Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092037	A. BUILDING. _____ B. WING _____	01/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF APEX	901 SPRING ARBOR COURT APEX, NC 27502

(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 Section conducted an annual survey on 01/20 - 01/21/16 with an exit conference via telephone on 01/25/16.	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 observation, interview and record review, the facility failed to contact the primary care physician for 2 of 5 sampled residents (#4, #5) with elevated blood pressures and 1 of 5 sampled residents (#3) with orders for wound care. The findings are: 1. Review of Resident #4's current FL-2 dated 9/17/15 revealed: -The resident's diagnoses included chronic kidney disease, high blood pressure and diabetes mellitus. -An order for Norvasc 5 milligrams (mg) daily (used to help treat high blood pressure). -An order for Clonidine 0.1 mg daily (used to help treat high blood pressure). -An order for Cozaar 100 mg daily (used to help treat high blood pressure). The Resident Register revealed Resident #4 was admitted to the facility on 7/17/14. Record review revealed Resident #4 had an order	D 273		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Tonya Hedden-Lee TITLE E.D. (A.I.T) (X6) DATE 2/29/16

REVIEWED PCC & ACCEPTED - [illegible] RN
3/24/16

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D 273	Continued From page 1 dated 10/16/15 which revealed: -Check blood pressures daily. -Notify the physician if the systolic blood pressures are greater than 170 or less than 100. Review of the December 2015 Medication Administration Records (MARs) revealed: -The blood pressures were documented as taken on the 7-3 shift from 12/1-12/31/15. -The systolic blood pressures ranged from 111-185. -Three out of thirty one times, the systolic blood pressures were greater than 170. -On 12/7/15, the blood pressure was 174/81. -On 12/19/15, the blood pressure was 171/91. -On 12/20/15, the blood pressure was 185/99. Review of the January 2016 MARs revealed: -The blood pressures were documented as taken on the 7-3 shift from 1/1-1/21/16. -The systolic blood pressures ranged from 104-189. -Three out of twenty one times, the systolic blood pressures were greater than 170. -On 1/2/16, the blood pressure was 185/111. -On 1/3/16, the blood pressure was 189/91. -On 1/7/16, the blood pressure was 177/92. Telephone interview with Resident #4's primary care physician's Administrative Organizer on 1/21/16 at 3:50 p.m. revealed: -There was an order dated 12/15/15 to contact the primary care physician if the systolic blood pressure was greater than 170 or less than 100. -There was no documentation the primary care physician was notified when the resident's systolic blood pressures were greater than 170. -If the physician had ordered when to be notified for blood pressure parameters, the facility should contact the physician when the resident was	D 273		

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D 273	Continued From page 2 outside of the parameters. Interview with a Medication Aide (MA) on 1/21/16 at 4:24 p.m. revealed: -Blood pressures are usually taken on first shift. -She had not taken Resident #4's blood pressures. -The MAs are supposed to call the Resident #4's primary care physician if the systolic blood pressure was greater than 170 or less than 100. -She did not know if Resident #4's primary care physician was contacted when the systolic blood pressure was greater than 170. Interview with a second MA on 1/21/16 at 6:25 p.m. revealed: -If a resident had orders for parameters, staff followed the parameters when to notify the primary care physician. -After the MA contacted the primary care physician, the MA documented the physician contact in the progress notes. Interview with Resident #4 on 1/21/16 at 4:30 p.m. revealed: -The resident's blood pressure are fine most of the time. -The resident did not get dizzy or have a headache when the systolic blood pressure was greater than 170. -If the blood pressure was high, staff would retake the pressure. Interview with the Resident Care Coordinator (RCC) on 1/21/16 at 4:53 p.m. revealed: -Resident #4 had order to contact the resident's primary care physician if the systolic blood pressure was greater than 170 or less than 100. -The resident's primary physician checked the MARs when the he saw the resident.	D 273		

