	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL032013	B. WING		07/23/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE	1 077	
SPRING A	RBOR OF DURHAM	4523 HO	PE VALLEY RO			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X COMP DA
D 000	Initial Comments		D 000		:	-
		ure Section conducted an 21, 2015 - July 23, 2015.				
	10A NCAC 13F .0305 (h) The requirements exits are:	for outside entrances and	D 067	It is the Community's standa practice to comply with the relicensure rule. Procedures hamodified.  D 067 10A NCAC 13F .0305	eferenced ave been	
	(4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel.			Physical Environment  Plan of Correction: Immediately expanded require ALL staff, the responsibility to ally acknowledge the alarm a exterior door by immediately appropriate door for investigation of the each exterior door to allow for volume that can be heard by regardless of their current local controls.	rement to o physic- it each going to ation. stalled on r sufficient all staff	
f y s o	Based on interview and ailed to assure all 9 exi were loud enough to be showering residents for			Prevention of Reoccurrence: Maintenance Director to mon functionality and compliance.  Monitor Responsibility and Fr Maintenance Director, Reside Coordinator and Executive Di monitor on an ongoing basis.	equency: ent Care	
re "i	ategory.	ocumented as d" under the orientation		Plan of Correction Completion August 14, 2015	ı Date:	
n of Health	Service Regulation	care plan dated 10/16/14			7	
$\nu$	indva la	PLIER REPRESENTATIVE'S SIGNATURE	.~	Executive Dire	(15)	DATE, Q//8

AUG 18 2015
ADULT CARE
LICENSURE SECTION
RALEIGH

Division (	of Health Service Regu	lation			T	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
	1	] '				
			B MINIC		08/00/0048	
		HAL032013	B. WING		07/23/2015	
MANE OF D	NAME OF PROVIDER OR SUPPLIER STREET A			ATE, ZIP CODE		
NAME OF F	NOVIDER ON SULT LIER		E VALLEY ROA			
SPRING A	SDDING ADROD OF DURHAM			RD .		
•,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		DURHAM	, NC 27707	· · · · · · · · · · · · · · · · · · ·		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	NEW CO.	
D 067	Continued From page	e 1	D 067			
	revealed:					
	-Resident #1 was not					
	"wanderer" under the	mental health and social				
	history category.					
	-Resident #1 was doo	cumented as "sometimes				
		e orientation category.				
	Review of the facility's	s Incident Report dated				
	6/28/15 at 1:50 a.m.					
		ved outside in front of the		, 4		
	building in his wheeld					
					, and the second	
	-The wheelchair went	oir the edge of the				
	sidewalk.					
		left side on the ground.				
		was going to the (Road		,		
	and (Blvd.)					
	Telephone interview v	vith Resident #1's				
	Responsibility Party of	n 7/23/15 at 11:36 a.m.				
	revealed:					
	-She was made awar	e that Resident #1 had exit				
	seeking behaviors as					
		nd outside in front of the				
	building on 6/28/15.	nd odloldo ili nom or oro				
		y to provide a sitter for				
	Resident #1.	y to provide a sitter for				
	Resident #1.					
	Donator of Desident #	dia Nussala Natao rayaalad:				
		1's Nurse's Notes revealed:			·	
	-On 7/21/15 at 10:50					
		vas notified by the Resident				
		Resident #1's increased				
		ing behavior. The resident	1			
	may require a locked	unit within a memory care				
	community in order to	keep him safe.	1			
		shift, Resident, "Stated he	1	·		
	wanted to go home."					
		n., Executive Director (ED)				
		ent #1 about attempts to				
	leave the facility unsu					
		s to go to the service station				
	reported that he want	a to Bo to the actains gration	1	l		

