STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL084004	A. BUILDING: _____ B. WING _____	03/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF ALBEMARLE	315 PARK RIDGE ROAD ALBEMARLE, NC 28001

(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 March 17-18, 2015.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure medication was administered as prescribed for 2 of 6 sampled residents (Resident # 2 and #4) with prescribing practitioner orders for Coumadin (an anticoagulant used to prevent blood clots in the blood vessels). The findings are: A. Review of Resident #2's current FL2 dated 12/01/14 revealed: -Diagnoses that included atrial fibrillation, pacemaker, congested heart failure, and aortic valve replacement. -Medication orders that included Coumadin 2.5 mg daily on Sunday, Monday, Tuesday, Friday, Saturday and Coumadin 5 mg on Wednesday. Review of Resident #2's record revealed a signed subsequent physican order dated 2/20/15 to hold Coumadin for 2 days and then restart on Monday,	D 358		

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give 2 mg daily.

Review of Resident #2's facility electronic Medication Administration Record (eMAR) for February 2015 revealed:
-Order entry transcribed as Coumadin 2.5 mg tablet take 1 tablet by mouth daily.
-Documentation from February 1st through the 28th Coumadin 2.5mg tablets were administered to Resident #2 at 5:00 pm daily.
-No documentation Coumadin had been held for two days as ordered by the physician on 2/20/15.
-No documentation Coumadin 2mg tablet was administered as ordered by the physican on 2/20/15.

Review of Resident#2's facility eMAR for March 2015 revealed:
-Order entry transcribed as Coumadin 2.5 mg tablet take 1 tablet by mouth daily.
-Documentation Coumadin 2.5 mg as administered daily at 5:00 pm to Resident #4 on March 1st through the 16th.

Further review of Resident #2's record revealed a signed subsequent physican order dated 3/6/15 to continue Coumadin 2.5 mg daily, recheck in one week.

Observation of medications on hand for Resident #2 on 3/17/15 at 2:20 pm revealed a pharmacy generated punch card with instructions to give Coumadin 2.5 mg daily at 5pm.

Interview on 3/17/15 at 12:10 pm with the contract pharmacist revealed:
-The current order for Resident #2 was Coumadin 2.5 mg daily at 5:00 pm.
-She recalled an order on 1/11/15 for Resident #2 to stop the 5mg of Coumadin on Wednesdays.

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-They received a facilty fax order for Resident #2 on 3/6/15 to continue the Coumadin 2.5 mg daily.
-The pharmacy was not aware of Resident #2's order dated 2/20/15 to decrease the Coumadin to 2mg daily or to hold Coumadin for 2 days prior to administering the 2mg of Coumadin.
-It was the facility's responsibility to fax all new orders to the pharmacy so they could fill and dispense medications to the residents.

Review on 3/17/14 of Resident #2's record revealed:
-Lab values International Normalized Ratio (INR) (used to determine and measure the clotting factor in the blood) for Resident #2 were as follows:
-On 1/8/15 INR=2.41 Normal range 2-3
-On 2/9/15 INR=2.32
-On 2/27/15 INR 1.87
-On 3/11/15 INR 1.87
-On 3/13/15 INR 1.93

Interview on 3/17/15 at 2:45 pm with a Medication Aide (MA) revealed:
-She worked primarily on first shift.
-She was unaware of the dose of Coumadin Resident #2 was taking because it was given on second shift.
-The Supervisor was responsible for reviewing and faxing new orders to the pharmacy.
-The MAs could not approve or reject new orders placed on the eMAR by the pharmacy, only Supervisor could do this.

Interview on 3/17/15 at 2:50 pm with the Supervisor revealed:
-She said Resident #2 was taking Coumadin 2.5 mg daily.
-She never administered Coumadin 2 mg tablet to Resident #2 during the month of February or

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March 2015.
-She was responsible for reviewing and faxing new orders for the residents to the pharmacy.
-She made 2 copies of the new order and placed it into the box for the Resident Care Coordinator (RCC) and the nurse to review.
-She had not reviewed or faxed the order on 2/20/15 for Resident #2's Coumadin to be held for 2 days and Monday start Coumadin 2mg daily.
-She said the order must had been missed.

Interview on 3/17/15 at 3:15 pm with the RCC revealed:
-She had been employed as the RCC for 1 year.
-She was unaware of the physican order dated 2/20/15 for Resident #2 to hold Coumadin for 2 days and then start on Monday Coumadin 2mg daily.
-She thought the physican's office assistant possibly transcribed the order wrong from the physican's notes.
-She said the physican's office assistant had transcribed orders wrong previously for other residents in the facility.