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D 273	Continued From page 3 -The MAs contacted the resident's primary care physician when resident's blood pressures were outside the parameters. -She could not provide documentation Resident #4's primary care physician was aware of Resident #4's systolic blood pressures greater than 170. -Staff checked behind each other to make sure they contacted the primary care physician. -She did not check behind the MAs to make sure they contacted the resident's primary care physician when a resident was outside of the parameters. -She was not aware Resident #4's primary care physician had not been contacted about the resident's elevated blood pressures. -Resident #4 had not complained of headaches or dizziness. Interview with the Administrator on 1/21/16 at 6:00 p.m. revealed: -If there was an order to contact the primary care physician for blood pressures outside of the parameters, staff should notify the physician as ordered. -She was not aware there was no documentation Resident #4's primary care physician had not been contacted when the systolic blood pressures were greater than 170. Resident #4's primary care physician's nurse could not be reached by the end of the survey. Refer to interview with the facility's Administrator on 01/22/16 at 2:16pm 2. Review of Resident #3's Resident Register on 1/21/16 revealed that Resident #3 was admitted to the facility on 12/18/15.	D 273		

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D 273	Continued From page 4 Review of Resident #3's current FL2 dated 12/18/15 revealed: -Resident #3's medical diagnoses included nonketotic hyperosmolar hyperglycemia, chronic atrial fibrillation, diabetes, hypertension, hyperlipidemia, thrombocytopenia, and history of subdural hematoma. -Resident #3 was intermittently disoriented. -Resident #3 was semi-ambulatory and required set-up assistance with bathing. Review of the Progress Notes for Resident #3 revealed: -Resident #3 had a fall on 1/9/16 resulting in skin tears to both elbows and abrasions on knees. -Resident #3 was sent to the hospital emergency department on 1/9/16. Review of Subsequent Physician Orders for Resident #3 revealed: -A standing order dated 12/18/15 for general first aid: clean with normal saline, apply Neosporin daily until healed, and cover with non-adhesive dressing. -An order for "wound care per home health" was faxed to the primary physician on 1/11/16 by the facility. -The physician signed the order for "wound care per home health" on 1/16/16. Review of Resident #3's Medication Administration Record (MAR) for January 2015 revealed: -An order to provide "wound care per home health" was initiated on 1/12/16. -Wound care was documented as provided per home health on eight occasions beginning on 1/13/16 through 1/21/16. -On 1/14/16, the wound care was documented as not done due to "home health."	D 273		

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D 273	Continued From page 5 Interview with Resident #3 on 1/21/16 at 3:45pm revealed: -The home health nurse was not providing wound care. -The only wound Resident #3 was aware of was a rash to his abdomen that had been itching for the last two days. -Physical therapy had been seeing Resident #3 for a few weeks. -Resident #3 recalled falling but did not remember the date of the fall. -Resident #3 recalled being sent to the hospital because of the fall and thought the staff had been "putting cream on his elbows, but no bandage." Interview with the Resident Care Coordinator (RCC) on 1/21/16 at 4:00pm revealed: -Resident #3 had been receiving physical and occupational therapy. -Resident #3 was taken to the physician by his family member, and the physician must have arranged for Resident #3 to have a different home health agency to provide nursing for wound care. -The order for wound care per home health would print on the Treatment Administration Record (TAR). -The order was not clarified with the primary physician. -Staff would follow the standing order on the chart if the physician had order standing orders. -If the staff needed to use the standing order, the staff would enter a temporary order onto the MAR or TAR. -Standing orders do not print on the MAR or TAR unless the resident is receiving the medication or treatment frequently. -The home health agency would be contacted to determine if home health nursing was ordered for	D 273		

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D 273	Continued From page 6 Resident #3's skin tears to his elbows. Observation of Resident #3's profile in the facility's Electronic Medication Administration Record revealed that no Treatment Administration Record existed for Resident #3. Telephone interview with the facility pharmacist on 1/21/16 at 4:17pm revealed: -Standing orders do not print on the MAR unless the staff are using the standing orders. -If the staff need to activate a standing order, the staff click on the protocol tab, select the order they need, and the order will flow to the MAR or TAR. -If the standing order is an as needed order that is not used frequently, the order will not print on the MAR or TAR. -The only order for wound care for Resident #3 on file is dated 1/12/16 and reads wound care per home health. -There is nothing documented under the standing order for general first aid, apply Neosporin daily until healed. Observation and interview with a staff on 1/21/16 at 4:50pm revealed: -There were no dressings on Resident #3's elbows. -There were no open areas or wounds to Resident #3's elbows. -The staff was not aware of what the wound care order was because day shift staff provided the wound care. -The staff had not seen the skin tears to Resident #3's elbows, but was aware of the rash on Resident #3's abdomen because the physician had been notified about the rash. Interview with the RCC on 1/21/16 at 5:15pm	D 273		