QTRG11

STATEMEN	of Health Service Regul of OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		TE SURVEY MPLETED
		HAL032013	B. WNG		n	7/23/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE. ZIP CODE		774072010
enniue a	DOOD OF BURLING		PE VALLEY RO			
SPRING A	ARBOR OF DURHAM		1, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COM (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 067	Continued From page	2	D 067			
	and get some gas. El no longer drives or ow aware how dangerous community unsupervis -On 7/05/15 at 3:00 all observed coming out of going toward the Summersident where was he (Road). Redirected attempted to leave out -On 7/4/15 (no date), F confused. Roaming in roomsOn 7/04/15 on 11-7 st confused. Resident tries Sunroom. Stated that the resident every 1 ho into other residents room. Observation on 7/23/15-The exit door alarm on -The door exit alarm coresident's bathroom wit-The door exit alarm coresident with the resident with the r	O reminded resident that he ins a car. Resident made it is to leave the sed."  m., "Resident was of his room. Resident was oom. When I asked a going. Resident stated to the resident. Resident then the front door." Resident was very and out of other residents' was very and out of other residents' was very and to leave from the he is going home. Monitor our. Resident tried to go oms."  5 at 2:31 p.m. revealed: 6 Hall 100 L was trigged. 6 build be heard in the he the door closed.	D 067			
1	shower running.  Confidential interviews and they were in the resider resident a shower with the Resider (RCC) on 7/23/15 at 11:	with 7 of 7 staff revealed: ar the exit door alarm, if at's room giving the the door closed. , if the exit door alarms are in the resident's room ower with the door closed.  Sent Care Coordinator 30 a.m. revealed: door exit alarms could be alarm went off when staff				

Division	of Health Service Regu	lation				
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL032013	B. WING		07/23/2015	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, ST	and the second s		
SPRING A	ARBOR OF DURHAM		E VALLEY RO			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 067	Continued From page	3	D 067			
D 139	exit door alarm, if in in bathroom door closed shower.  -The monitoring plan assigned hallway to in door on assigned hall staff should alert sup to exit door alarm on a linterview with the Adr 3:00 p.m. revealed: -She was not aware the heard by the staff, -No staff had reported the exit door alarm, if -She did not know all the exit door alarmsThe monitoring plan assigned hallway to realarm on assigned hallway to realarm on assigned hallway to exit door alarm on a staff should alert sup to exit door alarm on a 10A NCAC 13F .0407 Qualifications  10A NCAC 13F .0407 Qualifications  10A NCAC 13F .0407 This Rule is not met a sacordance with G.S.  This Rule is not met a Based on observation review, the facility fail sampled had a crimin	If they could not heard the esident's room with the or giving resident a in plan was for staff on the espond to the exit alarm in plan was for staff on the espond to the exit alarm in plan was for alarm could not assigned hall.  In the exit door alarm could not if giving resident a shower. If that they could not heard giving resident a shower, staff should be able to hear in place was for staff on the espond to the exit door all.  Dervisor, if unable to respond assigned hall.  If (a)(7) Other Staff  Other Staff Qualifications at an adult care home shall: tockground check in 114-19.10 and 131D-40;	D 139	D 139 10A NCAC 13F .0407(a) Other Staff Qualifications  It is the Community's standard Practice to comply with the referenced licensure rule. The safety of our residents is and will always be our primary conc. All staff hired undergoes a crimi back-ground check.  Plan of Correction Staff B scheduled to obtain fing on 8/14/15 to accompany a nat criminal background check.  Prevention of Re-occurrence: Immediately put into place the I Manager during interview proce to enquire if lived in NC less the years. The Business Office Ma (BOM) will ensure that any new that has State residence less the years, will obtain fingerprints to accompany nationwide backgrochecks.  Monitor Responsibility and Free The Hiring Manager and BOM, Time of each Hiring moving for Plan of Correction Completion August 14, 2015	ern. inal erprints ionwide  Hiring ess is an 5 anager hire han 5 ound  quency: at the ward.	

