STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF SAND HILLS	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(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 an annual survey, a state involved complaint and two complaint investigations from 07/08/25 to 07/11/25. The complaint investigations were initiated by the Hoke County Department of Social Services on 05/29/25 and 06/20/25.	D 000		
D 163	10A NCAC 13F .0504(d) Competency Eval & Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (d) If a physician certifies that care can be provided to a resident in an adult care home on a temporary basis in accordance with G.S. 131D-2.2(a), the facility shall ensure that the staff performing the care task(s) authorized by the physician are competent to perform the task(s) in accordance with Paragraphs (b) and (c) of this Rule. For the purpose of this Rule, "temporary basis" means a length of time as determined by the resident's physician to meet the care needs of the resident and prevent the resident's relocation from the adult care home. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to obtain physician certification that the facility staff were competent to administer a subcutaneous anticoagulant as ordered for 1 of 5 sampled residents (#4). The findings are: Review of Resident #4's FL-2 dated 11/20/24	D 163		

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revealed diagnoses included Alzheimer's disease, insomnia, anxiety disorder unspecified, and hypertensive heart disease.

Review of Resident #4's Transition of Care Visit note dated 06/23/25 revealed additional diagnoses included transient ischemic attack, osteoarthritis, anemia, hypoproteinemia, dysphasia, vitamin d deficiency, and vitamin B12 deficiency.

Review of Resident #4's After Visit Summary Note dated 06/16/25 revealed:
-Resident #4 had two surgeries to repair a left and a right hip fracture during the hospitalization.
-Resident #4 was started on Enoxaparin in the hospital (Enoxaparin is a medication used to thin the blood to prevent blood clotting).
-There was an order for Enoxaparin 30mg/0.3 mL inject 0.3 mL under the skin one time each day for 24 days to begin on 06/17/25.

Review of Resident #4's June and July 2025 electronic medication administration records (eMARs) revealed:
-There was an entry for Enoxaparin 30mg/0.3 mL syringes inject 0.3 mL subcutaneously every day for blood clot prevention for 24 days at 8:00am starting on 06/18/25 and ending on 07/11/25 (subcutaneously means to inject the medication into the fat under the skin, typically into the skin of the stomach).
-Enoxaparin was documented as administered 22 times by facility medication aides (MAs).
-MAs did not document the site of administration and there was no place available on the eMAR to document the site of injection.

Interview with a medication aide (MA) on 07/10/25 at 1:30pm revealed:

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-She was told yesterday, 07/09/25, that only hospice could administer Enoxaparin, but she did not know why.
-She had administered Enoxaparin multiple times to Resident #4.
-When she administered Enoxaparin, she pinched up an area on Resident #4's abdomen and administered it just like she would an insulin injection.
-She did not receive any training to administer Enoxaparin and a nurse did not check her off as skilled to administer the medication.
-She trained herself by looking up Enoxaparin and reading how to administer the medication.

Interview with a second MA on 07/11/25 at 11:10am revealed:
-She administered Enoxaparin to Resident #4 every date that was initialed by her on the eMAR.
-She administered Enoxaparin by cleansing Resident #4's stomach with alcohol, pinching up a fold of the stomach, and then injecting the medication.
-She administered Enoxaparin in the same place every time she gave the medication.
-She never noticed bruising or abnormal bleeding in Resident #4.
-She did not receive any special training or skills validation to administer Enoxaparin.
-She used her knowledge of giving subcutaneous insulin when administering the subcutaneous Enoxaparin.

Telephone interview with Resident #4's hospice nurse on 07/10/25 at 2:42pm revealed hospice had never administered Resident #4's Enoxaparin or had a discussion with the facility staff about administration of the medication being a task hospice needed to perform.

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D 163	Continued From page 3 Interview with the facility's Administrator and the Director of Quality and Education on 07/10/25 at 3:40pm revealed: -They both expected a nurse from a home health or hospice agency to administer Enoxaparin or the primary care provider (PCP) to change the medication to a form the medication aides (MAs) could administer. -MAs were educated to give subcutaneous insulin but did not receive any specific education or skills validation from the PCP or quality nurse to administer Enoxaparin. -The Director of Quality and Education expected facility staff to call her when a medication like Enoxaparin was ordered to discuss whether MAs were allowed to administer the medication or not. Telephone interview with Resident #4's PCP on 07/10/25 at 4:00pm revealed: -The PCP did not certify that the facility MAs were competent to perform administration of Enoxaparin. -MAs should not have been administering the Enoxaparin unless specifically trained to administer the medication and what side effects to watch for such as abnormal bleeding. -Possible side effects from Enoxaparin included blood in stool, increased bleeding, bruising, and blood in the urine. Based on observations, record reviews, and interviews, Resident #4 was not interviewable.	D 163		
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.	D 273		

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D 273	Continued From page 4 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure health care coordination and follow-up for 5 of 9 sampled residents (#3, #4, #6, #15, #16) including failing to report high blood pressures to the primary care provider (PCP) for two residents (#15, #16); failing to ensure a resident with history of falls was seen by the PCP after a fall (#6); failing to schedule a neurology referral and failing to notify the hospice provider of the neurology referral (#3); and failing to coordinate labwork for a resident (#4). The findings are: 1. Review of Resident #16's current FL-2 dated 12/16/24 revealed diagnoses included essential hypertension, heart failure, chronic obstructive pulmonary disease, dementia, diabetes mellitus type 2, chronic kidney disease, and muscle weakness. Review of Resident #16's primary care provider (PCP) order dated 03/24/25 revealed: -There was an order to check blood pressure (BP) two times daily and record for hypertension. -There was an order to notify the PCP for systolic blood pressure (SBP) greater than (>) 160. Review of Resident #16's PCP order dated 04/11/25 revealed an order to notify the PCP if SBP was >160 or less than (<) 100, diastolic blood pressure (DBP) >100 or <60. Review of Resident #16's June 2025 electronic	D 273		

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D 273	Continued From page 5 medication administration record (eMAR) revealed: -There was an entry with a BP medication scheduled 3 times a day at 8:00am, 2:00pm, and 8:00pm to notify provider if SBP >160 or <100 or DBP >100 or <62 (should have been <60). -There was no documentation of BP results with the BP medication entry. -There was an entry in the "Vitals" section of the eMAR for BP with scheduled times of 8:00am, 2:00pm, and 8:00pm. -There were no parameters listed with the BP entry under the "Vitals" section of the eMAR. -The BPs ranged from 102/74 - 240/88 from 06/01/25 - 06/30/25. -The SBP was documented as >160 on 24 occasions from 06/01/25 - 06/30/25. -For example, the resident's BP was documented as 240/88 on 06/18/25 at 8:00am; 236/100 on 06/14/25 at 8:00am; and 219/72 on 06/12/25 at 8:00am. -There was no documentation the PCP was notified of any SBPs >160 on the eMAR. -The DBP was documented as <60 on 5 occasions from 06/01/25 - 06/30/25. -For example, the resident's BP was documented as 145/52 on 06/08/25 at 2:00pm; 135/52 on 06/20/25 at 2:00pm; and 143/52 on 06/30/25 a 8:00pm. -There was no documentation the PCP was notified of any of the DBPs <60 on the eMAR. Review of Resident #16's July 2025 eMAR revealed: -There was an entry with a BP medication scheduled 3 times a day at 8:00am, 2:00pm, and 8:00pm to notify provider if SBP >160 or <100 or DBP >100 or <62 (should have been <60). -There was no documentation of any BP results with the BP medication entry.	D 273		

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-There was an entry in the "Vitals" section of the eMAR for BP with scheduled times of 8:00am, 2:00pm, and 8:00pm.
-There were no parameters listed with the BP entry under the "Vitals" section of the eMAR.
-The BPs ranged from 119/79 - 245/93 from 07/01/25 - 07/09/25.
-The SBP was documented as >160 on 6 occasions from 07/01/25 - 07/09/25.
-For example, the resident's BP was documented as 231/93 on 07/01/25 at 8:00am; 245/93 on 07/02/25 at 8:00am; and 224/76 on 07/05/25 at 8:00am.
-There was no documentation the PCP was notified of any SBPs >160 on the eMAR.
-The DBP was documented as <60 on 4 occasions from 07/01/25 - 07/09/25.
-For example, the resident's BP was documented as 149/48 on 07/08/25 at 2:00pm and 131/54 on 07/05/25 at 8:00pm.
-There was no documentation the PCP was notified of any of the DBPs <60 on the eMAR.

Review of Resident #16's electronic facility progress notes for June 2025 - July 2025 revealed no documentation the PCP was notified of any of the BPs that were outside of the ordered parameters.

Observation of the 8:00am medication pass on 07/09/25 revealed:
-The medication aide (MA) checked Resident #16's BP at 7:53am and it was 212/73 but it was checked with the BP cuff upside down.
-The MA was asked by surveyor to recheck the resident's BP.
The MA rechecked the resident's BP with the BP cuff applied correctly at 7:59am and it was 214/111.
-The MA did not notify the PCP and continued

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with the medication pass after documenting the resident's BP on the eMAR.

Interview with Resident #16 on 07/09/25 at 8:01am revealed:
-She felt okay but was a little dizzy.
-She thought she was dizzy because she did not sleep well last night.
-She felt "wobbly" sometimes, but she was not sure why she felt that way.

Interview with the MA on 07/09/25 at 9:02am revealed:
-She had not contacted Resident #16's PCP about Resident #16's high BP that morning.
-She was going to recheck Resident #16's BP after the resident ate breakfast to make sure it was accurate.
-She still planned to call the PCP after she rechecked the resident's BP.