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D 273	Continued From page 7 revealed: -The home health agency had been contacted and the agency was not providing home health nursing to Resident #3. -Resident #3 had skin tears on his elbows from a fall. -An order was faxed to the physician to discontinue wound care order and home health nursing order because wound was healed on 1/21/16. Observation of Resident #3's physician orders revealed the RCC did fax an order to discontinue wound care on 1/21/16 due to wound being healed. 3. Review of Resident #5's current FL-2 dated 12/22/15 revealed: - Diagnoses included hypertension, chronic pain, anemia, and arthritis. - An order to check Resident #5's blood pressure (BP) daily; "notify [physician] if systolic blood pressure (SBP) is greater than 170 (mm/Hg) or diastolic blood pressure (DBP) is greater than 100." - An order for Hydralazine 100mg. three times daily with directions to "hold" for BP less than 110/60. (Hydralazine is a medication used to treat elevated BP). Interview with Resident #5 on 01/21/16 at 11:40am revealed: - Staff checked Resident #5's BP several times every day. - Resident #5's BP ran "high" sometimes. - Resident #5 did not have any side effects or complaints when her BP was elevated because her BP had been elevated a "long time" and she was used to it. - Resident #5 only had complaints if her BP got	D 273		

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D 273	Continued From page 8 too low. - Resident #5 did not know if facility staff contacted her physician when her BP was elevated or low. Review of Resident #5's electronic Medication Administration Records (MARs) for December 2015 revealed: - An entry to "check blood pressure daily, if SBP is greater than 170 or DBP is greater than 100 notify [physician]." - An entry for Hydralazine 100mg. three times daily with administration times of 06:00am, 12:00pm, and 6:00pm; "hold for BP less than 110/60." - Documentation beside the Hydralazine entry that Resident #5's SBP was greater than 170 on two occasions between 12/22/15 and 12/31/15. - On 12/26/15 at 12:00pm, Resident #5's BP was 179/88. - On 12/27/15 at 6:00pm, Resident #5's BP was 179/91. Review of Resident #5's electronic MARs for January 2016 revealed: - An entry to "check blood pressure daily, if SBP is greater than 170 or DBP is greater than 100 notify [physician]." - An entry for Hydralazine 100mg. three times daily with administration times of 06:00am, 12:00pm, and 6:00pm; "hold for BP less than 110/60." - Documentation beside the Hydralazine entry that Resident #5's SBP was greater than 170 on 8 occasion out of 82 times checked between 01/01/16 and 01/21/16. - On 01/04/16 at 6:00pm, Resident #5's BP was documented as 175/69 - On 01/05/16 at 6:00am Resident #5's BP was documented as 171/69; at 6:00pm BP was	D 273		

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D 273	Continued From page 9 documented as 179/81. - On 01/06/16 at 6:00pm, Resident #5's BP was documented as 177/82. - On 01/09/16 at 6:00am, Resident #5's BP was documented as 172/91. - On 01/12/16 at 6:00am, Resident #5's BP was documented as 186/95. - On 01/17/16 at 6:00pm, Resident #5's BP was documented as 174/88. - On 01/18/16 at 6:00pm, Resident #5's BP was documented at 180/92. Review of Resident #5's record revealed there was no documentation that Resident #5's physician was notified on the 2 occasions in December 2015 or 8 occasions in January 2016 when her SBP was greater than 170. Interview with a Medication Aide (MA) on 01/21/16 at 10:25am revealed: - The MAs were responsible for checking and documenting BPs on each resident's MAR. - The MAs were responsible for notifying the physician by fax when a resident's BP was greater than the ordered parameters. - It was facility procedure to document when the physician was notified in each residents ' record by retaining a copy of the fax or by written documentation in the record. Interview with the MA and the Resident Care Coordinator (RCC) on 01/21/16 at 10:28am revealed if there was no documentation found in Resident #5's record, the physician was not notified about the blood pressure. Telephone interview with the medical records staff member at Resident #5's physician office on 01/21/16 at 11:30am revealed: - The physician had taken over Resident #5's	D 273		

