STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl032171	A. BUILDING: _____ B. WING _____	R 02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGDAILE ASSISTED LIVING	4315 HOLDER ROAD DURHAM, NC 27703

(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
C 000	Initial Comments The Adult Care Licensure section conducted an annual and follow-up survey survey on 02/06/2025.	C 000	In response to the compliance concern regarding FL2 procedures, we have implemented a new policy to ensure staff adherence and regulatory compliance. The following corrective actions have been established:	2/12/2025
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify an order for 1 of 3 residents sampled (#1) including an anti-psychotic medication. The findings are: Review of Resident #1's current FL-2 dated 01/23/25 revealed: -Diagnoses included schizoaffective disorder, obsessive compulsive disorder, depression, and mild intellectual disabilities. -There was an order for clozapine 100mg (used to manage hallucinations and delusions related to schizophrenia) 2 tablets at bedtime. -The FL-2 was received by the facility on	C 315	1. **Staff Notification** - All FL2 staff members are required to promptly contact the administrator upon receiving a new FL2 form. 2. **Pharmacy Communication** - Staff will fax the FL2 form to the pharmacy immediately to ensure timely medication updates. 3. **Verfication Process** - Staff will match the FL2 form with the MAR (Medication Administration Record) to confirm accuracy and compliance. 4. **Administrative Oversight**- The administrator will follow up within 24 hours of receiving a new FL2 form to ensure that all necessary actions have been completed. This policy has been communicated to all relevant staff, and ongoing training will be provided once a month for six months to ensure accuracy and compliance with the rules and regulations of the State of North Carolina.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angelica Rambert | TITLE: Administrator | (X6) DATE: 02/12/2025

Received and Acknowleged 02/14/2025

Janet Thornburg

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C 315	Continued From page 1 01/30/25. Review of Resident #1's signed physician's order dated 01/14/25 revealed there was an order to increase clozapine 100mg to 3 tablets at bedtime. Review of Resident #1's January 2024 medication administration record (MAR) from 01/15/25 to 01/31/25 revealed: -There was an entry for clozapine 100mg take 3 tablets every night. -There was documentation clozapine 3 tablets was administered each night. Review of Resident #1's February 2024 MAR from 02/01/25 to 02/06/25 revealed: -There was an entry for clozapine 100mg take 3 tablets every night. -There was documentation clozapine 3 tablets was administered every night. Review of Resident #1's record revealed there was no documentation the primary care provider (PCP) was contacted to clarify the dosage of clozapine. Observation of Resident #1's medication on hand on 02/06/25 at 10:30am revealed there was a bottle containing 116 of 180 clozapine 100mg tablets available for administration with a dispensed date of 01/14/25. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 02/06/25 at 11:04am revealed: -Resident #1 had an order for clozapine 100mg 3 tablets at night dated 01/14/25. -The pharmacy did not receive the FL-2 dated 01/23/25 for Resident #1. -The pharmacy accepted FL-2s as orders.	C 315		

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C 315	Continued From page 2 -If the pharmacy had received the FL-2 dated 01/23/25 and noticed the discrepancy in the clozapine, they would have notified the PCP for clarification. Telephone interview with a representative from Resident #1's mental health provider (MHP) on 02/06/25 at 10:15am revealed: -Resident #1's clozapine 100mg was increased to 3 tablets at night on 01/14/25. -Resident #1 should take clozapine 100mg 3 tablets every night to help control her thought process. -The MHP did not complete the FL-2s, the PCP would complete them. -The PCP could see all medication changes made by the MHP in the computer system when completing the FL-2. Interview with a medication aide (MA) on 2/06/25 at 10:45am revealed: -When he received the FL-2 he compared the medications on the FL-2 with the MAR for accuracy. -If he noticed a discrepancy, he would look in the chart for the current order. -He would notify the administrator for discrepancies. -He did not fax FL-2s to the pharmacy. -He was not working when Resident #1's FL-2 dated 01/23/30 was faxed to the facility. Interview with the Administrator on 02/06/24 at 10:50am revealed: -The FL-2 was sent to the PCP on 09/03/24 to be completed and returned to the facility. -The FL-2 was faxed to the facility on 01/30/25. -The order to increase the clozapine was received from the MHP before the FL-2 was completed.	C 315		

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C 315	Continued From page 3 -The MAs should compare the FL-2 with the MAR to ensure they were the same. -The MA should notify the PCP if there was a discrepancy for clarification. -The MA should fax the FL-2 to the pharmacy. Attempted telephone interview with Resident #1's PCP on 02/06/25 at 10:43am was unsuccessful.	C 315		