Second interview with the MA on 07/09/25 at 9:22am revealed:
-She had just rechecked Resident #16's BP and it was 145/70.
-She had not contacted the resident's PCP about the high BP that morning.
-She would recheck the resident's BP again before lunch.
-If the resident's BP went back up, she would call the PCP.

Third interview with the MA on 07/09/25 at 1:13pm revealed:
-She rechecked Resident #16's BP right before lunch today, and it was 139/63.
-She did not notify Resident #16 of the resident's high BP that morning, because the resident's BP had come down when she rechecked it.

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Interview with the Resident Care Coordinator (RCC) on 07/09/25 at 1:50pm revealed:
-The MAs should notify the PCP immediately of any BPs that were outside of the ordered parameters.
-The MA should have contacted Resident #16's PCP immediately that morning, 07/09/25, when the resident's BP was high and outside of the ordered parameters.

Interview with the facility's Director of Quality and Education / Registered Nurse (RN) on 07/09/25 at 1:46pm revealed:
-The MAs failed to notify the PCP of Resident #16's BPs that were outside of the parameters.
-The MAs should notify a resident's PCP of any vital signs outside of the ordered parameters.
-The MA should have called Resident #16's PCP immediately when the resident's BP was so high that morning.
-The PCP would have given further instructions to the MA on what to do about the Resident #16's high BP.

Telephone interview with a nurse at Resident #16's PCP office on 07/10/25 at 1:59pm revealed:
-Resident #16's PCP was unavailable for interview.
-There was no documentation of the PCP being notified by the facility of Resident #16's BP being outside of ordered parameters in June 2025 or July 2025.
-She was not aware of the resident's BP being 214/111 on 07/09/25.
-The resident could have a stroke or heart attack with her BP being that high.
-The resident needed to be seen by the PCP as soon as possible to be assessed.

2. Review of Resident #15's current FL-2 dated

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D 273	Continued From page 9 01/08/25 revealed: -Diagnoses included hypertension, peripheral vascular disease, chronic kidney disease, edema, end stage renal disease with dialysis, gastroesophageal reflux disease, osteoarthritis, and history of falls. -There was an order to check blood pressure (BP) daily, report if systolic blood pressure (SBP) was 160 or greater (>) and if below (<) 100, report to primary care provider (PCP). Review of Resident #15's June 2025 electronic medication administration record (eMAR) revealed: -There was an entry to check BP daily for hypertension and notify provider if SBP >160 or "DBP" (diastolic blood pressure) <100 (should have read SBP <100 not DBP) scheduled at 8:00am. -There was a space to document the MAs' initials but no space to document the BP reading. -There was another entry under the "Vitals" section of the eMAR for BP. -The BP was documented daily at 8:00am and ranged from 121/59 - 196/87. -The SBP was documented as >160 on 8 occasions from 06/01/25 - 06/30/25, with the SBP ranging from 161/81 - 196/87 on those 8 occasions. -There was no documentation the PCP was contacted on 8 of 8 occasions when the resident's SBP was >160. Review of Resident #15's July 2025 eMAR dated 07/01/25 - 07/09/25 revealed: -There was an entry to check BP daily for hypertension and notify provider if SBP >160 or DBP <100 (should have read SBP <100 not DBP) scheduled at 8:00am. -There was a space to document the MAs' initials	D 273		

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but no space to document the BP reading.
-There was another entry under the "Vitals" section of the eMAR for BP with a scheduled time of 8:00am.
-The BP was documented daily at 8:00am and ranged from 132/93 - 197/69 from 07/01/25 - 07/09/25.
-The SBP was documented as >160 on 3 occasions from 07/01/25 - 07/09/25, with the SBP ranging from 163/61 - 197/69 on those 3 occasions.
-There was no documentation the PCP was contacted on 3 of 3 occasions when the resident's SBP was >160.

Review of Resident #15's electronic facility progress notes for June 2025 - July 2025 revealed no documentation the PCP was notified of any of the BPs that were out of the ordered parameters.

Observation of the 8:00am medication pass on 07/09/25 revealed:
-The medication aide (MA) checked Resident #15's BP at 7:33am and it was 169/71.
-The MA did not notify the PCP and continued with the medication pass after documenting the resident's BP on the eMAR.

Interview with the MA on 07/09/25 at 1:06pm revealed:
-If there were parameters the PCP needed to be notified about, she would call the PCP and document that in the resident's electronic facility progress notes.
-She did not notify Resident #15's PCP about the resident's SBP being >160 that morning on 07/09/25, because she did not notice the instructions on the eMAR to do so.

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D 273	Continued From page 11 Interview with Resident #15 on 07/10/25 at 5:15pm revealed: -Her BP was usually checked by staff at the dialysis center 3 times a week. -She was not sure how often facility staff usually checked her BP. -Her BP usually ran "pretty good" as far as she knew. -She had a headache yesterday, 07/09/25, and it was the first headache she had in a long time. -She denied any other symptoms of high BP. Interview with the Resident Care Coordinator (RCC) on 07/09/25 at 1:50pm revealed: -The MAs should notify the PCP immediately of any BPs that were outside of the ordered parameters. -The MA should have contacted Resident #15's PCP that morning, 07/09/25, when the resident's SBP was >160. Interview with the facility's Director of Quality and Education / Registered Nurse (RN) on 07/09/25 at 1:46pm revealed: -The MAs failed to notify the PCP of Resident #15's BPs that were outside of the parameters. -The MAs should notify a resident's PCP of any vital signs outside of the ordered parameters. -The MA should have called Resident #15's PCP immediately when the resident's SBP was >160 that morning. Telephone interview with a Nurse Practitioner (NP) at Resident #15's PCP office on 07/11/25 at 12:01pm revealed: -Resident #15 took a few medications for high blood pressure. -The resident's BP needed to be checked to make sure the BP medications were working, and the parameters were to make sure the resident's	D 273		

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BP did not get too high or too low.
-She did not see any documentation that the PCP was notified of Resident #15's BP being outside of the ordered parameters in July 2025.
-It was important to know whether the BP was out of the parameters to be able to adjust the medications and to prevent complications of high blood pressure such as stroke.

3. Review of Resident #6's current FL-2 dated 01/21/25 revealed:
-Diagnoses included chronic kidney disease, hyperlipidemia, congestive heart failure, vitamin B12 deficiency and retention of urine with a catheter.
-He was admitted on 08/16/24.

Review of Resident #6's care plan dated 02/13/25 revealed he was totally dependent on ambulation and transferring.

Review of Resident #6's accident and incident report dated 02/16/25 revealed:
-He was found on the floor.
-He stated he was reaching for something and fell out of his wheelchair.
-He refused to go to the emergency department (ED).
-There were no visible injuries.

Review of Resident #6's accident and incident report dated 02/28/25 revealed:
-His urine was cloudy.
-He complained of pain in his groin and legs.
-He stated he wanted to go to the ED.

Review of Resident #6's ED after visit summary dated 02/28/25 revealed:
-The reasons for his visit were difficulty urinating and ankle pain.

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-The diagnoses included closed fracture of distal end of left fibula and a urinary tract infection.

Review of Resident #6's ED after visit summary dated 03/02/25 revealed:
-The reason for his visit was ankle pain.
-The diagnosis included closed nondisplaced fracture of shaft of the left fibula with healing.
-The medication given was acetaminophen-codeine (Tylenol). (Tylenol codeine is used to treat severe pain).

Review of Resident #6's primary care providers' (PCP) note dated 03/03/25 revealed to continue Tylenol for pain.

Telephone interview with Resident #6's family member on 07/09/25 at 3:30pm revealed:
-She visited Resident #6 on 02/28/25 and he complained of leg pain.
-Resident #6 notified her on 03/01/25 he had a broken leg.

Interview with the Resident Care Coordinator (RCC) on 07/09/25 at 12:47pm revealed:
-The PCP conducted an assessment on residents after each fall.
-She was responsible for ensuring the residents were seen by the PCP after a fall.
-She did not know why Resident #6 was not seen by the PCP after his fall on 02/16/25 because the PCP was notified.
-She found out Resident #6 had a broken leg when he came back from the ED on 02/28/25.

Telephone interview with Resident #6's PCP on 07/10/25 at 1:45pm revealed:
-She expected the facility to ensure she completed an assessment to determine level of pain and check range of motion after a resident

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fell.
-She did not recall being notified that Resident #6 fell on 02/16/25.
-She saw Resident #6 on 03/03/25 after he was diagnosed with a leg fracture on 02/28/25.
-She ordered Tylenol for pain to continue 03/03/25 because she was following up with his visit at the ED on 02/28/25 and 03/02/25.

Interview with the Administrator on 07/10/25 at 2:56pm revealed:
-It was the protocol of the facility to ensure the PCP saw a resident after a fall.
-The RCD and/or the RCC were responsible for ensuring the PCP completed an assessment on Resident #6 after his fall on 02/16/25.
-She was not sure why the PCP did not see Resident #6 after he fell.

Attempted telephone interview with Resident #6 on 07/10/25 at 11:19am was unsuccessful.

4. Review of Resident #4's FL-2 dated 11/20/24 revealed diagnoses included Alzheimer's disease, insomnia, anxiety disorder unspecified, and hypertensive heart disease.

Review of Resident #4's Transition of Care Visit Note dated 06/23/25 revealed additional diagnoses included transient ischemic attack, osteoarthritis, anemia, hypoproteinemia, dysphasia, vitamin d deficiency, and vitamin B12 deficiency.

Review of Resident #4's progress note dated 03/17/25 revealed there were lab orders for a complete blood count (CBC), comprehensive metabolic panel (CMP), and vitamin B12 level.