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D 273	Continued From page 10 care on 12/20/15 and had first evaluated Resident #5 in the facility on 12/30/15. - It was procedure for the facility to contact the physician's office by fax or telephone call as needed. - The facility had left a telephone voicemail message for the physician on 12/29/15 that Resident #5's BP was 180/80. - The physician's office had not received any additional documentation from the facility about Resident #5's BP being greater than the parameters ordered. Interview with the RCC on 1/21/16 at 4:53 p.m. revealed: - The MAs contacted the resident's primary care physician when residents were outside the parameters. - Staff checked behind each other to make sure they contacted the primary care physician. - She [the RCC] did not check behind the MAs to make sure they contacted the resident's primary care physician when a resident was outside of the parameters. Resident #5's physician was not available for interview on 01/21/16. Interview with the Executive Director (ED) on 01/21/16 at 10:15am revealed the MAs were responsible for checking resident's BP and documenting the readings on each resident's MAR. Refer to interview with the facility's Administrator on 01/22/16 at 2:16pm. _____ Interview with the facility's Administrator on	D 273		

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D 273	Continued From page 11 01/22/16 at 2:16pm revealed: - If a resident had an order to monitor blood pressure with or without perimeters for reporting to health care providers, the RCC was responsible for checking documented blood pressures and reporting any blood pressures outside of perimeters to the health care providers. - The RCC should be checking the MARs weekly for blood pressure documentation and assure follow-up if needed. - The RCC will immediately put a system in place to assure orders for blood pressures are followed-up by medication staff.	D 273		
D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure water was served to all residents in the special care unit (SCU) during meals. The findings are: Observation of the lunch meal in the SCU on 01/21/16 from 12:00pm through 12:38 revealed: - Twelve of thirteen residents were not served water. - One of thirteen residents was served water. - Twelve of thirteen residents were served iced tea only.	D 306		

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D 306	Continued From page 12 - Two of the twelve residents served iced tea were also served coffee. - Staff did not offer water to the residents who were served tea/coffee. Review of the notes located on the bottom of the "Thursday Week 1" cycle menu revealed: - " All meals come with coffee/tea and water. " - "All meals should also provide coffee or tea and water unless otherwise indicated by a physician." Interview with Medication Aide (MA) assisting with the lunch meal service in the SCU on 01/21/16 at 12:10pm revealed: - Staff do not "usually" serve water to residents in the SCU during the lunch meal. - "They [the residents] like tea." - Some residents became agitated when extra items are placed on the table. Interview with a resident of the SCU on 01/21/16 at 12:43pm revealed: - Water was not normally served with meals. - The resident requested water with meals whenever she wanted water; staff provided water to her upon request. Interview with the Special Care Coordinator (SCC) on 01/21/16 at 12:15pm revealed: - Water is not served at meals to the residents residing in the SCU. - The facility had a "hydration station" that was open at all times for all residents to maintain hydration. - Staff "pushed fluids" for residents with physician orders for fluids. Interview with the SCC on 01/21/15 at 1:11pm revealed:	D 306		

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D 306	Continued From page 13 - The SCC was unsure how long residents in the SCU had not been served water with their meals. - Water had not been served to residents of the SCU during meals "really since I've been here" in December 2013. - The SCC acknowledged that some of the residents would not know to ask for water due to their cognitive status. Interview with the Dietary Manager on 01/21/16 at 12:36pm revealed: - If was facility procedure for water to be served to all residents at every meal. - The staff members working in the SCU were responsible for serving water to the residents at each meal. - "They are supposed to give water [to all residents] every meal." Interview with the Administrator on 01/21/16 at 6:45pm revealed: - Water should be provided to all residents at each meal. - The Administrator was not aware water had not been served to residents in the SCU at every meal. - If the Administrator had known water was not being served at every meal in the SCU, she would have told the SCC to make sure water was served to residents in the SCU at every meal. Interview with the Administrator on 01/25/15 at 3:50pm revealed: - The SCC was responsible for monitoring the meals in the SCU to assure the residents were served water at each meal. - If the SCC observed that water was not served at every meal in the SCU, the SCC was supposed to follow-up with dietary.	D 306		