Interview on 3/17/15 at 3:15pm with Resident #2's physican revealed:
-She was aware of the order on 2/20/15 for Resident #2 to hold Coumadin for 2 days and then give Coumadin 2mg tablet daily.
-She said Resident #2 had unstable angina and should be followed closely.
-She was not aware Resident #2 did not receive the Coumadin 2mg as ordered nor was she aware the Coumadin was not held for 2 days.
-She had been out of the country for several weeks and referred any more questions to her nurse.

Interview on 3/17/15 at 3:30 pm with Resident

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D 358	Continued From page 4 #2's physican's nurse revealed: -She was aware of the physican's order on 2/20/15 for Resident #2 to hold Coumadin for 2 days and then start Coumadin 2mg daily. -The facility called on 3/6/15 and informed her the physican's order for 2/20/15 for Resident #2 was "missed". -Resident #2's primary physican was out of the country and she reported to another physican in the medical practice about the missed order. -The physican had given a new order for Resident #2 on 3/6/15 to continue Coumadin 2.5 mg daily and recheck in 1 week. -It was her expectation the facility would follow the primary physican's order dated 2/20/15 for Resident #2. Interview on 3/17/15 at 3:45 pm with Resident #2 revealed she was unaware of the dose of Coumadin she took daily, but relied on the facility staff for the administration of the Coumadin. Interview on 3/17/15 at 4:15 pm with second shift MA revealed: -She administered Coumadin to Resident #2 daily at 5:00 pm when she worked. -She said the dose of Coumadin for Resident #2 was 2.5 mg daily. -She had not given Coumadin 2mg to Resident #2 in February or March 2015. -She was unfamiliar with the order for Resident #2's Coumadin dose change or the hold for 2 days, until about 2 weeks ago. -The Assistant Resident Care Coordinator (ARCC) found the missed order March 6, 2015 when she was completing the Coumadin audits. -The MA did receive a fax order from Resident #2's physican office on 3/6/15 to "Continue Coumadin 2.5 mg daily and recheck in 1 week". -She processed the order on 3/6/15 for Resident	D 358		

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#2, made 2 copies, and placed in the box for the RCC and the nurse as well as faxed the order to pharmacy.

Interview on 3/18/15 at 10:10 am with the ARCC revealed:
-She had been employed as the ARCC for a few months.
-The facility had a tracking system for residents who were taking Coumadin medication.
-One of her responsibilities was to track the Coumadin orders and document the INR for the residents that were taking Coumadin in the facilty.
-She had completed the Coumadin audit weekly, most of the time.
-She recalled getting busy and missed completing the Coumadin audit two week ago.
-She found the order for Resident #2 dated 2/20/15 to hold Coumadin for 2 days and then give Coumadin 2mg daily on 3/6/15 while completing the Coumadin audit.
-She called the physican office on 3/6/15 to inform the physican the order from 2/20/15 for Resident #2 was not initiated by the staff.
-She said "The order must have been missed".
-She obtained a new order on 3/6/15 from Resident #2's physican office to continue the Coumadin 2.5 mg daily.

Review on 3/18/15 of the facility Medication Variance Report revealed an occurrence form was completed and signed for the missed physican order dated 2/20/15 for Resident #2 in which the Coumadin medication dose change was not initated and the hold of Coumadin for 2 days was missed.

Interview on 3/18/15 at 2:20 pm with the Executive Director (ED).
- She was aware the Coumadin order dated

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2/20/15 for Resident #2 had been missed.
- She was aware the prescribing practitioner had been notified and the order had been clarified by the ARCC.
- She stated the facility would implement an order tracking tool which was formerly used when the facility had paper MARs.
- The tracking tool required two signatures to ensure that orders would not be overlooked.

B. Review of Resident #4's current FL-2 dated 01/08/15 revealed diagnoses included:
- Hypertension
- Mitral Valve Prolapse
- Hyperlipidemia
- Cardiac arrhythmia.

Further review of the current FL-2 revealed medications ordered included:
- Coumadin 1 mg 2 days/week on Tuesdays and Fridays.
- Coumadin 2.5 mg the remaining 5 days/week.

Review of Resident #4's record revealed a signed prescribing practitioner's order dated 01/28/15 included:
- Coumadin 1 mg 2 days/week on Tuesdays and Fridays.
- Coumadin 2.5 mg the remaining 5 days/week.

Further review of Resident #4's record revealed a INR lab result of 1.7 dated 03/09/15 included a signed prescribing practitioner's order for:
- Coumadin 1 mg for 1 day (03/01/15).
- Coumadin 2.5mg for 6 days and to recheck the INR in 1 week.