Review of Resident #4's record revealed there

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D 273	Continued From page 15 were no CBC, CMP, or Vitamin B12 level results. Interview with the Administrator and the Director of Quality and Education on 07/10/25 at 10:40am revealed: -Resident #4's ordered March 2025 labs were not performed. -The Special Care Coordinator (SCC) or assistant coordinator should have gotten the orders for labs and sent it to the facility contracted laboratory. -The facility contracted laboratory would then send a staff member to draw the labs once they received the order. -They were unsure if the resident lab order was passed along to the laboratory. -If a resident was out of the facility for any reason when the laboratory employee arrived, the SCC should have rescheduled the lab work. -The primary care provider (PCP) never inquired about the status of the labs. -They received an order today, 07/10/25, from the PCP to discontinue the lab order. 5. Review of Resident #3's current FL-2 dated 08/27/25 revealed: -Diagnoses included type 2 diabetes, hypertension, vitamin D deficiency, and major depressive disorder. -The resident was non-ambulatory. Review of Resident #3's care plan dated 04/09/25 revealed she was totally dependent for toileting, bathing, grooming, dressing, and transfers. Review of Resident #3's hospital after visit summary dated 06/18/25 revealed: -Resident #3 was admitted for peripheral artery disease (PAD). -Resident #3 was to follow up with Neurology in 4 weeks.	D 273		

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D 273	Continued From page 16 Review of Resident #3's record revealed there was no documentation Resident #3 had an appointment scheduled or was seen by a neurologist. Interview with the facility's Regional Nurse on 07/10/25 at 10:07am revealed the Receptionist scheduled resident's appointments. Interviews with the Receptionist on 07/10/25 at 10:21am and 11:01am revealed: -She scheduled resident appointments. -She scheduled appointments when she received referrals from the Resident Care Coordinator (RCC) and the Resident Care Director (RCD). -The referrals received were usually from a provider or the hospital. -Resident #3's family member scheduled most of her appointments. -She had not received any information regarding a referral to neurology for Resident #3 until yesterday (07/09/25). -The Administrator and RCD asked her about a neurology appointment for Resident #3 yesterday (07/09/25). -Resident #3's appointment information was in a sealed packet from the hospital addressed to Resident #3's family member and had not been opened. -The hospital did send discharge paperwork with residents for the facility, but she did not know what information was sent. -She scheduled a neurology appointment for Resident #3 this morning (07/10/25) for 07/18/25. Interviews with the RCC on 07/10/25 at 10:30am, 11:20am and 11:50am revealed: -The Receptionist made all resident appointments and was given all discharge paperwork.	D 273		

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D 273	Continued From page 17 -She was unsure what discharge paperwork the Receptionist was given for Resident #3. -The facility did not receive a copy of Resident #3's discharge paperwork with appointment information listed. -Resident #3's neurology appointment information was sent in a sealed packet addressed to the resident's family member. -She did not open the packet addressed to the resident's family member. -She did not request discharge paperwork from the hospital for Resident #3. -The facility should have obtained a copy of Resident #3's discharge paperwork from the hospital. -The neurology appointment was scheduled yesterday (07/09/25) for 07/18/25. -Hospice was not informed of the neurology appointment. Interview with the RCD on 07/10/25 at 5:27pm revealed: -She was not aware of the neurology referral for Resident #3. -Resident #3's discharge paperwork was in a sealed envelope addressed to the resident's family member. -The facility received discharge paperwork but that paperwork did not have the referral to neurology listed. -She could not locate the discharge paperwork the facility received for Resident #3. -Discharge paperwork for all residents was kept in a stack in the RCC/RCD office. Second interview with the RCD on 07/11/25 at 11:49am revealed: -All orders and referrals were given to the Receptionist for her to make the appointments. -The RCD was responsible for giving the orders	D 273		

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and referrals to the Receptionist.

Telephone interview with the Administrator/Registered Nurse for Resident #3's hospice provider on 07/10/25 at 11:45am revealed:
-She was not aware Resident #3 had been referred to neurology.
-She did not know why Resident #3 had been referred to neurology
-Hospice would not have referred Resident #3 to neurology because it would not be covered by hospice and the family would receive a bill.
-The fact that the neurology services were not covered by hospice did not mean Resident #3 could not attend the appointment.
-If the facility had notified hospice of the neurology referral, they and the family would have been informed that the service was not covered.

Interview with the Administrator on 07/10/25 at 4:10pm revealed:
-She found out about the neurology referral for Resident #3 within the past few days.
-She did not know when the neurology appointment was.
-She expected the RCC and RCD to give referral and appointment information to the Receptionist because she managed the transportation and appointment schedule.
-She spoke with the RCC and RCD yesterday (07/09/25) and was informed that the discharge paperwork was sent from the hospital in a sealed packet addressed to Resident #3's daughter.
-The facility did not receive a copy of Resident #3's discharge paperwork.
-The facility should have requested a copy of Resident #3's discharge paperwork.

Telephone interview with a Nurse Practitioner at

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D 273	Continued From page 19 Resident #3's PCP office on 07/10/25 at 1:45pm revealed: -Resident #3 was seen by neurology while in the hospital. -She was aware of the 4 week follow up referral to neurology due to review of the hospital notes. -Neurology suspected possible microvascular ischemia (spots on the brain that were possibly dying off or not working properly). -She was not aware Resident #3 had not attended the neurology appointment or had not had an appointment scheduled. -Due to the fact that Resident #3 was on hospice, the neurology appointment would have had to be approved because hospice did not typically pursue aggressive treatment. -She did not see the need for a neurology follow up due to the resident being on hospice. -She had no concern with Resident #3 not attending the neurology appointment. Attempted telephone interview with the Neurology office on 07/10/5 at 9:40am was unsuccessful. Attempted telephone call to Resident #3's family member on 07/10/25 at 11:10am was unsuccessful. _____ The facility failed to ensure health care referral and follow-up for 5 of 9 sampled residents. Resident #16's high blood pressure (BP) on 24 occasions in June 2025 and 6 occasions in July 2025 were not reported to the primary care provider (PCP) as ordered. The resident reported feeling dizzy and "wobbly" and could have caused the resident to have a stroke or heart attack according to the nurse at the resident's PCP office. Resident #15's high BP on 8 occasions in June 2025 and 3 occasions in July 2025 were not	D 273		

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D 273	Continued From page 20 reported to the PCP as ordered putting the resident at risk of complications including stroke. Resident #6 had a fall on 02/16/25 and the PCP was not notified. On 02/28/25, the resident complained of severe ankle pain, went to the emergency department and was diagnosed with a broken leg. The failure of the facility to provide health care coordination and follow-up resulted in substantial risk of serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/11/25 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 10, 2025.	D 273		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care	D 280		

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being provided;
(3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and
(4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure the quarterly licensed health professional support (LHPS) reviews and evaluations for 5 of 5 sampled residents (#1, #2, #3, #4, #5) with LHPS tasks were completed and included a physical assessment, evaluation of care provided, and recommendations based on the physical assessment and evaluation of the resident including tasks for assistance with ambulation and transferring (#1, #2, #3, #4, #5), medication through injection (#5), and care of a urinary catheter (#3).

The findings are:

1. Review of Resident #3's current FL-2 dated 08/27/24 revealed:
-Diagnoses included type 2 diabetes, hypertension, unspecified systolic and vitamin D deficiency.
-She was intermittently disoriented.
-She was non-ambulatory.
-She was incontinent of bladder and bowel.
-She required personal care assistance with bathing, feeding and dressing; total care.

Review of Resident 3's Resident Register revealed she was admitted to the facility on 09/13/19.

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Review of Resident #3's current care plan dated 04/09/25 revealed:
-Resident #3 was non-ambulatory.
-She was incontinent of bowel and bladder.
-She was sometimes disoriented, was forgetful and needed reminders.
-She was totally dependent for toileting, bathing, grooming, dressing, and transfers.
-She required supervision with eating.

Review of Resident #3's Licensed Health Professional Support (LHPS) evaluation and quarterly review dated 05/03/25 revealed:
-Review of health status and care provided and physical assessment included shower, dressing, occasional feeding, wheelchair, hoyer-2 person assists, toileting and hospice.
-There was no physical assessment documented.
-There were no recommendations documented.
-LHPS personal care tasks provided included wheelchair, transfer/mobility, bathing and feeding.

Observation of Resident #3 on 07/08/25 at 9:32am revealed:
-Resident #3 was observed sitting in a high back wheelchair in her room.
-She had a catheter bag.
-She was clean and well groomed.
-She was intermittently oriented.

Refer to interview with the Special Care Director (SCD) on 07/11/25 at 12:24pm.

Refer to interview with the Administrator on 07/11/25 at 1:45pm.

Refer to attempted telephone interview with the LHPS nurse on 07/11/25 at 1:36pm.

2. Review of Resident #2's current FL-2 dated

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D 280	Continued From page 23 03/24/25 revealed: -Diagnoses included dementia, hypertension and hydronephrosis with renal and ureteral calculus obstruction. -He was constantly disoriented. -He was ambulatory. -He was incontinent of bladder. -He required personal care assistance with bathing. Review of Resident 2's Resident Register revealed he was administed to the facility on 07/22/20. Review of Resident #2's current care plan dated 10/29/24 revealed: -Resident #2 was ambulatory with the assistive device. -He was occasionally incontinent of bowel and bladder. -He was oriented but forgetful and required reminders. -He required extensive assistance with toileting, ambulation and dressing. -He was totally dependent on staff for transferring and bathing. Review of Resident #2's Licensed Health Professional Support (LHPS) evaluation and quarterly review dated 02/03/25 revealed: -Review of health status and care provided and physical assessment included incontinent at times, 1 person assist with wheelchair, bathing and dressing. -There was no physical assessment documented. -There were no recommendations documented. -LHPS personal care tasks provided included wheelchair, toileting, bathing and dressing. -Transferring was not addressed on the LHPS.	D 280		

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Review of Resident #2's LHPS evaluation and quarterly review dated 05/16/25 revealed:
-Review of health status and care provided and physical assessment included assist with toileting at times and assist with bathing/dressing.
-There was no physical assessment documented.
-There were no recommendation documented.
-LHPS personal care tasks provided included toileting every 2 hours and assistance with bathing and dressing.

