STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065046	A. BUILDING: _____ B. WING _____	R 07/03/2024

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 July 2-3, 2024.	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, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#2) including a medication to treat infection. The findings are: Review of Resident #2's current FL-2 dated 08/04/23 revealed diagnoses included Parkinson's disease, coronary artery disease, depression, failure to thrive, restless leg syndrome, anxiety, and underweight. Review of Resident #2's after visit summary from a local hospital dated 06/18/24 revealed: -There was a diagnosis of a neck infection. -There was an order for Augmentin 875-125mg twice daily for 8 days (Augmentin is an antibiotic used to treat infection). -There was a prescription for Augmentin 875-125mg twice daily for 8 days attached to the	D 358		

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D 358	Continued From page 1 after-visit summary. Interview with Resident #2's family member on 07/02/24 at 8:00am revealed: -A hospice nurse called her on 06/16/24 at 10:00am and said that Resident #2 was not as responsive, lethargic, had a low-grade fever, and had swelling to the left side of her face. -The family member requested Resident #2 be sent to the emergency room for evaluation. -Resident #2 was admitted to the hospital on 06/16/24. -Resident #2 was discharged from the hospital on 06/18/24. -The Resident Care Director (RCD) received the hospital discharge documentation from the ambulance staff. -The family member spoke with a hospice nurse on 06/21/24 about the resident's antibiotic because it had not been started yet. -The hospice nurse helped to facilitate getting the antibiotic from the backup pharmacy on 06/21/24 and had the medication changed to a liquid. -The daughter picked up the antibiotic from the backup pharmacy on 06/21/24 and delivered it to the facility around 9:00pm. -Resident #2 did not get her first dose of the antibiotic until 06/22/24. -The Administrator found the discharge paperwork for Resident #2 on the RCD's desk. Review of Resident #2's June 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Augmentin 600-42.9mg/5ml 7.3ml twice daily at 8:00am and 8:00pm. -Augmentin 600-42.9mg/5ml 7.3ml was documented as administered at 8:00am on 06/23/24-06/24/24 and 06/26/24-06/28/24.	D 358		

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D 358	Continued From page 2 -Augmentin 600-42.9mg/5ml 7.3ml was documented with a (zero and a line through the zero) as not administered at 8:00am on 06/22/24 and 06/25/24. -There was documentation on the eMAR in the medication notes for 06/22/24 and 06/25/24 that Resident #2 was unable to take the medication. -Augmentin 600-42.9mg/5ml 7.3ml was documented as administered at 8:00pm on 06/22/24-06/29/24. Interview with Resident #2's hospice nurse on 07/02/24 at 3:25pm and 07/03/24 at 9:04am revealed: -She had helped facilitate Resident #2 obtaining her antibiotic on 06/21/24 after the daughter had talked to her about a blood culture report. -She had talked with the Administrator on 06/21/24 about Resident #2's discharge papers from the hospital. -The Administrator located the discharge papers on the RCD's desk and found the order for the Augmentin. Telephone interview with the facility's contracted pharmacy technician on 07/03/24 at 10:20am revealed: -A prescription for Resident #2 for Augmentin 875-125mg twice daily for 8 days was written on 06/18/24. -The prescription for Augmentin 875-125mg was faxed to the pharmacy on 06/21/24 at 3:34pm. -Augmentin 875-125mg was dispensed to the facility on 06/21/24. -The order for Augmentin 875-125mg was changed to liquid Augmentin 600-42.9mg per ml administer 7.3ml twice daily for 8 days on 06/21/24 after hours and was dispensed to the facility on 06/22/24.	D 358		

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D 358	Continued From page 3 Interview with a medication aide (MA) on 07/03/24 at 10:35am revealed: -The MAs documented on the new order tracking form when a resident had new, changed, or discontinued medications. -All orders were faxed to the pharmacy, or they called the backup pharmacy. -All the discharge paperwork from a hospital was faxed to the pharmacy, documented on the tracking form and copies of it and the fax sheet were attached to the tracking form. -The RCD or Assistant Resident Care Director (ARCD) reviewed the tracking form and signed and dated it. Review of Resident #2's new order tracking form dated 06/21/24 revealed: -Resident #2's Augmentin order for 600-42.9mg/ml was received and faxed to the pharmacy and sent to the backup pharmacy on 06/21/24 at 8:04pm. -Medication "delivered and correct" was dated 06/21/24 at 8:04pm. -Pending order was accepted in the eMAR on 06/21/24 at 10:15pm. Interview with the RCD on 07/03/24 at 1:50pm revealed: -The new order tracking form was implemented in May 2024. -A copy of the tracking form, order, and fax sheet were made for all orders. -If the provider sent an order to the pharmacy the tracking form would be implemented as soon as the facility knew about the new order. -She received a call before 12:00pm on 06/18/24 that Resident #2 would be returning from the hospital, that she would need to be on antibiotics, and a family member would be picking up the Augmentin.	D 358		

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D 358	Continued From page 4 -She had not notified staff that Resident #2 would be on Augmentin. -Resident #2 arrived after 5:00pm and she and the MA checked on the resident when she arrived at the facility. -She did not sign a form from the transport service that she was receiving Resident #2. -She was not sure who received Resident #2's paperwork from the transport team. -The receptionist was who normally received the paperwork and then handed it to a MA. -She did not know why Resident #2 Augmentin was not started when she was discharged from the hospital. Review of the transport team's handoff care document on 06/18/24 at 5:03pm revealed that the RCD had signed that she had received a verbal report, personal effects, records, and equipment for Resident #2. Interview with the ARCD on 07/02/24 4:38pm revealed: -The MAs were responsible for sending new orders to the pharmacy or the RCD and herself could. -The new orders were not removed from pending status until the medication was available in the facility. -All pending orders should be available within 24 hours. -The RCD was responsible for reviewing all documents from the hospital. -She was not sure who had received the documents from the hospital for Resident #2. Interview with the Administrator on 07/02/24 at 4:14pm and 07/03/24 at 2:05pm revealed: -The MAs received the report on residents returning from the hospital or other appointments.	D 358		

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D 358	Continued From page 5 -The MAs sent orders to the pharmacy then the ARCD and the RCD followed up to make sure the medications arrived within 24 hours. -The pharmacy placed the orders in pending status and we two MAs and the ARCD, RCD, and herself could remove the pending status. -She did not know that Resident #2 had been ordered Augmentin until the hospice nurse asked her about the medication on 06/21/24. -She had found Resident #2's discharge paperwork on the RCD's desk in a stack of papers. -The MA faxed the documents to the pharmacy. -The hospice nurse helped to facilitate getting the Augmentin changed to a liquid. -Antibiotics were very important and there was a delay in starting them for Resident #2. -The ARCD and the RCD had been faxing the orders to pharmacy which was not the facility's process. Telephone interview with the facility's contracted pharmacist on 07/03/24 revealed: -It would have taken 1-2 days for the Augmentin to get into Resident #2's system to obtain the full effect. -There would be an increase in negative outcomes by waiting until 06/22/24 to start the antibiotic. -The delay in starting Resident #2's Augmentin would decrease the effect of the medication. Attempted telephone interview with Resident #2's hospice provider on 07/03/24 at 9:30am was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable.	D 358		