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	HAL029004	A. BUILDING: _____ B. WING _____	R 08/08/2019

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SPRING ARBOR OF THOMASVILLE	915 WEST COOKSEY DRIVE THOMASVILLE, NC 27360

(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 on 08/08/19.	{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 observations, interviews and record reviews, the facility failed to notify the primary care provider for 1 of 5 sampled residents (Resident #2) regarding blood pressure readings which exceeded parameters ordered by the physician. The findings are: Review of Resident #2's current FL2 dated 11/07/18 revealed diagnoses included diabetes mellitus II, hypertension, peripheral vascular disease, chronic kidney disease - stage 3, insomnia, vitamin D deficiency, and hyperlidemia. Review of a subsequent physician's order dated 04/04/19 revealed an order to check blood pressure 2 times a day and contact provider if less than 100/60 or over 160/90. Review of Resident #2's June 2019 Medication	{D 273}		

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{D 273}	Continued From page 1 Administration Record (MAR) revealed 36 opportunities to notify the primary care provider for blood pressure readings which exceeded the parameters. Examples included: -On 06/03/19, the morning blood pressure was documented as 164/82 and the evening blood pressure was documented as 184/96. -On 06/17/19, the morning blood pressure was documented as 196/64 and the evening blood pressure was documented as 164/89. -On 06/12/19, the morning blood pressure was documented as 186/87 and the evening blood pressure was documented as 174/86. -On 06/17/19, the morning blood pressure was documented as 170/92 and the evening blood pressure was documented as 160/72. -On 06/24/19, the morning blood pressure was documented as 168/79 and the evening blood pressure was documented as 172/92. Review of Resident #2's July MAR revealed 33 opportunities to notify the primary care provider for blood pressure readings which exceed the parameters. Examples included: -On 07/02/19, the morning blood pressure was documented as 190/88 and the evening blood pressure was documented as 181/78. -On 07/04/19, the morning blood pressure was documented as 174/86 and the evening blood pressure was documented as 168/92. -On 07/19/19, the morning blood pressure was documented as 162/84. -On 07/13/19, the evening blood pressure was documented as 163/91. -On 07/24/19, the morning blood pressure was documented as 192/62 and the evening blood pressure was documented as 184/96. Review of Resident #2's August MAR revealed 3 opportunities to notify the primary care provider	{D 273}		

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{D 273}	Continued From page 2 for blood pressure readings which exceed the parameters. The readings were: -On 08/01/19, the morning blood pressure was documented as 162/79. -On 08/05/19, the morning blood pressure was documented as 177/77. -On 08/07/19, the morning blood pressure was documented as 167/78. Review of Resident #2's record revealed: -The facility staff notified the primary care provider on 07/11/19 of all blood pressure readings from 03/22/19 to 07/05/19. -No other documentation of notification was located. Interview with the Medication Aide (MA) revealed: -We usually contact the primary care provider through a special tablet we have. -The tablet was provided by the primary care provider. -"I have never documented the communication with the doctor anywhere else, like in the resident record, I didn't know I needed to". Interview with the Resident Care Director (RCD) on 08/07/19 at 3:50 pm revealed: -The MAs were expected to contact the primary care provider each and every time the blood pressure readings were outside of the parameters as ordered. -The MAs usually contact the primary care provider by using the tablet she provided to the facility. -The MAs could also call the primary care provider via the telephone. -Any communication concerning the blood pressure readings outside the ordered parameters should be documented in Resident #2's record.	{D 273}		

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{D 273}	Continued From page 3 -He did not know the MAs were not documenting the communication with the primary care provider in Resident #2's record. Interview with the Administrator on 08/08/19 at 11:12 am revealed: -She expected all communication with the primary care provider to be documented in Resident #2's record. -The communication could occur via telephone, text, fax or other electronic communication, but it needed to be documented in the resident record. Interview with the primary care provider on 08/08/19 at 3:15 pm revealed: -Resident #2 had co-morbidities that could contribute to the elevated blood pressure readings. -She expected the facility staff to notify her of each time the blood pressure reading was outside of the parameters she provided. -The notifications would alert her to abnormal blood pressure readings, then she could follow-up with Resident #2 as needed. Interview with Resident #2 on 08/08/19 at 9:00 am revealed: -Resident #2 did not know what medications he took. -"I do know my blood pressure runs high sometimes"	{D 273}		
{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	{D 358}		

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{D 358}	Continued From page 4 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: FOLLOW-UP TO TYPE A2 VIOLATION. The Type A2 Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 2 of 5 sampled residents related to antihypertensive medication (Resident #3) and a probiotic (Resident #5). The findings are: 1. Review of Resident #3's current FL-2 dated 12/19/18 revealed diagnoses included systolic and essential hypertension, congestive heart failure, dementia, anemia, sinus bradycardia, hypothyroid, and hyperlipidemia. Review of Resident #3's physician's orders dated 07/19/19 revealed: -There was an order to check blood pressure (BP) twice daily and administer Clonidine 0.1mg	{D 358}		

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{D 358}	Continued From page 5	{D 358}		

(used to treat high blood pressure) for blood pressure greater than 160/90.
-The order included to wait one hour and repeat blood pressure; if it was still high then notify the Primary Care Provider (PCP).