Observation of Resident #2 on 07/08/25 at 2:14pm revealed:
-Resident #2 was observed ambulating independently without the use of assistive device.
-He was clean and well groomed.
-He was oriented to self only.

Telephone interview with Resident #2's guardian on 07/09/25 at 1:12pm revealed:
-Resident #2 had a hip replacement in July 2024 and returned to the facility at the end of 2024.
-Resident #2 used a wheelchair upon return but was currently able to walk independently.
-Resident #2's dementia was progressing and he required a lot of assistance from staff for toileting, bathing and dressing.

Attempted telephone interview with Resident #2's primary care provider on 07/09/25 at 4:18pm was unsuccessful.

Based on observation,record review and interviews, it was determined that Resident #2 was not interviewable.

Refer to interview with the Special Care Director (SCD) on 07/11/25 at 12:24pm.

Refer to interview with the Administrator on

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D 280	Continued From page 25 07/11/25 at 1:45pm. Refer to attempted telephone interview with the LHPS nurse on 07/11/25 at 1:36pm. 3. Review of Resident #1's current FL-2 dated 07/23/24 revealed diagnoses included dementia, anorexia, hypertension, hyperlipidemia, major depressive disorder, vitamin deficiency, and insomnia. Review of Resident #1's Resident Register revealed she was admitted from another facility on 10/10/22. Review of Resident #1's assessment and care plan dated 03/24/25 revealed the resident was totally dependent on toileting, ambulation, dressing, grooming and transferring. Review of Resident #1's record on 01/23/24 revealed: -There was documentation of a Licensed Health Professional Support (LHPS) completed on 06/09/25. -The personal care tasks currently present were toileting every 2 hours, assist with showering, dressing, geri chair, transfers, and feeding. -The documentation under the review of health status and care provided, physical assessment as related to diagnoses included incontinent care every 2 hours, assist with bathing and dressing, geri chair for ambulation, hospice, assist with feeding, and wounds. -The documentation under the changes and follow up recommendation included to keep the area free of clutter for ambulation to prevent falls. -There was no documentation a physical assessment was completed.	D 280		

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SPRING ARBOR OF SAND HILLS	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(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 280	Continued From page 26 Refer to interview with the Special Care Director (SCD) on 07/11/25 at 12:24pm. Refer to interview with the Administrator on 07/11/25 at 1:45pm. Refer to attempted telephone interview with the LHPS nurse on 07/11/25 at 1:36pm. 4. Review of Resident #4's FL-2 dated 11/20/24 revealed diagnoses included Alzheimer's disease, insomnia, anxiety disorder unspecified, and hypertensive heart disease. Review of Resident #4's Transition of Care Visit on 06/23/25 revealed additional diagnoses included transient ischemic attack, osteoarthritis, anemia, hypoproteinemia, dysphasia, vitamin d deficiency, and vitamin B12 deficiency. Review of Resident #4's Resident Register revealed she was admitted to the facility on 05/31/21. Review of Resident #4's current care plan dated 06/17/25 revealed: -Resident #4 was non-ambulatory and utilized a gerichair. -Resident #4 was totally dependent on facility staff for eating, toileting, ambulation/locomotion, bathing, dressing, personal hygiene, and transfers. Review of Resident #4's Licensed Health Professional Support (LHPS) evaluation and quarterly review dated 02/03/25 revealed: -Review of health status and care provided and recommended changes in care included assist with toileting, showering/dressing, resident used a walker, and wheelchair at times.	D 280		

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-There was no physical assessment documented.
-Changes and follow up recommended to meet the Resident's needs included redirect resident when confused.
-LHPS personal care tasks provided included toileting every 2 hours, assist with showering/dressing, and assist with wheelchair.

Review of Resident #4's LHPS evaluation and quarterly review dated 05/16/25 revealed:
- Review of health status and care provided and recommended changes in care included assist with toileting, showering/dressing, resident used a walker, and wheelchair at times.
-There was no physical assessment documented.
-Changes and follow up recommended to meet the Resident's needs included redirect resident when confused.
-LHPS personal care tasks provided included toileting every 2 hours, assist with showering/dressing, and assist with wheelchair.

Observation of Resident #4 on 07/09/25 at 7:55am revealed:
-Resident #4 was in her gerichair in the dining room.
-Resident #4 was unable to answer questions and once stated "I don't know".

Interview with Special Care Coordinator (SCC) on 07/10/25 at 10:30am revealed:
-Resident #4 had very different care needs now versus prior to her hospitalization in mid-June 2025.
-Resident #4 was walking with a walker or using a wheelchair before hospitalization and now required total care for all personal care needs including transfers.

Based on observations, record review, and

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interviews, it was determined that Resident #4 was not interviewable.

Refer to interview with the Special Care Director (SCD) on 07/11/25 at 12:24pm.

Refer to interview with the Administrator on 07/11/25 at 1:45pm.

Refer to attempted telephone interview with the LHPS nurse on 07/11/25 at 1:36pm.

5. Review of Resident #5's current FL-2 dated 06/03/25 revealed:
-Diagnoses included cardiac arrest and vascular dementia.
-The resident was non-ambulatory and required assistance with bathing and dressing.
-There was an order for Repatha 140mg/ml inject 140mg subcutaneously every 14 days for hyperlipidemia. [Repatha is used to treat hyperlipidemia (high cholesterol and high triglycerides).]

Review of Resident #5's Resident Register revealed:
-The resident was admitted to the facility on 03/24/25.
-The resident required assistance for dressing, bathing, nail care, shaving, ambulation, getting in/out of bed, toileting, hair/grooming, skin care, and orientation to time and place.
-The resident had significant memory loss and must be directed.
-The resident used a walker.

Review of Resident #5's current assessment and care plan completed 06/03/25 revealed:
-The resident was documented as ambulatory with aide or device, but the type of device was not

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documented.
-The resident was documented as being forgetful and needed reminders.
-The resident was documented as totally dependent on staff assistance with toileting, ambulation, bathing, dressing, grooming, and transferring.

Observation of Resident #5 on 07/09/25 at 8:00am revealed the resident was pushed in a wheelchair to the dining room by staff.

Interview with Resident #5 on 07/11/25 at 11:44am revealed:
-The facility staff assisted the resident with tasks including ambulation with her wheelchair and transferring.
-She could not recall if she received an injection.

Review of Resident #5's current Licensed Health Professional Support (LHPS) review dated 05/16/25 revealed:
-The nurse documented the resident's LHPS tasks were ambulation using assistive devices that required physical assistance and transferring semi-ambulatory or non-ambulatory residents.
-The nurse did not include medication through injection as a task for the resident.
-The section for vital signs and weight was blank.
-The section to document the physical assessment noted: assist with showering/dressing, wheelchair assistance, toileting every 2 hours, and hospice.
-There was no physical assessment related to any of the resident's LHPS tasks.
-There was no physical assessment related to the resident's need for assistance with ambulation or transferring including how many staff were required for assistance with those tasks.
-There was no physical assessment related to the

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resident's medication through injection including no documentation regarding the injection sites.
-There were no recommendations related to a physical assessment of the resident.

Refer to interview with the Special Care Director (SCD) on 07/11/25 at 12:24pm.

Refer to interview with the Administrator on 07/11/25 at 1:45pm.

Refer to attempted telephone interview with the LHPS nurse on 07/11/25 at 1:36pm.

_____

Interview with the Special Care Director (SCD) on 07/11/25 at 12:24pm revealed:
-The LHPS nurse usually came to the facility to do LHPS reviews.
-The LHPS nurse would see the residents and assess the residents and she used the LHPS form to document her assessment.
-If there were any major issues or concerns, the LHPS nurse would notify her or the Resident Care Director (RCD), Special Care Coordinator (SCC), or the Resident Care Coordinator (RCC).
-She usually checked to make sure the LHPS reviews were done quarterly and included all LHPS tasks for the residents.
-She had not noticed the LHPS nurse had not documented a physical assessment on the LHPS reviews or that some tasks were not included on the LHPS reviews.

