Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X3) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074010	A. BUILDING: _____ B. WING _____	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF GREENVILLE	2087 WEST ARLINGTON BOULEVARD GREENVILLE, NC 27834

(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 3/30/16 and 3/31/16.	D 000	Please see attached Plan of Correction.	
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 observation, interview, and record review the facility failed to administer medications for 1 of 5 sampled resident's (Resident #2) who had orders for Mirtazapine (a medication used to treat depression, anxiety, and can help assist with weight gain). The findings are: Review of Resident #2's current FL2 dated 01/22/16 revealed diagnoses of anxiety, degenerative disc disease, dementia, major depressive disorder, delusions, hyperlipidemia, irritable bowel syndrome, osteoporosis, and senile dementia Alzheimer type. Observation of Resident #2 on 03/30/16 at 12:30 PM revealed that she was pacing up and down the hall of the special care unit and was mumbling words that could not be understood. Based on record review, observation, and	D 358		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Megan Panko	Executive Director	4/27/2016

Reviewed + Accepted
Amount for BSN
4/27/16

DHSR Annual Survey March 31, 2016
Spring Arbor of Greenville HAL-074-010, Pitt County
Plan of Correction

10A NCAC 13F .1004(a) Medication Administration
It is Spring Arbor of Greenville's policy to comply with all state rules and regulations regarding medication administration. All Medication Aides and licensed nurses were In-Serviced on Spring Arbor's Policy on medication administration (5 April 2016) by a RN that included our protocol for processing new orders ensuring timely delivery of resident's medications, and the availability of each of these medications. Implementation of a New Order Tracking System will ensure on-going compliance of these regulations and documentation. This system is to ensure all new medication orders received in the community are transcribed to the Medication Administration Record and all medications are received /delivered from the pharmacy for administration to the resident.
On-going compliance will be conducted to confirm accuracy by the Resident Care Coordinator and Cottage Care Coordinator utilizing the Weekly Monitoring Log to document compliance in the above areas. They will document their weekly reviews and submit to the Executive Director monthly for her review.

Completion Date: 18 April 2016

GS 131D-4.5B (b) ACH Medication Aides; Training and Competency
It is Spring Arbor of Greenville's policy to comply with all state rules and regulations regarding medications administration. All employee files will be reviewed and audited using the Perpetual Staff Log. Additionally, a Personnel Check List will be used for all current and new employees to ensure on-going compliance in employee training and competency. This system will demonstrate documentation by the hiring manager, Resident Care Coordinator and/or Cottage Care Coordinator, then be reviewed for completion by the Business Office Manager.

Completion Date: 1 May 2016

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interview, Resident #2 was determined to not be interviewable.

Review of Resident #2's record revealed there was an order for Mirtazapine (a medication used to treat depression, anxiety, and can help assist with weight gain) 7.5 milligrams 1 tablet at bedtime.

Observation of Resident #2's medications on hand on 03/31/16 revealed there was no Mirtazapine available on hand.

Review of Resident #2's care notes on 03/30/16 revealed:
-A Medication Aide had documented that Resident #2 had returned from the medical doctor's office with one new prescription for Remeron (another name used for Mirtazapine).
-She had faxed the orders to the pharmacy on 03/02/16 at 4:25 PM.

Review of Resident #2's March Medication Administration Record (MAR) revealed that there was no entry for Mirtazapine on the MAR and none had been administered.

Review of the documented weights for the facility revealed:
-On 02/13/16 the Resident weighed 100 pounds.
-On 03/01/16 the Resident weighed 96 pounds.
-On 03/31/16 the Resident weighed 93 pounds.

Telephone interview with a Registered Nurse at the Primary doctor's office on 03/31/16 at 9:22 AM revealed:
-The doctor's office had not been made aware of the Resident's weight loss.
-The doctor did want the Resident to be taking Mirtazapine (a medication used to treat

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depression, anxiety, and can help assist with weight gain) as ordered by her psychiatrist.
-The doctor's office was not made aware that the Mirtazapine had not been given until 03/30/16.
-The doctor does expect the facility to notify him of any weight loss and medications that have been ordered but not been given.

Telephone interview with the Psychiatrist on 03/31/16 at 10:53 AM revealed:
-He was the prescribing doctor for the Mirtazapine.
-He did expect the resident to be on this medication.
-He prescribed this medication to help with her history of depression and assist with weight gain.
- He was not aware that the medication had not been given until his office was notified on 03/30/16.

