STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL084010	A. BUILDING: _____ B. WING _____	C 10/13/2021

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 from 10/12/21 to 10/13/21.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure referral and follow up to meet the healthcare needs for 1 of 5 sampled residents (#1), related to a resident who had orders for daily weights with parameters of an increase of 3 pounds (lbs) in one day or 5 lbs in one week. The findings are: 1. Review of Resident #1's current FL2 dated 01/13/21 revealed: -Diagnoses included cardiac arrhythmia, coronary artery disease (CAD), chronic kidney disease (CKD) and deep vein thrombosis (DVT) of the right lower leg. -Resident #1 ambulated independently in a wheelchair. Review of Resident #1's Care Plan dated 04/29/21 documented the resident required assistance for transfers. Review of Resident #1's physician's order dated 06/25/21 revealed: -There was an order for daily weights. -If there was a 3lb increase in 24 hours or a 5lb	D 273		

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D 273	Continued From page 1 increase in one week, the primary care physician (PCP) should be notified. Review of Resident #1's electronic medication administration record (eMAR), from 08/01/21 through 10/11/21 revealed: -There was an entry for daily weights, notify the physician if the resident had a weight gain of 3lbs in 24 hours or 5lbs in one week. -There was documentation from 08/01/21 through 10/10/21 the resident was not weighed daily. -The eMAR note for exceptions documented the resident refused to be weighed. Observation in the facility's activity room on 10/13/21 at 11:20am revealed a weight chair with arm rests that could be raised, used to measure the residents' weights. Interview with a first shift medication aide (MA) on 10/13/21 at 12:05pm revealed: -Resident #1 was scheduled to be weighed at 6:00am on third shift. -She knew he refused to be weighed regularly because there was shift report from third shift every morning . -There was no directive to re-approach Resident #1 to weigh him during first shift. -Resident #1 was unable to stand on the bathroom scale in the medication room. -She did not know if he was able to transfer to the weight chair in the activity room. -She did not know why he had orders to be weighed. -She had never contacted the physician to report Resident #1's refusal to be weighed. -She did not know if there was a policy for notifying the PCP if a resident refused to be weighed daily.	D 273		

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D 273	Continued From page 2	D 273		

Interview with the third shift MA on 10/13/21 at 2:40pm revealed:
-It was her responsibility to assist the personal care aides (PCAs) in getting the residents up and dressed on third shift.
-She knew Resident #1 had orders to be weighed daily, but he refused.
-She documented the refusals in the eMARs.
-He was often confused in the morning and did not remember that she asked him to be weighed.
-She was not directed to inform anyone else of the refusals.
-She did not notify the physician of the resident's refusals to be weighed.

Interview with the assistant Resident Care Coordinator (ARCC) on 10/13/21 at 1:50pm revealed:
-Third shift staff assisted Resident #1 with dressing, toileting and weighing him daily.
-The staff used a sliding board to transfer the resident from the bed to the wheelchair.
-He was very unsteady in a standing position stating his legs were weak.
-He could not move his feet to pivot during transfers.
-She knew he refused to get weighed in the morning.
-He could not stand on the bathroom scale and did not like the weight chair.
-He had not been able to stand independently since before his last hospital visit in July 2021.
-She did not notify the physician that he was refusing to be weighed.
-She did not know of any policy to notify the physician if a resident refused to be weighed.

Interview with Resident #1 on 10/13/21 at 2:10pm revealed:
-He remembered being asked to take monthly

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weights, but he did not remember the staff telling him the physician ordered daily weights.
-He did not remember the physician discussing this with him at their last office visit.
-He had never refused to be weighed and does not remember the staff asking him to be weighed daily

Telephone interview with Resident #1's responsible family member on 10/13/21 at 1:32pm revealed:
-The resident had an order for daily weights to be taken due to a diagnoses of chronic kidney disease related to diabetes mellitus.
-The PCP wanted to ensure the resident was not taking on extra fluid.
-He was not aware the staff were not weighing him daily due to his refusals.
-He thought the PCP weighed him during their visits but was not sure when his last visit was.

Interview with the former RCC on 10/13/21 at 12:50pm revealed:
-She was training the current RCC during this transition of roles.
-She did not know Resident #1 was refusing to be weighed daily as ordered.
-It was the responsibility of the MAs to inform the RCC if a resident was refusing medications or other physician's orders.
-She would then notify the physician and wait for new orders.
-She had not notified the resident's PCP of the weight refusals.
-The community did not have a policy on weight or treatment refusals, just on medication refusals.

Interview with the Executive Director on 10/13/21 at 2:40pm revealed:
-She did not know Resident #1 had refused to

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D 273	Continued From page 4 have his weight taken daily as ordered. -She expected the MAs to report the refusals to the RCC in a timely manner. -The RCC should also be reviewing the eMARS monthly for refusals and follow up with the resident and the physician. -She expected the PCP to be notified of a resident's refusal of a physician order, but the facility did not have a policy on refusals of daily weights and when the physician should be notified. Attempted telephone interview with the PCP on 10/13/21 at 1:10pm was unsuccessful.	D 273		