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D 306	Continued From page 14 - The Resident Assistants (RAs) should also monitor the meals to assure each resident was served water and report to the SCC if water was not being served.	D 306		
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 assure residents' prescription medications were administered as ordered by a licensed prescribing practitioner for 1 of 4 sampled residents (Resident #3). The findings are: Review of Resident #3's Resident Register revealed that Resident #3 was admitted to the facility on 12/18/15. Review of Resident #3's current FL2 dated 12/18/15 revealed: -Resident #3's medical diagnoses included nonketotic hyperosmolar hyperglycemia, chronic atrial fibrillation, diabetes, hypertension, hyperlipidemia, thrombocytopenia, and history of subdural hematoma.	D 358		

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D 358	Continued From page 15 Review of Resident #3's current FL2 dated 12/18/15 included the following medication orders: -Insulin NPH (an intermediate acting insulin given to lower blood sugar) 14 units at bedtime. -70/30 Insulin (an intermediate acting combination insulin given to lower blood sugar) 36 units every morning. -Humalog (fast acting insulin used to lower blood sugar) sliding scale before meals and at bedtime: -blood glucose less than 60, no insulin; -160-199 = 1 unit; -200-239 = 2 units; -240-279 = 3 units; -280-319 = 4 units; -320-250 = 5 units; -360-399 = 6 units; -greater than 400, give 6 units and call physician. Review of Subsequent Physician Orders for Resident #3 dated 12/28/15 revealed: -An order to decrease NPH insulin to 12 units. -An order to change Humalog sliding scale to the following: -200-250 = 2 units; -251-300 = 4 units; -301-350 = 6 units; -351-400 = 8 units; -greater than 400, give 8 units. Review of Resident #3's Medication Administration Record (MAR) for December 2015 revealed: -Humalog sliding scale before meals and at bedtime: -blood glucose less than 60, no insulin; -160-199 = 1 unit; -200-239 = 2 units; -240-279 = 3 units;	D 358		

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D 358	Continued From page 16 -280-319 = 4 units; -320-250 = 5 units; -360-399 = 6 units; -greater than 400, give 6 units and call physician. -On 12/8/15 at 8:00pm, Resident #3's blood glucose reading was documented as 171 mg/dl. -Resident #3 did not receive sliding scale insulin as ordered per sliding scale for blood glucose reading of 171 mg/dl on 12/18/15. -Medication notes on the MAR revealed the dose was missed. Review of Resident #3's MAR for January 2016 revealed: -Resident #3 did not receive the correct insulin dose 5 times from 1/1/16-1/21/16. -On 1/4/16, Resident #3's blood glucose was 258 at 8:00pm and documented that Resident #3 received 2 units of Humalog insulin. -On 1/14/16, Resident #3's blood glucose was 252 at 8:00pm and documented that Resident #3 received 2 units of Humalog insulin. -On 1/16/16, Resident #3's blood glucose was 345 at 4:30pm and documented that Resident #3 received 8 units of Humalog insulin. - On 1/16/16, Resident #3's blood glucose was 328 at 8:00pm and documented that Resident #3 received 8 units of Humalog insulin. - On 1/17/16, Resident #3's blood glucose was 347 at 8:00pm and documented that Resident #3 received 8 units of Humalog insulin. Interview with Resident #3 on 1/21/16 at 3:45pm revealed: -The staff checked his blood sugar four times every day. -He received insulin depending on what his blood sugar reading was. -He did not know how much insulin the staff gave	D 358		

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D 358	Continued From page 17 him, but he knew he received sliding scale insulin. Interview with the Resident Care Coordinator (RCC) on 1/21/16 at 5:15pm revealed: -The staff did not administer the correct dose based on the documentation on the MAR. -The staff should have notified the physician if the incorrect dose of insulin was administered since Resident #3 had fluctuations in blood sugars. Interview with a Medication Aide on 1/21/16 at 5:50pm revealed: -If a medication error is made, the policy is to report the error to the physician and document that the physician was notified. -We are also supposed to let the RCC know of any medication errors. -Depending on the medication, we may have to monitor the resident more closely, like checking more frequent blood sugars if the wrong insulin dose was given. The staff who administered the insulin on 1/4/16, 1/14/16, 1/16/16, and 1/17/16 were not available for interview.	D 358		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by:	D 438		