Interview with the Administrator on 07/11/25 at 1:45pm revealed:
-The LHPS nurse usually reviewed residents' orders and records and also physically visited with each resident.
-The LHPS review should include a physical assessment which should be documented on the

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D 280	Continued From page 31 LHPS form. -The LHPS review should include an assessment for all LHPS tasks for each resident. -The RCD, RCC, SCD, and SCC were responsible for checking the LHPS quarterly reviews to make sure the reviews were complete. Attempted telephone interview with the LHPS nurse on 07/11/25 at 1:36pm was unsuccessful.	D 280		
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: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 4 residents (#16, #17) observed during the medication pass including errors with an eye drop for glaucoma, an eye drop for dry eye disease and a medication for constipation (#16), and a medication for high blood pressure and a topical pain patch (#17); and for 4 of 8 sampled residents (#4, #5, #15, #17) including errors with a blood thinner and an antibiotic (#4), and medications for high blood pressure (#5, #15, #17).	D 358		

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D 358	Continued From page 32 The findings are: 1. The medication error rate was 16% as evidenced by 5 errors out of 30 opportunities during the 8:00am medication pass on 07/09/25. a. Review of Resident #16's current FL-2 dated 12/16/24 revealed: -Diagnoses included essential hypertension, heart failure, chronic obstructive pulmonary disease, dementia, diabetes mellitus type 2, chronic kidney disease, and muscle weakness. -There was an order for Miralax 17 grams (g) every morning and at bedtime. (Miralax is a laxative used to treat and prevent constipation. Miralax is a powder and the inside of the cap on the bottle has a marking for 17g that should be used to measure the dosage at the top of the white section of the inner cap.) Observation of the 8:00am medication pass on 07/09/25 revealed: -There was a white section lining the inside of the purple cap on the Miralax bottle. -There was "17g" imprinted near the top of the white section with an arrow pointing up to indicate the measurement for 17g was at the top of the white section inside the cap. -The medication aide (MA) poured the Miralax powder halfway below the marking for the 17g dose. -The MA mixed the Miralax powder in water and gave it to Resident #16 to take with her oral medications at 7:49am. -The resident drank all the water with Miralax. -The MA did not measure the Miralax correctly and the full dosage was not mixed in the cup of water. -The resident did not receive the full dosage of Miralax.	D 358		

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D 358	Continued From page 33 Review of Resident #16's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Miralax, mix 17 grams in fluid and drink twice a day for constipation scheduled at 8:00am and 8:00pm. -Miralax was documented as administered daily from 07/01/25 - 07/09/25. Observation of Resident #16's medications on hand on 07/09/25 at 1:11pm revealed there was a bottle of Miralax dispensed on 05/30/25 with a direction change sticker placed over the instructions on the medication label. Interview with the MA on 07/09/25 at 1:13pm revealed: -She was taught to measure the Miralax dosage using the white inner cap. -She usually measured the Miralax powder below the "17g" marking. -She had not noticed the marking for 17g pointing to the top of the inner white lining of the cap. -She thought the marking for 17g was the groove below the "17g". -Resident #16 usually had bowel movements every day and the resident did not complain of constipation. Interview with Resident #16 on 07/09/25 at 1:22pm revealed: -She usually received Miralax every day and she usually drank all of it. -She felt like she was currently constipated because her last bowel movement was a couple of days ago. Interview with the Resident Care Coordinator (RCC) on 07/09/25 at 1:50pm revealed:	D 358		

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-The MAs were supposed to use the white inner lining of the Miralax cap to measure the correct dosage.
-There should be a marking to measure 17 grams on the white inner lining of the cap.

Interview with the Administrator on 07/09/25 at 1:58pm revealed the MAs should use the correct marking for 17 grams to measure the correct amount of Miralax for Resident #16.

Telephone interview with a nurse at Resident #16's primary care provider (PCP) office on 07/10/25 at 1:59pm revealed:
-The resident's PCP was unavailable for interview.
-Not receiving the full dose of Miralax could cause constipation.
-Resident #16 had congestive heart failure and did not need to be constipated.
-The additional strain of being constipated could cause increased blood pressure.

b. Review of Resident #16's current FL-2 dated 12/16/24 revealed:
-There was an order for Combigan 0.2-0.5% instill 1 drop in both eyes 3 times a day. (Combigan is used to treat glaucoma.)
-There was an order for Cyclosporine Ophthalmic 0.05% instill 1 drop in both eyes every 12 hours for tear production. (Cyclosporine is used to treat dry eye disease.)

Review of the facility's eye medication administration policies and procedures (revision date of 05/2021) revealed:
-The facility provided a copy of the Medication Administration Skills Validation Form and highlighted eye drops and ointments.
-The Medication Administration Skills Validation

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D 358	Continued From page 35 Form referenced the Guidelines for Completing the Medication Administration Skills Validation Form. -According to the Guidelines, when two or more different eye drops must be administered at the same time, a 3 to 5-minute period should be allowed between each. Observation of the 8:00am medication pass on 07/09/25 revealed: -The medication aide (MA) administered 2 drops in each eye of Cyclosporine 0.05% to Resident #16 at 7:50am instead of 1 drop in each eye as ordered. -The MA immediately administered 1 drop in each eye of Combigan 0.2-05% to Resident #16, causing the resident's eyes to overflow and the eye drops ran out of the resident's eyes and down her face. -The MA did not wait 3 to 5 minutes between drops. Review of Resident #16's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Combigan 0.2-0.5% instill 1 drop in each eye 2 times daily for glaucoma scheduled at 8:00am and 8:00pm. -Combigan was documented as administered from 07/01/25 - 07/09/25 (8:00am). -There was an entry for Cyclosporine 0.05% place 1 drop in each eye 2 times daily scheduled at 8:00am and 8:00pm. -Cyclosporine was documented as administered from 07/01/25 - 07/09/25 (8:00am). Observation of Resident #16's medications on hand on 07/09/25 at 1:11pm revealed: -There were 180 single use vials of Cyclosporine 0.05% eye drops dispensed on 03/18/25.	D 358		

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-The instructions were to instill 1 drop in both eyes two times a day.
-There was a bottle of Combigan eye drops dispensed on 06/02/25.
-The instructions were to instill 1 drop into affected eye(s) two times a day as directed.

Interview with the MA on 07/09/25 at 1:13pm revealed:
-She thought she only administered 1 drop in each eye of Cyclosporine to Resident #16, but the drops sometimes came out of the single use vials very fast.
-She administered both of Resident #16's eye drops at the same time because they were both scheduled at the same time on the eMAR.
-She did not remember being trained to wait between different eye drops.

Interview with Resident #16 on 07/09/25 at 1:22pm revealed:
-She usually received Combigan, and one other eye drop at the same time.
-The MAs were supposed to wait 5 minutes between the drops, but they "never do".
-The eye drops usually ran out of her eyes.
-Her eye doctor had told her they should wait 5 minutes between the eye drops.
-She was not currently having any issues with dry eyes.

Interview with the Resident Care Coordinator (RCC) on 07/09/25 at 1:50pm revealed:
-The MAs were supposed to wait 3 to 5 minutes between different eye drops.
-If 1 drop in each eye was ordered, the MA should administer 1 drop in each eye, not 2 drops in each eye.

Interview with the Administrator on 07/09/25 at

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D 358	Continued From page 37 1:58pm revealed: -The MAs should wait 3 to 5 minutes between each different eye drop. -The MAs should only administer the amount of eye drops ordered. Telephone interview with a triage staff person at Resident #16's eye care provider's office on 07/10/25 at 9:08am revealed: -The eye care provider was unavailable for interview. -Resident #16 should only receive 1 drop in each eye of Cyclosporine. -There should be a 5-minute wait period between the administration of different eye drops to prevent the eye drops from running out of the eye, which would lower the dosage received and make the medication less effective. c. Review of Resident #17's current FL-2 dated 05/12/25 revealed diagnoses included Alzheimer's dementia, type 2 diabetes mellitus, osteoarthritis of the knees, and hyperlipidemia. Review of Resident #17's primary care provider (PCP) order dated 05/30/25 revealed an order for Hydralazine 10mg 1 tablet 3 times a day, hold if systolic blood pressure (SBP) is less than (<) 110 or diastolic blood pressure (DBP) is <60 and/or heart rate (HR) is <60. (Hydralazine is used to lower blood pressure.) Observation of the 8:00am medication pass on 07/09/25 revealed: -The medication aide (MA) prepared and administered morning medications to Resident #17 including Hydralazine 10mg at 8:23am. -The MA did not check Resident #17's BP or HR prior to administering Hydralazine to determine if the medication should have been held.	D 358		

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D 358	Continued From page 38 Observation on 07/09/25 at 8:27am revealed the MA checked Resident #17's BP and HR, after Hydralazine was administered, and the resident's BP was 162/86 and the HR was 78. Review of Resident #17's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Hydralazine 10mg take 1 tablet 3 times a day for BP, hold if SBP <110 or DBP ,60 or HR <60. -Hydralazine was scheduled at 8:00am, 2:00pm, and 8:00pm. -Hydralazine was documented as administered from 07/01/25 - 07/09/25 (8:00am). Observation of Resident #17's medications on hand on 07/09/25 at 12:52pm revealed: -There was a supply of Hydralazine 10mg tablets dispensed on 06/14/25. -The instructions were to take 1 tablet 3 times a day for BP, hold if SBP <110 or DBP <60 or HR <60. Interview with the MA on 07/09/25 at 12:53pm revealed: -She usually checked the Resident #17's BP prior to administering the Hydralazine. -This morning, 07/09/25, she was in a hurry and moving too fast with the medication pass because she was late getting to work that morning. -Resident #17's BP usually ran high. Interview with Resident #17 on 07/09/25 at 12:46pm revealed: -The MAs checked her blood pressure every day. -They sometimes checked it before she got her medications and sometimes it was after she got	D 358		

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(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
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her medications.

Interview with the Special Care Director (SCD) on 07/09/25 at 1:34pm revealed:
-The MAs had been trained to read the eMAR and medication labels and administer the medications as ordered.
-The MAs should check Resident #17's BP and HR prior to administering Hydralazine to determine if it should be held.

Interview with the Administrator on 07/09/25 at 1:58pm revealed:
-The MAs should read the instructions on the eMAR and medication label.
-If there were orders for parameters, Resident #17's BP and HR should be checked prior to administering the Hydralazine.