STATEMENT OF DEFICIENCIES (X1) PROVIE AND PLAN OF CORRECTION IDENTIF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION		E SURVEY MPLETED
		HAL032013	B. WING		0	7/23/2015
NAME OF F	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
éppine a	DDOD OF BUOLING	4523 HC	PE VALLEY ROAD	· }		
SPRING	ARBOR OF DURHAM		M, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 139	Continued From page	: 4	D 139			
	having been complete history background chistory background chief the history background chief the hist	n 1/09/15 as a aide and resident mentation of fingerprints d with a nationwide criminal eck.  5 at 4:15 p.m. revealed to pass medications on the t 4:15 p.m. with Staff B not lived in this state for 5 a from another state in ag as a medication aide				
	Office Manager reveal - She was responsible background checks for - The form previously is background check did is staff person had lived in - She had not asked S this state for 5 years in nationwide background completed or if a statev was needed The facility's new form how long the staff person	for the criminal new staff. used to complete the not indicate how long a n the state. taff B if she had lived in order to determine if a				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION    CX3 DATE   PROVIDER OF CORRECTION	Division	of Health Service Regu	lation				
SPRING ARBOR OF DURHAM  (X4) ID PREFIX TAGS  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 164  D 164  10A NCAC 13F .0505 Training On Care Of Diabetic Resident  10A NCAC 13F .0505 Training On Care Of Diabetic Residents  An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows:  (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner.  (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin action; (c) insulin action; (d) mixing, measuring and injection techniques for prescribing and proportion and injection techniques for prescribing and proportion and injection techniques for provide administration.	STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				
SPRING ARBOR OF DURHAM  (X4) ID PREFIX TAGS  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 164  D 164  10A NCAC 13F .0505 Training On Care Of Diabetic Resident  10A NCAC 13F .0505 Training On Care Of Diabetic Residents  An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows:  (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner.  (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin action; (c) insulin action; (d) mixing, measuring and injection techniques for prescribing and proportion and injection techniques for prescribing and proportion and injection techniques for provide administration.							
SPRING ARBOR OF DURHAM  (X4) ID PREPIX TAG  (X4) ID PREPIX TAG  (EACH DEFICIENCE) MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 164  D 164  10A NCAC 13F .0505 Training On Care Of Diabetic Resident  10A NCAC 13F .0505 Training On Care Of Diabetic Residents  An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows:  (1) Training shall be provided by a registered nurse, registered parmacist or prescribing practitioner.  (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for the province of the			HAL032013	B. WING	The second secon	07/2	23/2015
DURHAM, NC 27707    (X4) ID   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)    D 164   10A NCAC 13F .0505 Training On Care Of Diabetic Resident   10A NCAC 13F .0505 Training On Care Of Diabetic Residents   10A NCAC 13F .0505 Training On Care Of Diabetic Residents   10A NCAC 13F .0505 Training On Care Of Diabetic Residents   10A NCAC 13F .0505 Training On Care Of Diabetic Residents   10A NCAC 13F .0505 Training On Care Of Diabetic Residents   10A NCAC 13F .0505 Training On Care Of Diabetic Residents   10A NCAC 13F .0505 Training On Care Of Diabetic Resident   10A NCAC 13F .0505 Training On Care Of Diabetic Resident   10A NCAC 13F .0505 Training On Care Of Diabetic Resident   10A NCAC 13F .0505 Training On Care Of Diabetic Resident   10A NCAC 13F .0505 Training On Care Of Diabetic Resident   10A NCAC 13F .0505 Training On Care Of Diabetic Resident   10A NCAC 13F .0505 Training On Care Of Diabetic Resident   10A NCAC 13F .0505 Training On Care Of Diabetic Resident   10A NCAC 13F .0505 Training On Care Of Diabetic Resident   10A NCAC 13F .0505 Training On Care Of Diabetic Resident   10A NCAC 13F .0505 Training On Care Of Diabetic Resident   10A NCAC 13F .0505 Training On Care Of Diabetic Resident   10A NCAC 13F .0505 Training On Care Of Diabetic Resident   10A NCAC 13F .0505 Training On Care Of Diabetic Resident   10A NCAC 13F .0505 Training On Care Of Diabetic Resident   10A NCAC 13F .0505 Training On Care Of Diabetic Resident   10A NCAC 13F .0505 Training On Care Of Diabetic Resident   10A NCAC 13F .0505 Training On Care Of Diabetic Resident   10A NCAC 13F .0505 Training On Care Of Diabetic Resident   10A NCAC 13F .0505 Training On Care Of Diabetic Resident   10A NCAC 13F .0505 Training On Care Of Diabetic Resident   10A NCAC 13F .0505 Training On Care Of Diabetic Resident   10A NCAC 13F .0505 Training On Care Of Diabetic Resident   10A NCAC 13F .0505 Training On Care Of Diabetic Resident   10A NCAC 13F .0505 Training On Care Of Diabetic Res	NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE		
Discretive   Dis	epping /	4523			AD		
PREFIX TAG    CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PREFIX TAG	3FRING.F	DURI		M, NC 27707	T		
Diabetic Resident  10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows:  (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner.  (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques  for insulin administration:  D 164 10A NCAC 13F .0505 Training On Care Of Diabetic Resident  Plan of Correction: It is the Community's standard practice to comply with the referenced licensure rule.  Staff B was removed immediately from Med Cart until training was provided. Staff B completed the 15 hour Training Course on 8/4/15 and 8/5/15 that encompasses care of the Diabetic Resident.  An adult care home shall assure that training on the care of residents  Plan of Correction: It is the Community's standard practice to comply with the referenced licensure rule.  Staff B was removed immediately from Med Cart until training was provided. Staff B completed the 15 hour Training Course on 8/4/15 and 8/5/15 that encompasses care of the Diabetic Resident.  Plan of Correction: It is the Community's standard practice to comply with the referenced licensure rule.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE
(e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration.  This Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to assure 1 of 1 medication aide sampled (B) had completed the training on the care of the diabetic resident prior to administering insulin. The findings are:  Review of the employee record for Staff B revealed:  Staff B was hired on 1/09/15 as a supervisor/medication aide and resident	D 164	Diabetic Resident  10A NCAC 13F .0505 Diabetic Residents An adult care home s the care of residents unlicensed staff prior insulin as follows: (1) Training shall be nurse, registered pha practitioner. (2) Training shall incl (a) basic facts about in the management o (b) insulin action; (c) insulin storage; (d) mixing, measuring for insulin administrat (e) treatment and pre and hyperglycemia, in symptoms; (f) blood glucose more precautions; (g) universal precauti (h) appropriate admin (i) sliding scale insuling This Rule is not met Based on observation review the facility faile medication aide samp training on the care of to administering insuling Review of the employ revealed: Staff B was hired or	hall assure that training on with diabetes is provided to to the administration of provided by a registered rmacist or prescribing ude at least the following: diabetes and care involved f diabetes;  g and injection techniques ion; evention of hypoglycemia actuding signs and initoring; universal ions; nistration times; and in administration.  as evidenced by: interview and record and to assure 1 of 1 ioled (B) had completed the fine diabetic resident prior in. The findings are:  ee record for Staff B	D 164	Plan of Correction: It is the Community's standard to comply with the referenced livrule.  Staff B was removed immediate Med Cart until training was provided to complete the 15 hour of Course on 8/4/15 and 8/5/15 the encompasses care of the Diable Resident. Additional training by Pharmacy for all Medication Aid scheduled for 9/1/2015 & 9/2/20  Prevention of Re-occurrence: Resident Care Coordinator will ensure all Aids have proper training and dimented certification that meets State requirements.  Monitor Responsibility and Free Resident Care Coordinator and Executive Director will monitor regular basis.	practice censure ely from vided. Fraining at etic MAST des is 015. Resident I Med loculall the elicular all	Yun