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D 438	Continued From page 18 Based on observation, interview and record review, the facility failed to report injuries of unknown cause (bruise and skin tear of right arm, bruise of right breast and left chin and swollen left foot) to the North Carolina Health Care Personnel Registry (NCHCPR) for 1 of 1 resident (# 1) within 24 hours of facility becoming aware of injuries along with any investigation by facility within 5 working days. The findings are: Review of Resident #1's FL-2 dated 10/28/15 revealed: - Diagnoses included dementia without behavioral disturbances, hypertension, and arthritis. - The resident was intermittently disoriented, ambulatory and continent of bowels and bladder. - Current level of care was SCU (special care unit). Confidential resident interview revealed: - Resident #1's arm and chest were bruised a few weeks ago (did not know date). - The police came to the facility and was investigating the bruises because the bruises could have been caused by excessive force. - The bruises occurred around 1:00am, but did not know if the bruises were caused by a staff or if the resident fell. - The resident talked to the police officer regarding Resident #1's bruises. Review of documentation on a facility's "Resident Incident and Accident Report" dated 12/23/15 (7:45am) revealed: - Resident #1's type of incident was "unknown bruising". - Staff were getting resident [#1] dressed for breakfast and noticed new bruising in the upper right arm on left side of chin and the entire right	D 438		

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D 438	Continued From page 19 breast. Resident's left foot is swollen and resident claims there is pain only on the foot. - Staff asked resident if she remembered what happened and resident was unable to recall. Resident currently eating breakfast and seems to be in a good mood. Resident's [family member] agreed to take resident to an urgent care. Review of "Discharge Instructions" from a local emergency department dated 12/23/15 revealed: - Emergency department admission diagnoses for Resident #1 were right arm contusion and contusion of right breast. - The resident was to take Tylenol for discomfort or apply ice to any sore or tender areas. - A chest X-ray and right foot X-ray was negative. Review of a local law enforcement "Incident/Investigation Report" dated 12/23/15 revealed: - On 12/23/15 at 9:43am, a report of elder abuse [Resident #1] was received from a staff member of a local healthcare facility. - The crime occurred at [the adult care facility] and will be forwarded to adult protective services. Interview with 1st shift medication aide (MA), supervisor -in-charge (SIC) on 1/21/16 at 1:20pm revealed: - On 12/23/15 at the beginning of 1st shift, the resident assistant (RA) reported Resident #1 had bruises on right breast, right arm, left chin and complained of right foot hurting. - The MA assessed the resident and completed an incident report (unknown bruises/injuries) and reported injuries to special care unit coordinator. - The resident was transported to the local	D 438		

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D 438	Continued From page 20 emergency on 12/23/15 and no injuries reported. - The MA did not know if bruises were reported to the NCHCPR. Interview with 1st shift RA on 01/21/15 at 1:30pm revealed: - The RA assisted Resident #1 with dressing on 1st shift at approximately 7:00am - 7:15am. - When changing the resident's gown, observed bruises on the resident's right breast, left chin and right arm. The resident complained of right foot pain when putting on shoes. - Reported injuries to the 1st shift MA who wrote up an incident report. Staff interview with an RA on 01/21/16 at 4:00pm revealed: - RA was working 3rd shift on 12/23/15 (on the special care unit). - Resident #1 was more confused than usual and was agitated (told staff repeatedly someone called her and was coming to get her and take her upstairs). - Resident walked to the nurse's station and she gave her a cup of orange juice and walked with the resident to her room but the resident refused to go to bed. - The RA checked on the resident every 2 hours while making rounds and the resident was up and ambulating in room. - At 3:00am, while providing care for another resident, she heard noises from Resident #1's room. - She found the resident sitting on her walker (seat) at her closet trying to get clothes out of the closet. - The resident went to the bathroom without assistance and then was assisted to bed. Interview with the facility's Special Care	D 438		