Telephone interview with a Nurse Practitioner (NP) at Resident #17's PCP office on 07/11/25 at 12:01pm revealed:
-Resident #17's BP and HR should be checked prior to administering Hydralazine.
-If Hydralazine was administered when the resident's BP or HR were below the parameters, it could cause low BP and lead to dizziness and falls.

d. Review of Resident #17's primary care provider (PCP) order dated 05/30/25 revealed an order for Lidocaine 5% topical patch, apply 1 patch topically (for fracture of one rib, right side) one time each day; remove and discard patch within 12 hours or as directed. (Lidocaine 5% patch is a topical medication used to treat pain.)

Observation of the 8:00am medication pass on 07/09/25 revealed:
-Resident #17 was sitting up on the side of her

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bed.
-The medication aide (MA) applied a Lidocaine 5% patch to Resident #17's lower midback at 8:26am.
-The resident did not complain of pain in her back.
-The MA did not apply the Lidocaine patch to the resident's right side as ordered.

Review of Resident #17's July 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Lidocaine 5% patch, apply 1 patch to affected area of right side for fractured rib once daily for pain; remove old patch before applying a new patch; on for 12 hours and off for 12 hours.
-Lidocaine patch was scheduled for 8:00am and 8:00pm (removal).
-Lidocaine patch was documented as applied to the right side at 8:00am from 07/01/25 - 07/09/25.

Observation of Resident #17's medications on hand on 07/09/25 at 12:52pm revealed:
-There was a box of Lidocaine 5% patches dispensed on 06/04/25.
-The instructions were to apply 1 patch to affected area of right side for fractured rib once daily for pain.

Interview with the MA on 07/09/25 at 12:53pm revealed:
-She usually applied the Lidocaine patch to Resident #17's left side or back, wherever the resident complained of pain the most.
-She had not noticed the instructions indicated to put the Lidocaine patch on the resident's right side.

Interview with Resident #17 on 07/09/25 at

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D 358	Continued From page 41 12:46pm revealed: -She had pain at times on either her left or right side. -The MAs sometimes put a pain patch on her back or either her left or right side. -The pain patch usually helped with her pain. Interview with the Special Care Director (SCD) on 0/709/25 at 1:34pm revealed: -The MAs had been trained to read the eMAR and medication labels and administer the medications as ordered. -Resident #17's Lidocaine patch should be applied to the right side and indicated in the instructions on the eMAR and the medication label. -If a MA had questions, the MA should come to her or the Special Care Coordinator (SCC). Interview with the Administrator on 07/09/25 at 1:58pm revealed: -The MAs should read the instructions on the eMAR and medication label. -Resident #17's Lidocaine patch should be applied according to the instructions on the eMAR. Telephone interview with a Nurse Practitioner (NP) at Resident #17's PCP office on 07/11/25 at 12:01pm revealed if Resident #17's Lidocaine patch was not applied to the correct location, it could cause the resident pain due to not treating the affected area. 2. Review of Resident #15's current FL-2 dated 01/08/25 revealed: -Diagnoses included hypertension, peripheral vascular disease, chronic kidney disease, edema, end stage renal disease with dialysis, gastroesophageal reflux disease, osteoarthritis,	D 358		

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and history of falls.
-There was an order for Hydralazine 100mg 1 tablet 3 times a day for hypertension, hold of blood pressure (BP) is less than (<) 120/60. (Hydralazine lowers blood pressure.)

Review of Resident #15's June 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Hydralazine 100mg 1 tablet 3 times daily for hypertension, hold for BP < 120/60.
-Hydralazine was scheduled for administration at 8:00am, 2:00pm, and 8:00pm.
-Hydralazine was documented as administered 3 times daily from 06/01/25 - 06/30/25.
-There was no space designated with the entry for Hydralazine to document the resident's BP.
-There was an entry under the "Vitals" section of the eMAR for BP with scheduled times of 8:00am and 2:00pm.
-There was only one BP documented at 2:00pm from 06/01/25 - 06/30/25 which was 123/63 on 06/14/25.
-The resident's BP was documented daily at 8:00am and ranged from 121/59 - 196/87.
-There was no documentation of the resident's BP being checked prior to the administration of Hydralazine at 2:00pm and 8:00pm from 06/01/25 - 06/30/25, except for one BP check at 2:00pm on 06/14/25.
-It could not be determined if Hydralazine should have been held when the BP was not checked at 2:00pm and 8:00pm.

Review of Resident #15's July 2025 eMAR revealed:
-There was an entry for Hydralazine 100mg 1 tablet 3 times daily for hypertension, hold for BP < 120/60.

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D 358	Continued From page 43 -Hydralazine was scheduled for administration at 8:00am, 2:00pm, and 8:00pm. -Hydralazine was documented as administered 3 times daily from 07/01/25 - 07/09/25 at 8:00am. -There was no space designated with the entry for Hydralazine to document the resident's BP. -There was an entry under the "Vitals" section of the eMAR for BP with a scheduled time of 8:00am. -There was no scheduled BP check for 2:00pm or 8:00pm. -The resident's BP was documented at 8:00am and ranged from 132/93 - 197/69 from 07/01/25 - 07/09/25. -There was no documentation of the resident's BP being checked prior to the administration of Hydralazine at 2:00pm and 8:00pm from 07/01/25 - 07/09/25. -It could not be determined if Hydralazine should have been held when the BP was not checked at 2:00pm and 8:00pm. Interview with a medication aide (MA) on 07/09/25 at 1:06pm revealed: -She usually worked first shift. -She usually checked Resident #15's BP when it popped up on the eMAR to be checked at 8:00am. -Sometimes she checked the resident's BP before she administered the resident's medications and sometimes after. -She had not noticed the instructions to hold the Hydralazine based on the resident's BP. -She did not recall anything popping up on the eMAR at 2:00pm to check the resident's BP. Interview with Resident #15 on 07/10/25 at 5:15pm revealed: -She received medications for high BP. -Her BP was usually checked by staff at the	D 358		

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dialysis center 3 times a week.
-She was not sure how often facility staff usually checked her BP.
-Her BP usually ran "pretty good" as far as she knew.

Interview with the Resident Care Coordinator (RCC) on 07/09/25 at 1:50pm revealed:
-The MAs should check Resident #15's BP prior to administering each dose of Hydralazine.
-The BP should be checked and documented 3 times a day for the administration of Hydralazine on the eMARs.
-She was not aware Resident #15's BP was not being checked and documented prior to the administration of Hydralazine at 2:00pm and 8:00pm.
-The pharmacy entered orders into the eMAR system.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/10/25 at 3:57pm revealed:
-The pharmacy staff typically entered orders into the eMAR system, including hours of administration.
-It appeared there had been some problems with hours of administration in the facility's eMAR system.
-The facility was supposed to review and approve orders prior to the order becoming active.
-The facility could have rejected the Hydralazine entry and let the pharmacy know it needed to be fixed or the facility could have fixed it on their end.

Interview with the facility's Director of Quality and Education / Registered Nurse (RN) on 07/09/25 at 1:46pm revealed:
-The pharmacy usually entered orders into the eMAR system.

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D 358	Continued From page 45 -The Resident Care Director (RCD), RCC, Special Care Director (SCD), and Special Care Coordinator (SCC) had access to enter orders into the eMAR system, and they were also responsible for verifying all orders prior to the orders becoming active in the eMAR system. -The order for Resident #15's Hydralazine should have been checked to make sure it was set up correctly in the system to include a space for the resident's BP to be documented for the administration of Hydralazine. -They could not locate any documentation of Resident #15's BP being checked at 2:00pm or 8:00pm. -Resident #15's BP should have been checked prior to administering Hydralazine to determine if the medication should have been held. Telephone interview with a Nurse Practitioner (NP) at Resident #15's PCP office on 07/11/25 at 12:01pm revealed: -Resident #15 took a few medications for high blood pressure. -The resident's BP needed to be checked before administering Hydralazine to determine if the medication needed to be administered or held. -Administering Hydralazine when the resident's BP was below the ordered parameter could cause the resident's blood pressure to be too low which could cause dizziness and falls. 3. Review of Resident #17's current FL-2 dated 05/12/25 revealed diagnoses included Alzheimer's dementia, type 2 diabetes mellitus, osteoarthritis of the knees, and hyperlipidemia. Review of Resident #17's primary care provider (PCP) order dated 05/30/25 revealed an order for Hydralazine 10mg 1 tablet 3 times a day, hold if systolic blood pressure (SBP) is less than (<) 110	D 358		

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D 358	Continued From page 46 or diastolic blood pressure (DBP) is <60 and/or heart rate (HR) is <60. (Hydralazine is used to lower blood pressure.) Review of Resident #17's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Hydralazine 10mg take 1 tablet 3 times a day for BP, hold if SBP <110 or DBP <60 or HR <60. -Hydralazine was scheduled at 8:00am, 2:00pm, and 8:00pm. -Hydralazine was documented as administered 3 times a day from 07/01/25 - 07/09/25 (8:00am). -There was no space for BP or HR to be documented with the Hydralazine entry. -There was an entry in the "Vitals" section of the eMAR for BP daily at 8:00am. -The resident's BP was documented as being checked daily at 8:00am from 07/01/25 - 07/09/25 and ranged from 123/75 - 166/82 but there were no HRs documented. -There were no BP checks documented for 2:00pm or 8:00pm. -There were no HR checks documented at 8:00am, 2:00pm, or 8:00pm. -It could not be determined if Resident #15's Hydralazine should have been held or administered without BP and HR being checked. Observation of Resident #17's medications on hand on 07/09/25 at 12:52pm revealed: -There was a supply of Hydralazine 10mg tablets dispensed on 06/14/25. -The instructions were to take 1 tablet 3 times a day for BP, hold if SBP <110 or DBP <60 or HR <60. Interview with a medication aide (MA) on 07/09/25 at 12:53pm revealed:	D 358		