QTRG11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL032013	B. WING		07/2	3/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
SPRING A	RBOR OF DURHAM	4523 HO	PE VALLEY RO	JAD'		
		DURHAN	I, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X6) COMPLETI DATE
D 164	Continued From page	7	D 164			
	- She thought the trai	dication administration skills		D935 G.S.§ 131D-4.5B(b) ACI Medication Aides; Training a Competency		
	any unsupervised meditation aide during an adult care home or of the following: (1) A five-hour training Department that includin all of the following: a. The key principles of administration. b. The federal Centers Prevention guidelines of applicable, safe injection procedures for monitor bleeding occurs or the exists.	Adult Care Home ining and Competency ints.  1, 2013, an adult care in allowing staff to perform dication aide duties unless viously worked as a put the previous 24 months in successfully completed all program developed by the less training and instruction in for Disease Control and in infection control and, if on practices and ing or testing in which potential for bleeding unation consistent with 10A HOA NCAC 13G .0503. In the date of hire, the impleted the following: in training program intrement that includes in all of the following:	D935	It is the Community's standard Practice to comply with the referenced licensure rule. Sprir Arbor always hires Medication Aides, to meet regulated qualification requirements. Staff B has compher 15 hour medication aide training by MAST Pharmacy for Medication Aides is scheduled 9/1/2015 & 9/2/2015.  Prevention of Re-occurrence: Resident Care Coordinator will ensure all Med Aides have proptraining and documented certification that meets all the state requiremed that meets all the state requiremed Resident Care Coordinator and Executive Director will monitor or regular basis.  Plan of Correction Completion August 15 – September 2, 20	cation bleted ining al all for  eer cation nents.  uency:	