Interview with a Medication Aide (MA) on 03/31/16 at 3:09 PM revealed:
-The MAs are responsible that medication orders are sent from the facility to the pharmacy.
-They usually fax the orders over to the pharmacy and then the pharmacy transcribes those orders to the medication administration record.
-Then the Resident Care Coordinator or the Cottage Care Coordinator does periodic reviews of the charts to make sure the orders are being followed.
-She will fax the orders to the pharmacy as soon as they are received by the facility.

Telephone interview with a Pharmacist at the facility's contracted pharmacy provider on 03/31/16 at 4:00 PM revealed:
-The pharmacy did not receive the order dated for 03/02/16 until 03/30/16 at 2:45 PM.
-The Mirtazapine was not dispensed until

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D 358	Continued From page 3 03/30/16. Interview with the Cottage Care Coordinator (CCC) on 03/31/16 at 11:33 AM revealed: -It is the Medication Aide on duty responsibility to send any orders that come in to the pharmacy via fax. -The Medication Aides were to put a temporary order on the Medication Administration Record until the pharmacy goes in and changes that order. -The Medication Aide is to make a copy of that order and put in the CCC's box for review. -She did not ever receive the order for Mirtazapine for Resident #2 in her box. -The Medication Aide for that shift and she had overlooked the order when it was received by the facility. -The order was never faxed to the pharmacy. Interview with the Executive Director on 03/31/16 at 4:10 PM revealed: -The Medication Aides were responsible for signing and dating the order when it is received. -The Medication Aides were to fax the orders to the pharmacy. -After faxed to the pharmacy it goes in a second box. -The next Medication Aide coming on is to take it from the box and then sign and date it and place in the third box. -The Cottage Care Coordinator or Resident Care Coordinator then takes the order from the third box and sign and reviews the order. -The order is then placed into a fourth box. -Once in the fourth box the next Medication Aide coming in is to sign date and place in the chart. -The Cottage Care Coordinator and the Resident Care Coordinator were responsible for making sure that all orders are done using these steps.	D 358		

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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 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.	D935		

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D935	Continued From page 5 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: Based on record review and interview, the facility failed to assure 1 of 6 sampled staff (Staff D) had completed Medication Aide written exam and completed 5 hour or 15 hour training prior to administering medications and completed the additional 10 hour training, if necessary, and pass the written medication exam within 60 days of hire. The findings are: Review of Staff D's Personnel File revealed: -Staff D had a Medication Clinical Skills dated for 06/25/15. -There was no documentation that Staff D had medication training. -There was no documentation that Staff D had taken the state medication exam. Review of Staff D's time logs revealed that since 06/26/15 Staff D had worked as a Medication Aide passing medications to residents on all shifts. Interview with Staff D on 03/31/16 at 2:53 PM revealed: -She believed that she got her Medication Aide training done in March 2015. -Since she has been trained she mostly worked on the medication cart as a Medication Aide. -There was an old Resident Care Coordinator who no longer works with the company that did	D935		

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her medication training.
-She has not ever taken the state medication exam.
-She thought that she had one year from the time that she was trained to take the exam.
-She had functioned as a Medication Aide on the assisted living area and the special car unit.
-She had administered insulin to some resident's since she has been a Medication Aide.
-She had also administered some as needed narcotic medications to some resident's since she had been a Medication Aide.

Interview with the Cottage Care Coordinator (CCC) on 03/31/16 at 2:10 PM revealed:
-She took Staff D off the medication cart today due to Staff D never taking the state medication exam.
-She was not aware that Staff D had not taken the medication exam.
-Staff D did receive her medication training in July of 2015.
-Staff D had only been working on the medication cart since she finished her training in July of 2015.
-She felt that Staff D took the 15 hour medication training course.

Interview with the Administrator on 03/31/16 at 2:18 PM revealed:
-The Cottage Care Coordinator (CCC) is responsible for checking the personnel charts to make sure the staff have had their training and had taken all required state exams.
-Staff D was pulled off the medication cart today due to her not taking the state medication exam.
-Staff D will not be working on the cart anymore until she has been retrained and has completed the state medication exam.
-Staff D had taken her medication training back in

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D935	Continued From page 7 June 2015. -She was not aware until today the Staff D had not taken her state medication exam.	D935		