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D 358	Continued From page 47 -She usually checked the Resident #17's BP prior to administering the Hydralazine in the mornings. -The HR was also noted on the electronic BP machine when the resident's BP was checked. -The resident's BP usually ran high. -She usually checked the resident's BP when it appeared on the eMAR. -She did not recall checking the resident's BP or HR other than during the 8:00am medication pass because she did not recall a specific entry popping up on the eMAR to check it and document it at any other time. Interview with Resident #17 on 07/09/25 at 12:46pm revealed: -The MAs checked her blood pressure every day. -They sometimes checked it before she got her medications and sometimes it was after she got her medications. Interview with the Special Care Director (SCD) on 07/09/25 at 1:34pm revealed: -The MAs had been trained to read the eMARs and medication labels and administer the medications as ordered. -The MAs should check Resident #17's BP and HR prior to administering Hydralazine at each time it was scheduled to determine if it should be held. -If there were any questions about the eMARs, the MAs should notify her or the Special Care Coordinator (SCC). Interview with the Administrator on 07/09/25 at 1:58pm revealed: -The MAs should read the instructions on the eMAR and medication label. -If there were orders for parameters, Resident #17's BP and HR should be checked prior to administering the Hydralazine.	D 358		

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D 358	Continued From page 48 Interview with the facility's Director of Quality and Education / Registered Nurse (RN) on 07/09/25 at 1:46pm revealed: -The pharmacy usually entered orders into the eMAR system. -The Resident Care Director (RCD), Resident Care Coordinator (RCC), SCD, and SCC had access to enter orders into the eMAR system, and they were also responsible for verifying all orders prior to the orders becoming active in the eMAR system. -The order for Resident #17's Hydralazine should have been checked to make sure it was set up correctly in the system to include a space for the resident's BP and HR to be documented for the administration of Hydralazine. -She could not locate any documentation of Resident #17's BP and HR being checked at 2:00pm or 8:00pm. -Resident #17's BP and HR should have been checked prior to administering Hydralazine to determine if the medication should have been held. Telephone interview with a Nurse Practitioner (NP) at Resident #17's PCP office on 07/11/25 at 12:01pm revealed: -Resident #17's BP and HR should be checked prior to administering Hydralazine. -If Hydralazine was administered when the resident's BP or HR were below the parameters, it could cause low BP and lead to dizziness and falls. 4. Review of Resident #5's current FL-2 dated 06/03/25 revealed: -Diagnoses included cardiac arrest and vascular dementia. -There was an order for Carvedilol 25mg 1 tablet	D 358		

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2 times a day with meals, hold for systolic blood pressure (SBP) less than or equal to (<) 100 and heart rate (HR) <55. (Carvedilol is used to lower BP and HR.)

Review of Resident #5's May 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Carvedilol 25mg take 1 tablet 2 times a day with meals, hold for SBP <100 and HR <55.
-Carvedilol was scheduled at 8:00am and 8:00pm.
-Carvedilol was documented as administered 2 times a day from 05/01/25 - 05/31/25.
-There was no space for BP or HR to be documented with the Carvedilol entry.
-There was an entry in the "Vitals" section of the eMAR for BP at 8:00am.
-The resident's BP was documented as being checked one day on 05/11/25 at 8:00am and was 128/90 and the HR was 68.
-There were no other BP checks documented at 8:00am or 8:00pm.
-There were no other HR checks documented at 8:00am or 8:00pm.
-It could not be determined if Resident #5's Carvedilol should have been held or administered without BP and HR being checked.

Review of Resident #5's June 2025 eMAR revealed:
-There was an entry for Carvedilol 25mg take 1 tablet 2 times a day with meals, hold for SBP <100 and HR <55.
-Carvedilol was scheduled at 8:00am and 8:00pm.
-Carvedilol was documented as administered 2 times a day from 06/01/25 - 06/30/25 except on 06/12/25 and 06/25/25 at 8:00pm with no reason

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noted.
-There was no space for BP or HR to be documented with the Carvedilol entry.
-There were no BP or HR checks documented at 8:00am or 8:00pm.
-It could not be determined if Resident #5's Carvedilol should have been held or administered without BP and HR being checked.

Review of Resident #5's July 2025 eMAR revealed:
-There was an entry for Carvedilol 25mg take 1 tablet 2 times a day with meals, hold for SBP <100 and HR <55.
-Carvedilol was scheduled at 8:00am and 8:00pm.
-Carvedilol was documented as administered 2 times a day from 07/01/25 - 07/07/25.
-There was no space for BP or HR to be documented with the Carvedilol entry.
-There were no BP or HR checks documented at 8:00am or 8:00pm.
-It could not be determined if Resident #5's Carvedilol should have been held or administered without BP and HR being checked.

Observation of Resident #5's medications on hand on 07/10/25 at 11:26am revealed:
-There was a supply of Carvedilol 25mg tablets dispensed on 06/11/25 with 4 of 30 tablets remaining.
-There was a supply of Carvedilol 25mg tablets dispensed on 07/02/25 with 17 of 22 tablets remaining.
-The instructions were to take 1 tablet 2 times a day, hold for SBP <100 and HR <55.

Interview with a medication aide (MA) on 07/10/25 at 11:18am revealed:
-A block did not always pop up on the eMAR to

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check Resident #5's BP and HR.
-She usually tried to check the resident's BP and HR prior to administering the Carvedilol.
-If no block popped up with the Carvedilol entry, she would document the BP and HR in the vital signs section of the eMAR when she checked it.
-She did not know why there were no BPs or HRs documented on the eMARs for Resident #5.

Interview with Resident #5 on 07/11/25 at 11:44am revealed:
-The MAs checked her blood pressure, but she could not say how often.
-She denied any current symptoms of high or low BP.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/10/25 at 3:57pm revealed:
-The pharmacy staff typically entered orders into the eMAR system, including hours of administration.
-It appeared there had been some problems with hours of administration in the facility's eMAR system.
-She could see blocks for Resident #5's BP and HR to be checked and documented on the eMAR for the pharmacy's eMAR system but not on the facility's eMAR system.
-The facility was supposed to review and approve orders prior to the order becoming active.
-The facility could have rejected the Carvedilol entry and let the pharmacy know it needed to be corrected or the facility could have corrected it on their end.

Interview with the Special Care Coordinator (SCC) on 07/10/25 at 4:28pm revealed:
-She could not locate BPs or HRs on the eMARs for Resident #5's Carvedilol.

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SPRING ARBOR OF SAND HILLS	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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-She and the Special Care Director (SCD), Resident Care Director (RCD), and Resident Care Coordinator (RCC) were responsible for checking orders and approving the in the eMAR system.
-She usually checked the eMAR dashboard daily for accuracy.
-She had not noticed any problems with Resident #5's Carvedilol parameter not being followed.
-The facility just started using eMARs in April 2025, so they were still learning the eMAR system.

Interview with the facility's Director of Quality and Education / Registered Nurse (RN) on 07/09/25 at 1:46pm revealed:
-The pharmacy usually entered orders into the eMAR system.
-The RCD, RCC, SCD, and SCC had access to enter orders into the eMAR system and they were also responsible for verifying all orders prior to the orders becoming active in the eMAR system.
-Vital signs for medication orders with parameters should be checked prior to administering the medication and documented on the eMARs.

Telephone interview with the Clinical Manager for Resident #5's hospice provider on 07/11/25 at 10:56am revealed:
-Resident #5's BP and HR needed to be at a certain level prior to Carvedilol being administered.
-The resident could become hypotensive (low BP) if Carvedilol was administered when it should have been held.
-Low BP could cause the resident to feel lightheaded, weak, dizzy, and fatigued.

5. Review of Resident #4's FL-2 dated 11/20/24 revealed diagnoses included Alzheimer's disease,

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insomnia, anxiety disorder unspecified, and hypertensive heart disease.

Review of Resident #4's Transition of Care Visit Note dated 06/23/25 revealed additional diagnoses included transient ischemic attack, osteoarthritis, anemia, hypoproteinemia, dysphasia, vitamin d deficiency, and vitamin B12 deficiency.

Review of Resident #4's current care plan dated 06/17/25 revealed:
-Resident #4 was non-ambulatory and utilized a gerichair.
-Resident #4 was totally dependent on facility staff for eating, toileting, locomotion, bathing, dressing, personal hygiene, and transfers.

a. Review of Resident #4's After Visit Summary dated 06/16/25 revealed:
-Resident #4 was hospitalized from 06/08/25 to 06/16/25 for left and right femur fractures after an unwitnessed fall at the facility on 06/06/25 (the femur is the bone in the thigh).
-Resident #4 had surgery for the left femur fracture on 06/09/25 and for the right femur fracture on 06/10/25.
-Resident #4 started on Enoxaparin in the hospital (Enoxaparin is a medication used to thin the blood that prevents blood clotting).
-There was an order for Enoxaparin 30mg/0.3 mL inject 0.3 mL under the skin one time each day for 24 days to begin on 06/17/25.

Review of Resident #4's June 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Enoxaparin 30mg/0.3 mL syringes inject 0.3 mL subcutaneously every day for blood clot prevention for 24 days at 8:00am

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starting on 06/18/25 (subcutaneously means to inject the medication into the fat under the skin, typically into the skin of the stomach).
-Enoxaparin was documented as administered 12 of 13 opportunities.
-Enoxaparin was documented as "drug not given" on 06/18/25.

