

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/13/2023
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NAME OF PROVIDER OR SUPPLIER

SPRINGVIEW - STEWART BUILDING

STREET ADDRESS, CITY, STATE, ZIP CODE

611 W WHITSETT STREET
GRAHAM, NC 27253

(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 July 13, 2023.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain an uncluttered, clean, and orderly environment, free of obstructions and hazards related to an unsecured oxygen (O2) tank in Room #3. The findings are: Observation of a resident room #3 on 07/13/23 at 8:45 am during the initial tour revealed: -There was a 3-foot tall unsecured O2 tank sitting upright on the floor next to the unoccupied bed in the resident's room. -There was no rack or crate to stabilize the O2 tank. -The O2 tank had a sticker with the name of a medical equipment (ME) supplier on it. Interview with the resident residing in the room #3 on 07/13/23 on 8:50 am revealed: -The O2 tank in the room was brought "a while	D 079	On 7/13/2023 the O2 tank w/out stand was removed from the residents room into a closet On 7/13/2023 LinCare delivered equipment & stand @ 2pm & took the tank that didn't have a stand	7/13/2023 7/13/2023

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

Brendy Sue McHugh

TITLE

administrator

(X6) DATE

08/02/2023

STATE FORM

6899

2NZ811

If continuation sheet 1 of 4

Reviewed and
Acknowledged
8/11/23
W Edwards

Division of Health Service Regulation

PRINTED: 07/20/2023
FORM APPROVED

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NAME OF PROVIDER OR SUPPLIER SPRINGVIEW - STEWART BUILDING			STREET ADDRESS, CITY, STATE, ZIP CODE 611 W WHITSETT STREET GRAHAM, NC 27253		
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D 079	Continued From page 1 ago". -She used O2 continuously and used an O2 concentrator. -The O2 tank was brought to her as a backup in the event of a power outage. -She thought the O2 tank was very heavy and never tried to move it herself because she was afraid, she would hurt herself. -The staff moved the O2 tank from where it was located next to her nightstand during a storm a few days ago and did not say anything about the O2 tank not being in a stand or rack. -She had never used the O2 tank. Interview with the Resident Care Director (RCD) on 07/13/23 at 9:35 am revealed: -The O2 tank was brought to the facility when the resident was admitted. -The O2 tank was to be used as a backup in case the power went out. -The O2 tank did not have a stand. -She was not aware the O2 tank in the resident's Room #3 did not have a rack or stand and did not know the bigger tanks had to have a stand. -The facility never received a stand for the O2 tank. -The resident had never used the O2 tank. -She knew the O2 tank was heavy and did not want the resident to get hurt. -She was responsible for the safety of the residents. -She would call the O2 supplier and get a stand or rack delivered today if possible. Interview with the ME's office Center Manager on 07/13/23 at 9:53 am revealed: -The O2 tank the resident had in her room was an M60 back up tank in case of a no power emergency and contained 76 (seventy-six) hours of continuous oxygen.	D 079		7/13/2023	

Beulah G. [Signature]
8/9/2023

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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**611 W WHITSETT STREET
GRAHAM, NC 27253**

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D 079	Continued From page 2 -The O2 tank was sent to the facility on 03/27/23. -The M60 O2 tank should have been delivered with a stand, a stand would not have to be ordered separately. -She did not know how much the M60 O2 tank weighed. -The driver that delivered the M60 O2 tank would bring the stand today. -The facility did not request a stand for the M60 O2 tank until today. Second interview with the RCD on 07/13/23 at 10:55 am revealed, "if the ME supplier brought the stand, where is it?" Second interview with the ME's office Center Manger on 07/13/23 at 2:50 pm revealed: -She did not have information regarding the weight of the tank. -The delivery driver that delivered the tank in March 2023 would be bringing the stand today but would be unable to call the surveyor. Interview with the Operations Manager at the ME's office on 07/13/23 at 2:55 pm revealed: -The weight of the M60 O2 tank is 27 pounds and 8 ounces when full. -The M60 O2 tanks should be in a stand or rack to secure them. -If the M60 O2 tank was not secured and fell on the resident, it could cause significant injury. Interview with a Medication Aide on 7/13/23 at 3:00 pm revealed: -She was unaware there was an unsecured O2 tank in the resident's room. -She knew the portable O2 tanks were supposed to be in a stand. -If she knew the O2 tank in the resident's room did not have a base, she would have let the RCD	D 079		7/13/2023

B. W. [Signature]

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STATE FORM

6899

2NZ811

If continuation sheet 3 of 4

8/9/2023

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D 079	Continued From page 3 know. Interviewed with the ME's delivery driver on 07/13/23 at 3:05 pm revealed: -The protocol was O2 tanks were delivered with stands. -He was not the driver that delivered the M60 O2 tank to the resident in March 2023. Telephone interview with the Administrator on 07/13/23 AT 5:00 pm revealed: -She was unaware there was an unsecured O2 tank in the resident's room. -She understood O2 tanks needed to be secured for resident safety.	D 079		7/13/2023	

Beverly Sue McLaughlin
8/9/2023

Edwards, Wanda A

From: Beverly Dix McHugh <Bev@springviewassistedliving.com>
Sent: Wednesday, August 9, 2023 4:58 PM
To: Edwards, Wanda A
Subject: [External] Springview Stewart encrypt
Attachments: SVStewartPlanofCorrection07.2023.pdf

CAUTION: External email. Do not click links or open attachments unless verified. Report suspicious emails with the Report Message button located on your Outlook menu bar on the Home tab.

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Wanda,

Please find attached the completed and signed plan of Correction for Springview – Stewart Building HAL 001-163.

If you need anything else, please let me know.

Beverly Dix McHugh
Administrator/Owner



Office: 336.222.8913

Mobile: 336.260.8488

Fax: 336.222.1935

www.springviewassistedliving.com

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