Review of Resident #3's July 2019 and August 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry to check and record blood pressure twice daily and to check Clonidine order for blood pressure greater than 160/90.
-There was an entry for Clonidine 0.1mg take one tablet for blood pressure greater than 160/90 and repeat blood pressure in one hour and if still elevated call PCP.
-There were 15 episodes Resident #3's BP was greater than 160/90 and Clonidine was not administered.
-On 07/22/19 on 2nd shift Resident #3's BP was 174/77; there was no documentation Clonidine was administered.
-On 07/29/19 on 2nd shift Resident #3's BP was 166/77; there was no documentation Clonidine was administered.
-On 08/06/19 on 2nd shift Resident #3's BP was 162/94; there was no documentation Clonidine was administered.

Observation of Resident #3's medications on hand on 08/07/19 at 3:30pm revealed:
-There was a bubble pack of thirty Clonidine 0.1mg dispensed on 07/22/19.
-Nine tablets had been administered; twenty-one tablets were available to be administered.

Interview with a Medication Aide (MA) on 08/07/19 at 3:51pm revealed:
-If Resident #3's BP was over 160/90 he would administer Clonidine and recheck the BP in one

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{D 358}	Continued From page 6	{D 358}		

hour.
-On 07/22/19 Clonidine was not available to be administered when Resident #3's BP was high; the Clonidine was delivered late on 07/22/19.
-He documented the administration of the Clonidine in the eMAR and the daily log.
-If Resident #3's BP was close, say 162/94, he may not have administered the Clonidine; he remembered calling the PCP about it once and she told him she was more concerned with the top number.
-He recalled talking to the PCP once when Resident #3's BP was 164/80 and the PCP told him not to administer the Clonidine.

Telephone interview with the PCP on 08/07/19 at 3:10pm revealed:
-She expected the Clonidine to be administered if Resident #3's BP was greater than 160/90.
-She was concerned there were times Resident #3's BP was greater than 160/90 and Clonidine was not administered.
-She would like to know when Resident #3's BP was high what else may be going on because it may be related to the resident being agitated and not true hypertension.

Second interview with the PCP on 08/08/19 at 12:27pm revealed:
-She would expect the MAs to notify her if the BP was outside of the parameter.
-Clonidine had been ordered for Resident #3 who had random BP spikes.
-Resident #3 had a lot of variables that could cause her BP to spike, including sundowning and agitation.
-She did not feel Resident #3's BP spikes were related to hypertensive, just situational.
-If Resident #3's BP was elevated, and she was not administered Clonidine she was at risk for a

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{D 358}	Continued From page 7 stroke. Interview with a second MA on 08/08/19 at 10:29am revealed: -Resident #3 had a parameter of 160/90 for her blood pressure. -If Resident #3's blood pressure was over 160/90 she would administer Clonidine. -She did not think she had ever administered Clonidine. -She could not explain why she had documented Resident #3's BP was greater than 160/90 and she had not documented the administration of the Clonidine or recheck of Resident #3's BP. -She thought she may have called the PCP; she did not know where she documented the call to the PCP. Telephone interview with a third MA on 08/08/19 at 12:03pm revealed: -When she was working, she took Resident #3's BP on first shift and again on second shift. -She documented Resident #3's BPs on the eMAR. -She remembered there was one-time Resident #3's BP was high; she talked to the PCP and was told to administer an as needed blood pressure medication. -She did not know Resident #3's BP had set parameters. -She was not aware there was an order to administer medication if Resident #3's BP was outside the parameters. Second review of the July 2019 and August 2019 eMARs revealed the MA who was not aware of the order to administer a blood pressure medication did not administer Clonidine 10 of 10 times when she took Resident #3's BP and it was outside the parameter set by the PCP.	{D 358}		