Review of Resident #4's July 2025 eMAR revealed:
-There was an entry for Enoxaparin 30mg/0.3 mL syringes inject 0.3 mL subcutaneously every day at 8:00am.
-The last dose was scheduled to be administered on 07/11/25.
-Enoxaparin 30mg/0.3 mL was documented as administered on 10 out of 10 opportunities.

Observation of Resident #4's medications on hand on 07/10/25 at 1:20pm revealed:
-There were 6 single dose syringes of Enoxaparin on the medication cart for Resident #4.
-The pharmacy dispensed 7.2 total mL of Enoxaparin which was the equivalent of 24 single dose syringes on 06/17/25.
-There should have only been 2 syringes left of Enoxaparin on the medication cart to account for the unadministered dose on 06/18/25 and the upcoming 07/11/25 dose.

Interview with a medication aide (MA) on 07/10/25 at 1:30pm revealed:
-She documented administration of Resident #4's Enoxaparin dose due at 8:00am that morning, 07/10/25, but did not actually administer it because she was told that administration of Enoxaparin should be performed by a hospice nurse.
-She had administered Enoxaparin multiple times to Resident #4.

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D 358	Continued From page 55 Interview with a pharmacist from the facility's contracted pharmacy on 07/10/25 at 2:46pm revealed: -Enoxaparin was dispensed for Resident #4 on 06/17/25 with a total quantity of 7.2 mL and the pharmacist confirmed that 7.2 mL was the equivalent of 24 doses. -Resident #4's missing doses of Enoxaparin could have led to the development of blood clots. Interview with the Administrator and Director of Quality and Education on 07/10/25 at 3:40pm revealed: -Initialed medication on the eMAR indicated that the medication was administered. -Missed doses of medication and the reason for the missed dose should be documented on the eMAR. -Staff should not document administration of a medication unless they administered the medication. Interview with Resident #4's primary care provider (PCP) on 07/10/25 at 4:00pm revealed missing 5 doses of the ordered 24 doses of Enoxaparin could have caused a blood clot, stroke, or death of Resident #4. b. Review of Resident #4's Physician's Order Sheet dated 06/30/25 revealed an order for Sulfamethoxazole/Trimethoprim 400/80mg give 1 tablet by mouth every 12 hours for 1 week (Sulfamethoxazole/Trimethoprim is a medication used to treat infection). Review of Resident #4's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for	D 358		

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D 358	Continued From page 56 Sulfamethoxazole/Trimethoprim 400/80mg give 1 tablet by mouth every 12 hours for 7 days at 8:00am and 8:00pm starting on 07/01/25 and ending with the 8:00pm dose on 07/07/25. -Sulfamethoxazole/Trimethoprim was documented as administered 14 out of 14 opportunities. Observation of Resident #4's medications on hand on 07/10/25 at 1:20pm revealed: -There were 14 tablets of Sulfamethoxazole/Trimethoprim 400/80mg dispensed by the facility's contracted pharmacy on 06/30/25. -There were 2 of 14 tablets of Sulfamethoxazole/Trimethoprim 400/80mg still present on the medication cart. Telephone interview with Resident #4's hospice nurse on 07/09/25 at 3:50pm revealed: -She visited Resident #4 three times a week to perform wound care to her Stage II wound on her sacrum. -Resident #4's sacral wound was a Stage two pressure ulcer and the size of a fifty-cent piece. -She received an order for Sulfamethoxazole/Trimethoprim on 06/30/25 after noticing that Resident #4's wound had a foul odor which indicated infection. Interview with a pharmacist from the facility's contracted pharmacy on 07/10/25 at 2:46pm revealed: -Sulfamethoxazole/Trimethoprim was dispensed on 06/30/25 in a quantity of 14 tablets. -Resident #4's missing doses of Sulfamethoxazole/Trimethoprim could lead to reoccurrence of infection. Interview with the facility's Administrator and	D 358		

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D 358	Continued From page 57 Director of Quality and Education on 07/10/25 at 3:40pm revealed: -Medication aides (MAs) should have administered all 14 doses of the Sulfamethoxazole/Trimethoprim as ordered. -MAs should not have documented administering the medication if they did not administer it. -MAs were taught to review the eMAR at the end of their shift to ensure all medications were documented as ordered and could have potentially documented administration of a medication they did not give at that review time. Interview with Resident #4's primary care provider (PCP) on 07/10/25 at 4:00pm revealed that missing 2 of the 14 ordered doses of Sulfamethoxazole/Trimethoprim could have caused reoccurrence of infection. _____ The facility failed to administer medications as ordered to 2 of 4 residents observed during the medication pass on 07/09/25. Resident #16 did not receive a full dosage of a medication used to treat constipation due to the medication aide (MA) not measuring the dosage correctly and the resident complained of constipation. Resident #16's eye drops for glaucoma and dry eye disease were administered too close together causing the eye drops to run out of the resident's eyes thereby decreasing the dosage causing the eye drops to be less effective. Resident #5, Resident #15, and Resident #17 had parameters for blood pressure (BP) and/or heart rate (HR) that were not checked prior to administration of their BP medications, putting the residents at risk of low blood pressure including symptoms of lightheadedness, weakness, dizziness, and fatigue. Resident #17's Lidocaine patch was applied to her back instead of her right side for a fractured rib putting the resident at risk of her	D 358		

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D 358	Continued From page 58 pain being untreated. Resident #4 missed 5 doses of an injectable blood thinner after surgery which could have resulted in blood clots, stroke, and death. Resident #4 missed 2 doses of an antibiotic for a sacral wound infection which could have led to a reoccurrence of the wound infection. The failure of the facility to administer medications as ordered put the residents at substantial risk of serious physical harm or death and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/10/25 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 10, 2025.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,	D 367		

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D 367	Continued From page 59 (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on record reviews, interviews, and observations for 1 of 5 sampled residents (#4), the facility did not ensure that the medication administration record (MAR) was accurate and included documentation of the omission of medications, including the reason for the omission. The findings are: Review of Resident #4's FL-2 dated 11/20/24 revealed diagnoses included Alzheimer's disease, insomnia, anxiety disorder unspecified, and hypertensive heart disease. Review of Resident #4's Transition of Care Visit Note dated 06/23/25 revealed additional diagnoses included transient ischemic attack, osteoarthritis, anemia, hypoproteinemia, dysphasia, vitamin d deficiency, and vitamin B12 deficiency. a. Review of Resident #4's After Visit Summary Note dated 06/16/25 revealed there was an order for Enoxaparin 30mg/0.3 mL (Enoxparin is a medication used to thin the blood and prevent blood clots) inject 0.3 mL under the skin one time each day for 24 days to begin on 06/17/25. Review of Resident #4's June 2025 electronic medication administration record (eMAR)	D 367		

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revealed:
-There was an entry for Enoxaparin 30mg/0.3 mL syringes inject 0.3 mL subcutaneously every day for blood clot prevention for 24 days at 8:00am starting on 06/18/25 (subcutaneously means to inject the medication into the fat under the skin, typically into the skin of the stomach).
-Enoxaparin was documented as "drug not given" on 06/18/25.
-Enoxaparin was documented as administered 12 out of 13 opportunities.

Review of Resident #4's July 2025 eMAR revealed:
-There was an entry for Enoxaparin 30mg/0.3 mL syringes inject 0.3 mL subcutaneously every day at 8:00am.
-The last dose was scheduled to be administered on 07/11/25.
-The medication was documented as administered on 10 out of 11 opportunities in July 2025.

Observation of medications on hand on 07/10/25 at 1:20pm revealed:
-There were 6 single dose syringes of Enoxaparin on the medication cart for Resident #4.
-The pharmacy dispensed 7.2 mL which equaled 24 doses on 06/17/25.

Interview with a medication aide (MA) on 07/10/25 at 1:30pm revealed:
-She documented administration of Resident #4's Enoxaparin dose due at 8:00am that morning, 07/10/25, but did not actually administer it.
-She should not have documented administration of Enoxaparin since she did not administer the medication.

Refer to interview with the facility's Administrator

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D 367	Continued From page 61 and Director of Quality and Education on 07/10/25 at 3:40pm. Refer to telephone interview with Resident #4's primary care provider (PCP) on 07/10/25. b. Review of Resident #4's Physician's Order Sheet dated 06/30/25 revealed an order for Sulfamethoxazole/Trimethoprim 400/80mg give 1 tablet by mouth every 12 hours for 1 week (Sulfamethoxazole/Trimethoprim is a medication that treats infection). Review of Resident #4's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Sulfamethoxazole/Trimethoprim 400/80mg give 1 tablet by mouth every 12 hours for 7 days at 8:00am and 8:00pm starting on 07/01/25 and ending with the 8:00pm dose on 07/07/25. -The medication was documented as administered 14 of 14 opportunities. Observation of medications on hand on 07/10/25 at 1:20pm revealed: -There were 14 tablets of Sulfamethoxazole/Trimethoprim 400/80mg dispensed by the facility's contracted pharmacy on 06/30/25. -There were 2 of 14 tablets of Sulfamethoxazole/Trimethoprim 400/80mg still present on the medication cart. _____ Interview with the Administrator and Director of Quality and Education on 07/10/25 at 3:40pm revealed: -Medication aides (MAs) were instructed to document accurate administration of medications. -If a medication was omitted, MAs should	D 367		

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D 367	Continued From page 62 document why the medication was omitted. -MAs should not have documented administering a medication if they did not administer it. Interview with Resident #4's primary care provider (PCP) on 07/10/25 at 4:00pm revealed: -Accurate documentation on the eMAR is important because it reflects the care of the resident and determines future care of the resident. -Inaccurate documentation can lead to complications for residents and changes to a resident's medication orders that were not needed or are dangerous for the resident.	D 367		