Continued review of the record revealed a INR lab result of 1.6 dated 03/16/15 included an order to continue the Coumadin as ordered last week:

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D 358	Continued From page 7 - 2.5 mg 6 days/week. - 1 mg 1 day/week and to recheck the INR in one week. Review of Resident #4's January and February 2015 MARs revealed medication had been administered as ordered. Review of Resident #4's March 2015 MAR revealed: -Coumadin 2.5 mg was documented as administered on: March 1 (Sunday) March 2 (Monday) March 4 (Wednesday) March 5 (Thursday) March 7 (Saturday) March 8 (Sunday) March 9 (Monday) March 11 (Wednesday) March 12 (Thursday) March 14 (Saturday) March 15 (Sunday) March 16 (Monday) Review of the March 2015 MAR revealed: -Coumadin 1 mg was documented as administered on March 3 (Tuesday) March 6 (Friday) March 10 (Tuesday) March 13 (Friday) Coumadin 2.5mg was ordered to be administered on Friday, March 13, when 1 mg was documented as administered. Review of the facility's undated Medication Variance Report revealed:	D 358		

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D 358	Continued From page 8 - The medication error had been found during the routine Coumadin audit performed by the Assistant Resident Care Coordinator (ARCC). - The error had been reported to the prescribing practitioner. Interview on 03/18/15 at 10:05 am with the Supervisor revealed: - She did not know how the 03/09/15 order had been overlooked. - She was aware the mistake had been realized by the ARCC while performing the Coumadin audit. - She was the staff member who notified the prescribing practitioner of the mistake and clarified the current order. Interview on 03/18/15 at 3:15 pm with the ARCC revealed: - She noticed the discrepancy on the 03/09/15 Coumadin order while she performed the Coumadin record audit on 03/16/15. - She performed the Coumadin audit about once weekly. - The prescribing practitioner had been notified and the order was clarified by the Supervisor. Interview on 03/18/15 at 10:25 am with the Resident Care Coordinator (RCC) revealed: - She believed the 03/09/15 order had been overlooked by the way it was written on the paper. - The error was found by the ARCC during her weekly Coumadin audit on 03/16/15. - The prescribing practitioner was notified by the SIC and the order was clarified at that time. Interview on 03/18/15 at 2:20 pm the Executive Director (ED) revealed: - She was aware that the 2/20/15 Coumadin order for Resident #4 had been missed.	D 358		

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D 358	Continued From page 9 - She was aware that the prescribing practitioner had been notified and the order had been clarified by the Supervisor. - She stated that the facility would immediately implement an order tracking tool which was formerly used when the facility had paper MARs. - The tracking tool required two signatures to ensure that orders would not be overlooked. Interview on 03/17/15 at 4:07 pm with the prescribing practitioner revealed: - The facility notified her via telephone on 03/16/15 of the missed 03/09/15 Coumadin order. - The order was clarified at that time. Observation on 03/18/15 of the medication on hand for Resident #3 revealed ample Coumadin 1mg and Coumadin 2.5 mg available for administration. Interview on 03/18/15 at 10:20 am with Resident #4 revealed: - She had lived at the facility since January 2015 and very much enjoyed living there. - She was aware Coumadin was one of the medications she took. - She stated routinely her INR was checked in the lab and then the lab telephoned the results to her prescribing Practioner. - The prescribing practitioner then telephoned the facility with orders.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 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	D912		

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D912	Continued From page 10 regulations. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to assure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulation related to Medication Aide training requirements. The findings are: Based on observations, record reviews and interviews, the facility failed to assure 2 of 3 sampled Medication Aides (Staff B and Staff E), who were hired, or began performing Medication Aides duties after 10/01/13, met the requirements for performing Medication Aide duties. [Refer to Tag 0935, 10A NCAC G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (Type B Violation).]	D912		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the	D935		

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D935	Continued From page 11 Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to assure 2 of 3 sampled Medication Aides (Staff B and Staff E), who were hired, or began performing Medication Aides duties after 10/01/13, met the training requirements for performing Medication Aide	D935		

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D935	Continued From page 12 duties. The findings are: A. Review of Staff B's personnel file revealed: -A hire date of 10/3/14 as a Resident Assistant (RA). -A payroll change of position notification from RA to Medication Aide (MA) effective 1/1/15. -Results of successful passage of Medication Aide Testing on 12/16/14. -Medication Skill check list completed on 1/12/15. -There were a number of "Skills" check lists from the 5/10/15 hour Medication Training manual signed and dated on 1/2/15. -There were no 5/10/15 hour Medication Aide Training certificates of completion. -There was no prior MA employment verification. Interview with Staff B on 3/18/15 at 10:45 am revealed: -She had not previously been employed as a MA. -She was first employed as a RA in October 2014. -She took the medication aide test in December 2014, successfully passed the exam and began passing medications as a MA in January 2015. -She stated her training was with the Resident Care Coordinator (RCC) at first at various times and duration. -The RCC would read out of a manual and asked questions regarding the information she was reading. -The only handouts Staff B received was the study guide booklet for testing that she could take home to study. -Both the Nurse Consultant and the RCC watched her pass medications. Refer to interview with the RCC on 3/17/15 at	D935		