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D 438	Continued From page 21 Coordinator (SCC) on 01/21/16 at 2:50pm revealed: - On 12/23/15 (3rd shift) Resident #6 was agitated and was confused. - When the 1st shift RA was assisting the resident with getting dressed at the beginning of the shift, observed bruises on the resident's left chin, right breast and right arm (along with a skin tear). The resident's right foot was swollen. - The RA reported the SIC, who notified the resident's family member and physician. - The family member transported the resident to the local urgent care/ED and no findings reported. - The urgent care nurse reported the unexplained bruises to the county Adult Protective Services (APS). - An internal investigation was started immediately by the facility's Resident Care Coordinator (RCC) and SCC. - The facility's adult home specialist instructed the facility to senda 24 hour report and 5 day report to HCPR in January 2016. - A 24 hour report was completed and sent to HCPR on 01/06/15 and a 5 day report was sent to HCPR on 01/15/15 - The SCC stated this was my 1st HCPR report and did not know the 1st report was required to be sent within 24 hours after injuries discovered. - APS reported the injuries to the local law enforcement agency and a detective came to the facility on 01/18/16. - The detective looked at the resident's room and her bathroom. The detective informed the facility the resident's injuries were likely caused by a fall on the safety bar in the resident's bathroom. Review of a "24 Hour Initial Report/Notification of Facility Allegation to HCPR" revealed "	D 438		

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D 438	Continued From page 22 - The report (for Resident #1) was completed by the facility's SCC on 01/06/16. - The date of the injury of unknown source was 12/23/15. Review of a HCPR "5 Working Day Report" revealed the report (for Resident #1) was completed and submitted to HCPR by the facility's SCC on 01/15/15. Interview with the facility's Administrator on 01/21/15 at 4:45pm revealed: - She was aware of the bruises and skin tear (Resident #1) which was reported on 12/23/15. - The facility had completed an incident report and the resident was assessed at the local urgent care/ED on 12/23/15 (no injuries was noted). - The bruises were reported to APS and the local law enforcement. The detective visited the facility on01/05/16 and 01/18/16 and concluded the resident's injuries likely caused by a fall in the bathroom. - We (the facility) have not had any resident incidents which required HCPR reporting, therefore we did not sent a 24 hour report/5day report to HCPR until the AHS instructed me to. - The facility's RCC or SCC is required to complete both reports and fax reports to HCPR. Interview with Resident #1's family member on 01/25/16 at 3:30pm revealed: - The facility contacted her on 12/23/15 and reported bruises were discovered at the beginning of 1st shift on the resident's chin, breast and arm. The resident was compaining of foot pain. - The family member transported the resident to the local urgent care/ED and resident had no injuries. X-rays of foot and chest were negative for injuries.	D 438		

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D 438	Continued From page 23 - A detective talked to family member about bruises and explained the resident probably fell in bathroom and sustained injuries on safety bar. - The family had no concerns about the resident's care at the facility and did not think the injuries were caused by staff abuse or neglect. - The family member did not know if the bruises were reported "to the state". The investigating detective was not available for interview.	D 438		
D 477	10A NCAC 13F .1409 Special Care Unit Orientation ANd Training 10A NCAC 13F .1409 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit for residents with a mental health disability, the administrator shall document receipt of at least 20 hours of training specific to the population by a qualified mental health professional, as defined in 10A NCAC 27G .0104(18), for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, direct care	D 477		

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D 477	Continued From page 24 staff shall complete 20 hours of training specific to the population being served. (4) In addition to the training required in Rule .0501 of this Subchapter, direct care staff assigned to the unit shall complete at least 8 hours of continuing education annually that is specific to the needs of the residents. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that 2 of 6 sampled staff (Staff C and Staff D) received 20 hours of training related to the nature and needs of the residents on the special care unit. The findings are: 1. Review of the personnel file for Staff C (Supervisor-In-Charge and Medication Technician) on 1/21/16 revealed: -Staff C was hired as a Supervisor-In-Charge and Medication Aide on 2/7/14. -Staff C completed 6 hours of special care unit training during the first week of employment. -Staff C completed 12 hours of special care unit training within the first 6 months of hire. 2. Review of the personnel file for Staff D (Assisted Living and Cottage Resident Assistant) on 1/21/16 revealed: -Staff D was hired as an Assisted Living and Cottage Resident Assistant on 4/15/03. -Staff D completed 6 hours of special care unit training during the first week of employment. -Staff D did not have any additional special care unit training within the first 6 months of hire. Interview with the Special Care Unit Coordinator	D 477		

