STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065014	A. BUILDING: _____ B. WING _____	R 03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF WILMINGTON	809 JOHN D BARRY DRIVE WILMINGTON, NC 28412

(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 03/11/20 to 03/12/20.	{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: Based on observations, interviews, and record reviews, the facility failed to implement physician's orders for 1 of 5 sampled residents regarding the application and removal of thromboembolic deterrent hose (Resident #4). The findings are: Review of Resident #4's current FL-2 dated 10/14/19 revealed diagnoses included Alzheimer's disease and venous insufficiency. Review of Resident #4's signed physician's orders dated 03/10/20 revealed an order to apply thromboembolic deterrent hose (TED hose) daily	{D 276}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Angela E. Crawson ED TITLE (X6) DATE 4/7/2020

Mary R. Agena

Reviewed and accepted on 04/08/20 by Mary Agena/MA

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{D 276}	Continued From page 1 as needed for swelling. Review of Resident #4's current Care Plan dated 08/21/19 revealed she was totally dependent on staff for dressing. Observation of Resident #4 on 03/11/20 at between 9 30am and 10:30am revealed: -Resident #4 did not have TED hose on her legs. -Resident #4 was ambulating with her walker wearing white athletic socks and tennis shoes on both feet. -Resident #4's lower extremities from the knees to ankles were swollen. Observation of Resident #4 on 03/12/20 at between 10:00am and 11:30am revealed: -Resident #4 did not have TED hose on her legs. -Resident #4 was ambulating with her walker wearing white athletic socks and tennis shoes on both feet. -Resident #4's lower extremities from the knees to ankles were swollen. Review of Resident #4's January 2020 electronic Medication Administration Record (eMAR) revealed: -There was an entry to apply TED hose daily as needed for swelling. -There was no documentation TED hose had been applied the entire month. Review of Resident #4's February 2020 electronic Medication Administration Record (eMAR) revealed: -There was an entry to apply TED hose daily as needed for swelling. -There was no documentation TED hose had been applied the entire month.	{D 276}		

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{D 276}	Continued From page 2 Review of Resident #4's March 2020 electronic Medication Administration Record (eMAR) revealed: -There was an entry to apply TED hose daily as needed for swelling. -There was no documentation TED hose had been applied the entire month. Telephone interview with Resident #4's responsible party (RP) on 03/12/20 at 10:55am revealed: -She visited Resident #4 twice a week. -When she visited Resident #4 earlier this week Resident #4's legs were swollen. -Resident #4 wore TED hose in the past, but she was not good about keeping them on. -Resident #4 needed to wear TED hose when her legs were swollen to decrease the swelling and improve circulation. -She did not know when she last saw Resident #4 wearing TED hose. -She did not know Resident #4 had an order for TED hose. Interview with a first shift medication aide (MA) on 03/11/20 at 3:45pm revealed: -She did not know Resident #4 had an order for TED hose for swelling as needed. -She saw Resident #4 had swollen legs when it was brought to her attention. -She was not able to find Resident #4's TED hose on the medication cart or in Resident #4's room. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/12/20 at 9:30am revealed: -The pharmacy had received a hand-written physician order on 07/20/19 for TED hose to be applied as needed for swelling. -The order was entered into Resident #4's profile	{D 276}		

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{D 276}	Continued From page 3 on 07/20/19. -The pharmacy did not dispense TED hose to the facility because there was no record of measurements of the resident's calves, ankles, and length of her legs. -The facility had contacted the pharmacy yesterday (03/11/20) requesting what was needed in order to get the TED hose sent for Resident #4. Telephone interview with Resident #4's Primary Care Provider (PCP) nurse on 03/12/20 at 10:45am revealed: -Resident #4 had a physician order for TED hose as needed for swelling. -Resident #4 needed to wear TED hose to decrease swelling and improve circulation in her lower extremities. Interview with the Special Care Unit Coordinator on 03/11/20 at 1:21pm revealed: -The MAs were responsible for ensuring Resident #4's TED hose were applied when needed. -All physician orders for TED hose were supposed to be faxed to the pharmacy. -The pharmacy entered the order into Resident #4's profile and the third shift MAs reviewed the order when the TED hose were received from the pharmacy. -She would verify and initiate the order using a two person check with the Resident Care Coordinator the next day. -The third shift MAs performed monthly medication cart audits to ensure all orders on Resident #4's eMAR were being followed and items like TED hose were available as needed. -She did not know Resident #4 did not have TED hose available until she looked for them this afternoon (03/11/20). -The MAs did not inform her Resident #4 needed TED hose.	{D 276}		

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{D 276}	Continued From page 4 Interview with the Administrator on 03/12/20 at 12:02pm revealed: -The MAs were responsible for ensuring all physician orders were followed. -The MAs were supposed to apply TED hose when Resident #4's legs were swollen. -She did not know Resident #4 did not have TED hose. -When monthly medication cart audits were completed the MAs were to reorder the TED hose if Resident #4 did not have them. -She did not know why Resident #4's TED hose were not ordered. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable.	{D 276}		

PLAN OF CORRECTION for Follow Up Survey completed 3/12/20.

Spring Arbor of Wilmington

HAL-065-014

New Hanover County

It is Spring Arbor of Wilmington's policy and standard practice to comply with all North Carolina Adult Care rules and regulations.

10A NCAC 13F. 0902 (c) (3-4) Health Care

(c) The facility shall assure documentations 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.

Plan of Correction

Resident # 4 has an order to apply Thromboembolic Deterrent Hose. Her order states" Thermafirm Knee High Support" (TED hose) daily as needed for swelling.

Immediately upon being made aware that this resident did not have her Ted Hose available in house for an as needed order, the community contacted the pharmacy to ensure they had received the faxed order with the resident's measurements for TED Hose. Pharmacy manager verified they did and that the Ted Hose would be sent out that evening to community to have for resident as needed order.

An in-service was held with an urgent call to action for our Medication Aides (MA) and Supervisors in Charge (SIC) on Physician Order Clarifications-Our Process \ System conducted by our Regional Nurse on 3/11/20. Re-education for the MA's and SIC's to act upon all physician orders in a prompt, systematic and efficient manner to ensure medication and/or treatment supplies are delivered promptly this in-service was done by the Regional Nurse. Additional in-services were conducted on 3/13/20 and 3/17/20 regarding Physician Order Clarifications – Our Process \ System. Care givers and MAs were trained on the Resident Care Plan Overview Form developed to enhance communication with care givers.

Prevention of Re-occurrence

Implemented Individualized Resident Care Plan Overviews for each resident to communicate with care givers the specific care needs of each resident. The Resident Care Plan Overview Form is kept in the PCS / ADL log- book for review and initial tasks completed each shift by care givers. These Resident Care Plan Overview forms for each resident are updated when needs and orders change for that resident relevant to the care giver responsibilities.

The SIC's will verify each morning prior to Stand -Up that every resident with a physician's order for TED hose have TED hose and are available for use as indicated by the physician's order. These orders are discussed with the Executive Director, Care Coordinator and SIC each morning in Stand-Up.

Monitoring Responsibility and Frequency

The Care Coordinator or designee will verify that TED hose is available bi-weekly for a month and then weekly with the Med Cart Audit and then as needed.

The Regional Nurse and Regional Director will confirm this compliance during their on-site visits and will support and reinforce education as needed.

Correction Completion Date 4/1/2020

Angela E Crowson ED