

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL096004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 07/19/2024
NAME OF PROVIDER OR SUPPLIER WAYNE COUNTY REST VILLA NO 2			STREET ADDRESS, CITY, STATE, ZIP CODE 305 SOUTH VANCE STREET EUREKA, NC 27830		
(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 and follow-up survey on 07/19/24.	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 interviews and record reviews, the facility failed to meet the health care needs for 1 of 3 sampled residents (#2) by failing to assure an appointment for a referral to a dermatologist. The findings are: Review of Resident #2's current FL-2 dated 04/24/24 revealed: -Diagnoses included obesity, hypothyroidism, and hyperlipidemia. -He was ambulatory. Review of Resident #2's physician's order dated 04/24/24 revealed a referral to a dermatologist. Review of Resident #2's facility's progress noted dated 04/24/24 revealed resident was seen by his primary care provider (PCP) and had a referral to a dermatologist. Interview with Resident #2 on 07/19/24 at 2:10pm revealed: -His face turned red sometimes and he had a bad case of dandruff. -He knew his PCP wanted him to see a dermatologist, but he did not know he wrote the referral.	D 273			

Division of Health Service Regulation

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

TITLE

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL096004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 07/19/2024
NAME OF PROVIDER OR SUPPLIER WAYNE COUNTY REST VILLA NO 2			STREET ADDRESS, CITY, STATE, ZIP CODE 305 SOUTH VANCE STREET EUREKA, NC 27830		
(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 273	Continued From page 1 Interview with the Facility Manager on 07/19/24 at 12:04pm revealed: -She was aware Resident #2 had problems with redness to his face and hair. -She was not aware the dermatologist appointment had not been made for Resident #2. -She had been out on family leave from May 2024 to June 2024. -When she returned, she started auditing resident's records to ensure appointments were made. -She had not had a chance to review Resident #2's record to ensure referrals and appointments were made. Interview with the Administrator on 07/19/24 at 2:42pm revealed: -The Facility Manager was responsible for ensuring referrals were done for the residents. -The secretary was able to ensure appointments were made from referrals. -She completed resident record audits every 3 months and checked to ensure appointments were made from referrals. -She was not aware Resident #2 had a referral for a dermatologist. -She was always available for the facility staff to notify her, if they needed.	D 273			
D 321	10A NCAC 13F .0906(a) Other Resident Care And Services 10A NCAC 13F .0906 Other Resident Care And Services (a) Transportation. The administrator shall assure the provision of transportation for the residents of adult care homes to necessary resources and activities, including transportation	D 321			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL096004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 07/19/2024
NAME OF PROVIDER OR SUPPLIER WAYNE COUNTY REST VILLA NO 2		STREET ADDRESS, CITY, STATE, ZIP CODE 305 SOUTH VANCE STREET EUREKA, NC 27830		
(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 321	Continued From page 2 to the nearest appropriate health facilities, social services agencies, shopping and recreational facilities, and religious activities of the resident's choice. The resident shall not be charged any additional fee for this service. Sources of transportation may include community resources, public systems, volunteer programs, family members as well as facility vehicles. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure transportation was available for 1 of 3 sampled residents (#2) to attend a surgeon appointment. The findings are: Review of Resident #2's current FL-2 dated 04/24/24 revealed: -Diagnoses included obesity, hypothyroidism, and hyperlipidemia. -He was ambulatory. Review of Resident #2's physician's order dated 04/24/24 revealed: -There was a referral to a surgeon due to an abdominal panniculus (excess skin hanging from the abdomen). -The appointment for the surgeon was 05/17/24. Review of Resident #2's facility's progress noted dated 05/17/24 revealed he was not transported to his appointment because the facility did not have a driver. Interview with Resident #2 on 07/19/24 at 2:10pm revealed he was not aware of an appointment with the surgeon.	D 321		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL096004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 07/19/2024
NAME OF PROVIDER OR SUPPLIER WAYNE COUNTY REST VILLA NO 2			STREET ADDRESS, CITY, STATE, ZIP CODE 305 SOUTH VANCE STREET EUREKA, NC 27830		
(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 321	Continued From page 3 Interview with the secretary on 07/19/24 at 12:27pm revealed: -The person who drove residents to their appointments had quit. -The backup driver was not available to drive Resident #2 to his appointment on 05/17/24. -She was not able to drive Resident #2 to his appointment because of her health. -She did not remember if she notified the Administrator Resident #2 needed transportation to his appointment on 05/17/24. Interview with the Facility Manager on 07/19/24 at 12:04pm revealed: -She was not aware Resident #2 missed an appointment on 05/17/24. -She was out on family leave at the time of Resident #2's appointment. -The secretary, a new transportation worker, and herself were authorized to drive the facility vehicle to take residents to appointments. -Resident #2 should have gone to his appointment on 05/17/24. Interview with the primary care provider (PCP) on 07/19/24 at 11:48am revealed: -Resident #2 had a big mass in his abdomen area. -He made a referral for Resident #2 to see a surgeon to have the mass removed. -He was not concerned about the mass affecting Resident #2's health. -He was concerned about the mass effecting Resident # 2's quality of life. -He was not aware Resident #2 missed his appointment to see the surgeon. Interview with the Administrator on 07/19/24 at 2:42pm revealed: -She was not aware Resident #2 did not attend	D 321			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL096004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 07/19/2024
NAME OF PROVIDER OR SUPPLIER WAYNE COUNTY REST VILLA NO 2		STREET ADDRESS, CITY, STATE, ZIP CODE 305 SOUTH VANCE STREET EUREKA, NC 27830			
(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 321	Continued From page 4 an appointment due to lack of transportation. -There were multiple drivers at the facility authorized to drive the facility's vehicle. -She would have taken Resident #2 to his appointment if she was aware.	D 321			