis of	D 273		

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

TITLE

(X6) DATE

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D 273	Continued From page 1 Non-St Elevated Myocardial infarction (a heart attack). -There was an order for Resident #2 to follow-up with cardiac rehabilitation on 01/29/19 at 10:30am. Review of the facility appointment book calendar for January 2019 revealed there was not an appointment for the cardiac rehabilitation made for 01/29/19 at 10:30am entered for Resident #2. Telephone interview with Resident #2's cardiac office nurse on 01/30/19 at 9:25am revealed: -Resident #2 had an appointment on 01/29/19 at 10:30am made by the hospital, but did not show up for the appointment. -The facility staff never called the office to reschedule the missed appointment. -The physician wanted Resident #2 to attend a cardiac class on 01/29/19 at 10:30am prior to starting rehabilitation. -The class was mandatory before Resident #2 could start cardiac rehabilitation 3 times weekly. -The instructor of the class called Resident #2 cell phone on 01/29/19 and questioned why she had not kept the appointment. -The reason given was "missed due to transportation." -The instructor rescheduled Resident #2's cardiac class for 02/12/19 at 10:30am. -The cardiac class was very important for determining the best rehab for each individual and involved setting up a low level treadmill test. - "You must take the cardiac class prior to starting the cardiac rehab." - "If the class was not important the doctor would not had ordered it." Interview with Resident #2 on 01/30/19 at 9:50am revealed:	D 273		

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D 273	Continued From page 2 -Resident #2 had received a phone call from the cardiac office on 01/29/19 sometime in the afternoon. -She did not know she had an appointment scheduled for 01/29/19 at 10:30am, or that she had missed the appointment. -She had never seen the hospital discharge summary dated 01/18/19. -The cardiac office representative tried to reschedule the appointment, she told them to call the facility transportation person. -"All appointments must go through transportation for scheduling." -She relied on the facility to transport her to the appointments. -Transportation handled all appointments and transportation. -The facility did have a van and it was wheelchair accessible. -She told the transportation person the cardiac office called her on 01/29/19 and she had missed her appointment. Interview on 01/30/19 at 9:45am with a medication aide (MA) revealed: -She was responsible for reviewing new orders for residents and reviewing the discharge summary from the hospital. -She did not know Resident #2 had an appointment with cardiac rehabilitation on 01/29/19 at 10:30am. -She was not sure why the physician appointment was missed for Resident #2. -All resident appointments are handled through transportation. Interview with the Resident Care Coordinator (RCC) on 01/30/19 at 10:00am revealed: -She was responsible for overseeing the clinical staff.	D 273		

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D 273	Continued From page 3 -She knew Resident #2 had been admitted to the hospital with a diagnosis of a heart attack on 01/14/19 and returned to the facility on 01/18/19. -She had known Resident #2 had an order for the cardiac class on 01/29/19 at 10:30am. -She made a copy of Resident #2's order and had given it to transportation for scheduling and placing in the transportation appointment book. -Transportation was responsible for informing the residents when appointments were made and transporting the residents to the appointments. -She did not know why Resident #2 had missed the appointment. -Resident #2 sometimes made her own appointments and often a friend would take her to the appointments. Interview with the Administrator on 01/30/19 at 10:30am revealed: -She relied on the RCC to process new orders for the residents and review hospital discharge summary. -She relied on transportation to schedule resident's appointments and to transport residents to the appointments. -Resident #2 sometimes made and scheduled her appointments herself. -Resident #2 had a friend who had taken her to appointments sometimes. -She was unsure why Resident #2 missed the cardiac class that was ordered on 01/29/19 at 10:30am. Interview with the facility transportation person on 01/30/19 at 11:30am revealed; -He was responsible for scheduling resident's physician appointments and transportation to the appointments. -The RCC or the MA would give him a copy of the order and he would call and confirm the	D 273		

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D 273	Continued From page 4 appointment. -He would write the appointment on the transportation calendar and if there were exception or missed appointment he would document in the transportation notebook. -He could not recall seeing the discharge summary for Resident #2 dated 01/18/19. -He did not recall the order for Resident #2 for the cardiac class appointment on 01/29/19 at 10:30am. -If I had seen the order I would had written it on the calendar." -He was made aware on 01/29/19 Resident #2 had missed the cardiac appointment because Resident #2 had told him the cardiac rehab had called her and tried to reschedule. -He had told Resident #2 he was unable to transport her to the appointment without an order. Interview on 01/30/19 at 12:00pm with the facility Physician Assistant for Resident #2 revealed: -She had seen Resident #2 on 01/23/19 in the facility after she had returned from the hospital admission on 01/18/19. -She was not aware of Resident #2's cardiac history until the hospital admission 01/18/19. -She documented on her visit note on 01/23/19 the appointment with the cardiac rehabilitation on 01/29/19 at 10:30am. -She was not sure why Resident #2 had missed the appointment with the cardiac rehab. -The cardiac appointment is very importing due to [Resident #2's] cardiac history." -The facility was responsible for following all physician's orders as written, including making sure all referrals were completed in a timely manner. -The facility staff were responsible for following all physician's orders, including making sure all referrals were completed.	D 273		

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D 273	Continued From page 5 -The staff did not make her aware Resident #2 had missed the cardiac appointment. 2. Review of Resident #1's current FL-2 dated 01/06/19 revealed: -Diagnoses included dementia, dyslipidemia, diabetes, and Chronic Obstructive Pulmonary Disease (COPD). -Resident #1 was constantly disoriented. Review of Resident #1's Resident Register revealed an admission date of 09/21/17. Review of Resident #1's facility's contracted Physician Assistant (PA) visit summary dated 01/02/19 revealed: -The PA evaluated Resident #1 as a follow up for a fall resulting in an emergency room visit on 12/25/18. -Hip x-ray from the emergency room showed a "left pubis ramus fracture that appeared to be chronic." -Resident #1's PA ordered a referral for orthopedics to evaluate the left hip. Interview with the Resident Care Coordinator (RCC) on 01/30/19 at 10:00am and 1:13pm revealed: -She did not know Resident #1 had a referral for an orthopedic appointment. -She was responsible for reviewing all new orders including orders from a hospital discharge and referrals. -She was responsible for passing along information to the facility transportation representative if a resident had an order for a referral. -Transportation was responsible for setting up the appointment.	D 273		

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D 273	Continued From page 6 -Transportation was responsible for informing the residents when appointments were made and transporting the residents to the appointments. Interview with the facility transportation representative on 01/30/19 at 11:30am revealed: -He did not know Resident #1 had an order for a referral for an orthopedic appointment. -He did not remember seeing the order for Resident #1 to set up the referral. -He was responsible for scheduling resident's physician appointments and transportation to the appointments. -The RCC or the medication aide (MA) would give him a copy of the order. -After he received the order, he would call and confirm the appointment or schedule an appointment. -He would write the appointment on the transportation calendar and if there were exceptions or missed appointments he would document in the transportation notebook. Interview with the Administrator on 01/30/19 at 10:30am revealed: -She did not know Resident #1 had a referral to an orthopedic specialist. -She relied on the RCC to process new orders for the residents and review hospital discharge summary. -She relied on transportation to schedule resident's appointments and to transport residents to the appointments. Interview on 01/30/19 at 12:00pm with the facility Physician Assistant for Resident #2 revealed: -The facility was responsible for following all physician's orders as written, including making sure all referrals were completed in a timely manner.	D 273		

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D 273	Continued From page 7 -Resident #1's referral was not an emergency but the facility should make sure they follow through with all referrals.	D 273		