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D 477	Continued From page 25 on 1/21/16 at 5:00pm revealed: -She did not realize Staff C and Staff D had not had the required training during their first 6 months of employment. -There had not been any problems with Staff C or Staff D's work performance or resident care that she was aware of. -She had not received any complaints from residents or family members about the care Staff C or Staff D provided to residents on the special care unit. Staff C and Staff D were not available for interview on 1/21/16.	D 477		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure that 1 of 6 staff (Staff A)	D934		

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D934	Continued From page 26 completed the annual state infection control training. The findings are: Review of the personnel file for Staff A (Medication Aide) on 1/21/16 revealed: -Staff A was hired as a Medication Aide on 6/23/12. -There was a certificate of completion that Staff A completed State Infection Control training on 3/15/13 and 5/5/14. Interview with the Administrator on 1/21/16 at 5:15pm revealed: -Staff A was hired as a Medication Aide. -Staff A did not complete the annual infection control training in 2015. -Staff A will complete the infection control training during the next scheduled class. -I keep a folder for all the trainings that are done annually, such as CPR and infection control. -I try to keep the trainings up to date and make sure that the staff are current with their trainings.	D934		

Spring Arbor of Apex
Plan of Correction, from Annual Survey 01/25/16
SCB111; HAL-092-037

10A NCAC 13F .0902(b) Health Care

The community will ensure the follow-up to meet routine and acute health care needs of residents. The SIC taking the order will have the incoming-shift SIC review the order, ensuring accuracy. The Resident Care Coordinator, or Cottage Care Coordinator, will review all orders for accuracy. To ensure on-going compliance, the RCC or her designee, will document compliance checks at least monthly on a Monitoring Log. In-Service for SIC staff by the RN held on 02/12/16 on Documentation, including following through with medication orders and ensuring follow-up on Health Care referrals.

Compliance Date: 02/12/16

10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service

Water shall be served to each resident in addition to other beverages. Care Staff and all Dietary Staff have been in-serviced on this requirement. Water is being served at each meal in both AL and SC and on-going the Food Service Manager will have assigned cook for meals assure we continue this compliance with our posted menus.

Compliance Date: 01/21/16

10A NCAC 13F .1004(a) Medication Administration

SICs were re-in serviced on Medication Administration, including diabetic care and documentation, on 2/12/16 by RN. In order to ensure on-going compliance, Resident Care Coordinator/ Cottage Care Coordinator, and/or designee will review MARs and new orders, at least weekly, and documenting their review on a Monitoring Log.

Compliance Date: 02/12/16

10A NCAC 13F .1205 Health Care Personnel Registry

Injuries of unknown causes will be reported to the Registry within 24 hours of discovery and within 5 working days. Staff training has occurred to ensure staff are able to recognize and identify Reportable Events-Staff training included reporting of these concerns identified including time frames for the notification and it was reviewed when and where to be documenting on an Incident Report. All Incident Reports will be reviewed and after reviewed, signed by CCC or RCC and then the ED will review and sign acknowledging her review of the report. The CCC or RCC will be responsible for reporting any Reportable Event, if warranted, and the ED will follow-up to ensure on-going compliance. Reporting & review will be documented.

Compliance Date: 01/21/16

10A NCAC 13F .1409 Special Care Unit Orientation and Training

Special Care training is held at Orientation, and within 6 months of employment, 20 hours of dementia training will be conducted and documented. Training program is in place.
To ensure on-going compliance and documentation of training, the Cottage Care Coordinator will be responsible for tracking and documenting the required training on our training form for SC Unit/Cottage

staff. RCC and/or ED will review for compliance at least quarterly. All current staff training files have been audited and brought into compliance.

Compliance Date: 02/19/16

G.S. 131D-4.5B (a) ACH Infection Prevention Requirements

All required trainings, including Infection Control, will be documented for all staff on a Training Form by the Resident Care Coordinator. To ensure on-going compliance, RCC will keep record on a spreadsheet to track documentation of annual Infection Control training compliance. This tool will be reviewed by RN or Executive Director monthly. Annual 2016 Infection Control training was conducted on 2/20/16 by a LPN for all existing staff.

Compliance Date: 02/20/16