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{D 358}	Continued From page 8 Telephone interview with Resident #3's responsible party on 08/08/19 at 12:53pm revealed: -She had asked for a copy of Resident #3's MARs. -She had asked for a copy of Resident #3's MARs because she was concerned Resident #3 was having problems with her BP and she wanted to see what the staff were doing with Resident #3's medications. -She had not received a copy of the MARs. -Resident #3 had high BP for years and she did not think the facility staff were monitoring the blood pressure. -She had bought her own BP cuff to the facility and checked Resident #3's BP and it was "180/80 or 200." -Every reading she had seen the facility recorded was consistently the same range and she was not sure they were taking it correctly. -She took Resident #3's BP last week and it was "190 over something." -Resident #3's BP had always spiked in the afternoon for years. -She thought maybe Resident #3's medication needed to be reviewed and her BP medication be administered at a different time. Interview with the Resident Care Director (RCD) on 08/08/19 at 11:25am and 1:34pm revealed: -He expected the MAs to follow the orders. -If a resident had parameters for blood pressures, it would be imperative that it was followed. The MAs should document the BP and administration on the eMAR and in the care notes. -He did eMAR and cart audits 1-2 times per week. -He had not audited Resident #3's eMARs.	{D 358}		

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{D 358}	Continued From page 9 Interview with the Executive Director on 08/08/19 at 11:11 am revealed: -She expected the MAs to follow the PCP orders. -If Resident #3's BP was high the medication should have been administered; the MA should have documented the recheck of the blood pressure and communication with the PCP. -Documentation should be in the eMAR and resident record. 2. Review of Resident #5's current FL-2 dated 05/09/19 revealed diagnoses included gastro-esophageal without esophagitis, hypertension, iron deficiency anemia, abnormality of gait and mobility, and major depressive disorder. Review of Resident #5's physician's orders dated 05/16/19 revealed: -There was an order to discontinue Acidophilus. (Acidophilus is a probiotics that is used to improve digestion and restore normal flora.). -Immediately beneath the discontinue order there was a second order to start Acidophilus 1 billion daily; the family will provide. Review of Resident #5's June 2019, July 2019, and August 2019 electronic Medication Administration Record (eMAR) revealed: -There was no entry for Acidophilus. -There was no documentation Acidophilus had been administered. Review of Resident #5's medications on hand on 08/08/19 at 9:48am revealed there was no Acidophilus available to be administered. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 08/08/19 at	{D 358}		

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{D 358}	Continued From page 10 9:41am revealed: -They did not dispense Acidophilus for Resident #5; the family provided the supplement. -The facility had faxed the order for Acidophilus to the pharmacy, and it was entered in the eMAR. -A medication aide (MA) at the facility rejected the order on 05/17/19 and listed the reason as discontinued. -A fax was sent to the facility on 05/17/19 requesting clarification; they had not received any further communication from the facility for the Acidophilus order for Resident #5. Telephone interview with Resident #5's responsible party on 08/08/19 at 10:53am revealed: -He had provided a bottle of Acidophilus at the time of admission. -The facility would not allow him to provide over the counter medication without an extra cost so as far as he knew the Acidophilus was being ordered through the pharmacy. Interview with Resident #5 on 08/08/19 at 12:51pm revealed: -She was not sure what medications she took daily. -She had taken Acidophilus before; she did not know if she was taking it now. -She had not had any loose stools in the past couple of months. Interview with Resident #5's Primary Care Provider (PCP) on 08/08/19 at 12:27pm revealed: -Resident #5 had an order to take Acidophilus. -She was not aware Resident #5 was not been administered Acidophilus as ordered. -She was not aware of Resident #5 having any complaints of loose stools. -She was not concerned Resident #5 was not	{D 358}		

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{D 358}	Continued From page 11 taking Acidophilus if she had not had any loose stools. Attempted telephone interview on 08/08/19 at 12:09pm with the MA who rejected the order for the Acidophilus was unsuccessful Interview with the Resident Care Director (RCD) on 08/08/19 at 11:25am revealed: -The PCP send her visit summary by fax to the facility the same day of the visit (in the evening) or the next day. -The MA who received the fax was responsible for faxing new orders to the pharmacy. -The pharmacy processed new orders, and it would be marked as pending on the eMAR. -The MA would be responsible for accepting the order once the medication was available to be administered. -The order for Acidophilus should have been clarified. -He was concerned Resident #5 had not received Acidophilus per PCP's order for the past three months. Interview with the Executive Director on 08/08/19 at 11:47am revealed: -When new orders were received, the MA was responsible for sending the order to the pharmacy. -If there were any questions about an order, it should have been clarified. -She was concerned Resident #5 had not received her Acidophilus and the PCP had not been notified.	{D 358}		