STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001029	A. BUILDING: _____ B. WING _____	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGVIEW - STEWART BUILDING	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 a follow-up survey on 01/23/20.	{D 000}		
{D 276}	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: The facility failed to assure physician notification for 1 of 3 sampled residents (Resident #1) who had specific parameters of blood pressure (BP) notifications ordered. The findings are: Review of Resident #1's current FL2 dated 12/10/19 revealed: -Diagnoses included multi-infarct dementia, diabetes and hypertension. -There was an order to check BP every day and to notify the physician if systolic blood pressure (SBP) > (greater than) 120 or diastolic blood pressure (DBP) > (greater than) 110, SBP < (less	{D 276}		

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{D 276}	Continued From page 1 than) 90 or DBP < (less than) 50. Review of Resident #1's physician' order dated 03/19/19 revealed to call MD if SBP over 210 or DBP over 110 or if SBP less than 90 or DBP less than 50. Review of Resident #1's November 2019 Medication Administration Record (MAR) revealed: -There was an entry to check blood pressure once daily and record. Call MD if SBP > 120, DBP > 110, SBP <90 or DBP < 50. -Resident #1's SBP was documented as greater than 120 every day from 11/01/19 through 11/31/19 with examples as follows: 11/01/19 = 169/88 11/03/19 = 121/94 11/20/19 = 123/79 11/25/19 = 178/76 11/29/19 = 178/88. -There was no documentation on the November 2019 MAR that the physician was notified of SBP greater than 120. Review of Resident #1's December 2019 MAR revealed: -There was an entry to check blood pressure once daily and record. Call MD if SBP > 120, DBP > 110, SBP < 90 or DBP <50. -Resident #1's SBP was documented as greater than 120 every day from 12/01/19 through 12/31/19 with examples as follows: 12/01/19 = 174/99 12/04/19 = 178/99 12/15/19 = 198/91 12/22/19 = 168/77 12/27/19 = 184/94. -There was no documentation on the December 2019 MAR that the physician was notified of SBP	{D 276}		

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{D 276}	Continued From page 2 greater than 120. Review of Resident #1's January 2020 MAR revealed; -There was an entry to check blood pressure once daily and record. Call MD if SBP > 120, DBP > 110, SBP < 90 or DBP < 50. Resident #1's SBP was documented as greater than 120 every day from 01/01/20 through 01/23/20 with examples as follows: 01/01/20 = 169/80 01/06/20 = 166/91 01/08/20 = 183/78 01/17/20 = 188/96 01/23/20 = 179/65. -There was no documentation on the January 2020 MAR that the physician was notified of SBP greater than 120. Interview with a representative from the contracted pharmacy on 01/23/20 at 12:20pm revealed: -The current order in the electronic MAR system was check blood pressure once daily and record. Call MD if SBP greater than 120, DBP greater than 110, SBP less than 90 or DBP less than 50. -The pharmacy had a signed physician's order dated 03/19/19 which was to call MD if SBP over 210 or DBP over 110 or if SBP less than 90 or DBP less than 50. -The pharmacy staff had entered the order incorrectly. Interview with Resident #1's primary care provider (PCP) on 01/23/20 at 1:00pm revealed: -The order dated 03/19/19 was to call MD if SBP over 210 or DBP over 110 or if SBP less than 90 or DBP less than 50 was the most current order for BP parameters for Resident #1. -The orders on the FL2 had been printed from the	{D 276}		

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{D 276}	Continued From page 3	{D 276}		

current orders in the electronic MAR system.
-The order in the electronic MAR system was for check blood pressure once daily and record. Call MD if SBP greater than 120, DBP greater than 110, SBP less than 90 or DBP less than 50.
-She signed the order on Resident #1's current FL2 dated 12/10/19 for check blood pressure (BP) every day and to notify the physician if systolic blood pressure (SBP) greater than 120 or diastolic blood pressure (DBP) greater than 110, SBP less than 90 or DBP less than 50, as an oversight, "I should have caught that".
-She had not been notified by the facility of any questions or concerns about Resident #1's SBP.
-Her expectation was that facility staff followed orders as written, and to clarify any orders that were questionable.

Interview with the Medication Aide (MA) on duty on 01/23/20 at 4:10pm revealed:
-She administered medications and treatments for residents based on the electronic MAR system.
-She never noticed the BP parameters for notification of the PCP for the BP order for Resident #1 before.
-She had never notified the PCP of Resident #1's SBP > 120.
-The Resident Care Coordinator (RCC) was responsible for checking the electronic MARs monthly.
-The electronic MAR check was last performed on the first day of January 2020.

Interview with the RCC on 01/23/20 at 3:30pm revealed:
-She checked the orders monthly for each resident for accuracy.
-If a discrepancy concerning an order was noted, she would call the pharmacy to verify the order.

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{D 276}	Continued From page 4 -She had not noticded the BP order for Resident #1 was to notify the provider for a SBP greater than 120. -She had not noticed the staff had not called the MD with the BP parameters as ordered. -"I guess I overlooked it". Interview with Resident #1 on 01/23/20 at 3:30 pm revealed: -Staff checked her BP daily. -Facility staff would tell her the BP reading each time, but she did not remember the results. -She did not know if staff had ever notified the PCP of BP results.	{D 276}		