Division (	of Health Service Regu	ulation				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	,
		HAL032013	B. WING	07/23/2015		
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STA	TE, ZIP CODE		
	4523		PE VALLEY ROA	AD		
SPRING A	RBOR OF DURHAM	DURHA	W, NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COM	X5) IPLETE ATE
D 164	Continued From page	e 6	D 164			·
	assistant.				ŀ	
		ted 5 hour medication aide				
	training on 2/25/15.			•	1	
	- A medication admir					
	validation had been c - The medication adr	· · · · ·				
	examination was pass					
		mentation of medication	1			
	aide training on the ca	are of the diabetic resident.				
	Observation on 7/22/	15 at 4:15 p.m, revealed:				
		ng to pass medications on				
	the medication cart.					
		rveyor a resident's insulin,		•		ĺ
	meter used to monitor	ministration and the glucose				- 1
	results.	inigor onon gradoss				
	Interview on 7/22/15 a	at 4:15 p.m. with Staff B				
	revealed:					
	<ul> <li>Staff B had moved I January 2015.</li> </ul>	here from another state in				
		ing as a medication aide			ļ	
	since about a month of	• • • • • • • • • • • • • • • • • • • •				
	•	a medication aide before				
:	and some training her	e. ed insulin in this facility		,		
	since hire.	ed insulin in this facility			1	
		sulin pen here before for a				
	resident.					1
į		ent was now drawn up from			j	1
	a vial to administer to	ure resident.				
	Interview on 7/23/15 a	at 11a.m. with the Resident				
1	Care Coordinator (RC					
		e for ensuring training of the			1	
	medication aides by the	ne facility nurse. acility nurse had completed				
		istration check off and the 5	1			
	hour medication aide t					1

Division of Health Service Regulation

	T OF DEFICIENCIES			LE CONSTRUCTION (X3)		) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING:		COMPLETED		
-		HAL032013	B. WNG		07	/23/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATI	E, ZIP CODE			
SPRING A	RBOR OF DURHAM	4523 HC	PE VALLEY ROAD	)			
		DURHA	M, NC 27707				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
D935	Continued From pag	ge 8	D935				
	2. The federal Cente	ers of Disease Control and					
	Prevention guideline	es on infection control and, if					
	applicable, safe inje						
		itoring or testing in which he potential for bleeding					
	exists.	no potential for pieconity					
	b. An examination d	eveloped and administered					
	by the Division of Health Service Regulation in						
	accordance with sub	esection (c) of this section.					
	This Rule is not mel						
		on, interview and record led to assure one of one					
		pled (B) had completed the					
	10 hour medication a	aide training within 60 days of					
	hire. The findings ar	e.					
	Review of the emplo	yee record for Staff B					
	revealed:	. 4/00/47					
	<ul> <li>Staff B was hired of supervisor/medication</li> </ul>						
	assistant.	ili alde alid lesiderit					
	- Staff B had comple	eted 5 hour medication aide					
	training on 2/25/15.						
	- A medication administration clinical skills validation had been completed on 2/25/15.						
	<ul> <li>The medication ad</li> </ul>						
j	examination was pas	sed on 3//26/15.					
		mentation of 10 hour					
	medication aide train	ing.					
	Observation on 7/22/	15 at 4:15 p.m. revealed					
		to pass medications on the					
	medication cart.						
	Interview on 7/22/15	at 4:15 p.m. with Staff B					
	revealed:						
1.	<ul> <li>She had been work</li> </ul>	ing as a medication aide	]			I	

QTRG11

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_ HAL032013 07/23/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4523 HOPE VALLEY ROAD SPRING ARBOR OF DURHAM DURHAM, NC 27707 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D935 D935 Continued From page 9 since about a month or so after hire. - She had training as a medication aide before and some training here. Interview on 7/23/15 at 11a.m. with the Resident Care Coordinator (RCC)revealed: - She was responsible for ensuring training of the medication aides by the facility nurse. - The RCC said the facility nurse had completed the medication administration validation check off and the 5 hour medication aide training. - She thought Staff B had completed her training. - She was not aware the 10 hour training within 60 days of validation/hire was required.

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