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(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
D935	Continued From page 13 4:07 pm and on 3/18/15 at 9:00 am. Refer to interview with the Administrator/RN on 3/17/15 at 3:25 pm and on 3/18/15 at 8:30 am. B. Review of Staff E's personnel file revealed: -A hire date of 5/18/14 as a part-time Resident Assistant (RA) and conversion to full time RA on 7/27/14. -A payroll change of position notification from RA to Medication Aide (MA) effective 11/9/14. -Results of successful passage of Medication Aide Testing on 10/27/14. -Medication Skill check list completed on 10/13/14. -There were no 5/10/15 hour Medication Aide Training certificates of completion. -There were a number of Skills check lists from the 5/10/15 hour Medication Aide Training manual signed and dated on 10/13/14. -There was no prior MA employment verification. Interview with Staff E on 3/17/15 at 3:30 pm revealed: -She did not remember any class room type training from an RN. -She remembered the RCC reading a manual with discussion and/or questions during the reading. -The meetings with the RCC were at different times and of varying duration. Interview with the Nurse Consultant for License Health Professional Support and Medication Skills Checklist on 3/18/15 at 1:12 pm revealed: -She completed Staff E's Medication Skills Checklist, but did not participate in any classroom instruction with Staff B. -She completed the Medication Skills Checklist when notified by the RCC or the Administrator.	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL084004	A. BUILDING: _____ B. WING _____	03/18/2015

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D935	Continued From page 14 -When she came to the facility, the RCC would give her skills check lists for completion during the medication pass. -She did not know where the skills check lists came from, but they were all together in a packet. -She spent approximately one hour on completing the Medication Skills checklist and the other Skills checklists with mostly observation of the medication pass. -She occasionally asked for return demonstration from the prospective MAs. Refer to interview with the RCC on 3/17/15 at 4:07 pm and on 3/18/15 at 9:00 am. Refer to interview with the Administrator/RN on 3/17/15 at 3:25 pm and on 3/18/15 at 8:30 am. --- Interview with the Resdient Care Coordinator on 3/17/15 at 4:07 pm and on 3/18/15 at 9:00 am. revealed: -All prospective Medication Aides are first hired as Resident Assistants. -The staff were asked if anyone was interested in passing medication, and if so, are allowed to shadow a current MA several times to see if they like it and feel as if they can complete the duties of a MA. -She said she printed out the "old online study guide" for the staff to read and take home to study in preparation for the MA test. -She would begin to meet with the prospective MA over the next couple of weeks depending on time and would read through the 10/15 hour manual. -She would hand out the chapter appropiate handouts from the manual and discuss the content. -When all sections are completed, the RCC said	D935		

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D935	Continued From page 15	D935		

she would allow Staff to shadow MA for several medication passes.
-She gave the Staff the link for the online tutorial for the electronic medication administration record system used and required the staff to pass the online test for the system.
-The RCC would let the Administrator or the Nurse Consultant know the staff was ready to complete the Medication Skills Check list, and they usually completed 2-3 medication passes with them.
-The RCC said she did not complete the certificate for the 10/15 hours course and was not aware of the 5 hour course.

Interview with the Administrator/RN on 3/17/15 at 3:25 pm and on 3/18/15 at 8:30 am. revealed:
- She said the RCC holds classes using the course approved by the section (10/15 hours Medication Aides Training course), but did not know to complete the certificates of completion.
-She was not familiar with the 5 hour MA course.
-The Administrator required the prospective MA to work on the floor as a RA for 6-8 weeks before being considered for MA training.
-If Staff expressed a desire to pass medication, she would have them shadow MAs to see if they would like to do that job.
-The RCC was responsible for training with the electronic medication administration records and had the Staff complete the online tutorial and test.
-The RCC reviewed and read all of the 10/15 hours course materials with the prospective MA until all chapters had been completed.
-The RCC notified the Administrator or Nurse Consultant the Staff was ready for completion of the Medication Skills Check list and medication pass observations.
-The Administrator usually took 1-1/2 to 2 hours to complete the medication pass, completing the

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D935	Continued From page 16 10/15 hours Medication Aide Training course Skills Checklist for all categories. -She does not check off insulin administration until they have worked as a medication aide for several weeks. -The facility did not have a printed 5 hour Medication Aide Training manual available for review. _____ The facility provided the following plan of protection on 3/18/15 at 2:00 pm: -All staff records were audited for completion of Medication Aide training requirements. -A mandatory 15 hour Medication Aide Training course for all staff who were found not incompliance was scheduled for 3/19/15. -All new Medication Aides will have the 5 hour class taught by an RN prior to passing medications and have the 10 hour course before 60 days have passed. -The Executive Director will monitor for compliance of training requirements for Medication Aides and assure Certificates of Completion are in the employee files. _____ DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED May 3, 2015.	D935		