

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL047016	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/01/2025
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NAME OF PROVIDER OR SUPPLIER SPRING ARBOR OF SAND HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD RAEFORD, NC 28376
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{D 000}	Initial Comments	{D 000}		
D 079	<p>10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping and Furnishings</p> <p>(a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure the Special Care Unit (SCU) was free from hazards evidenced by unsecured oxygen cylinders in a resident's room.</p> <p>The findings are:</p> <p>Review of the facility's license revealed: -The facility was licensed as a Special Care Unit (SCU) effective 01/31/25 for a capacity of 75 residents. -The expiration date of the facility's license was 12/31/25.</p>	D 079		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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D 079	<p>Continued From page 1</p> <p>Review of the facility's census on 08/05/25 revealed the facility's census in the SCU was 47 residents.</p> <p>Observation of a resident room 411 on 09/30/25 at 9:30am revealed: -There were three portable oxygen cylinders sitting upright on the floor next to a chair in a paper crate. -There was one portable oxygen cylinder sitting on the floor next to the paper crate. -All four oxygen cylinders were not secured in a rack, cart, or holder.</p> <p>Interview with a medication aide (MA) on 09/30/25 at 10:13am revealed: -She did not know the policy on how the facility was to secure oxygen cylinders. -The oxygen cylinders had been sitting in the bedroom on the floor since the oxygen was ordered on 02/28/25 to her knowledge.</p> <p>Interview with a maintenance staff member on 10/01/25 at 4:45pam revealed: -He was not aware that oxygen cylinders were not secured in a resident's room on the SCU. -He was responsible to report any unsecured oxygen cylinders to upper management.</p> <p>Interview with the Resident Care Director (RCD) on 09/30/25 at 10:20am revealed: -She was not aware that oxygen cylinders were not secured in a resident's room on the SCU. -She did a walk through every day to ensure oxygen cylinders were secured and she was not sure how she missed the four unsecured oxygen cylinders. -She was responsible to check the oxygen cylinders to be sure they were secured.</p>	D 079		

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D 079	<p>Continued From page 2</p> <p>-She was responsible to call the supply company about a secure crate for all oxygen cylinders.</p> <p>Interview with the Administrator on 10/01/25 at 4:30pam revealed:</p> <p>-She was not aware that oxygen cylinders were not secured in a resident's room on the SCU.</p> <p>-The MA and the RCD did walk through the SCU every day to ensure oxygen cylinders were secured.</p> <p>-The Resident Care Coordinator (RCC), the RCD, and the memory care coordinator (MCC) were responsible for ensuring the oxygen cylinders were secured.</p> <p>Based on observations, interviews, and record reviews it was determined the resident who resided in room 411 was not interviewable.</p>	D 079		
{D 358}	<p>10A NCAC 13F .1004 (a) Medication Administration</p> <p>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:</p> <p>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and</p> <p>(2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 residents (#6, #7) observed during the medication pass including errors with a pain medication (#6), a medication used to treat mood disorders (#7),</p>	{D 358}		

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{D 358}	<p>Continued From page 3</p> <p>dementia symptoms (#7).</p> <p>The findings are:</p> <p>1. The medication error rate was 9% as evidenced by 3 errors out of 32 opportunities during the 8:00am medication pass on 10/01/25.</p> <p>a. Review of Resident #6's current FL-2 dated 11/20/24 revealed diagnoses including vascular dementia, hypertension, and hyperthyroidism.</p> <p>Review of a signed physician order review dated 07/14/25 revealed there was an order for Acetaminophen (used to treat pain) 500mg take two tablets three times a day for arthritis or pain.</p> <p>Observation of the 8:00am medication pass on 10/01/25 revealed:</p> <ul style="list-style-type: none"> -The medication aide (MA) prepared and administered Acetaminophen 500mg one tablet, instead of Acetaminophen 500mg two tablets, at 8:08am mixed in applesauce with 5 additional medications. -The MA spoonfed the medications to Resident #6 in the dining room of the memory care unit (MCU). <p>Review of Resident #6's October 2025 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for Acetaminophen 500mg tablet take two tablets by mouth three times a day for arthritis or pain scheduled at 8:00am, 2:00pm, and 8:00pm. -Acetaminophen 500mg two tablets was documented as administered at 8:00am on 10/01/25. <p>Interview with the MA on 10/01/25 at 8:07am</p>	{D 358}		

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{D 358}	<p>Continued From page 4</p> <p>revealed:</p> <ul style="list-style-type: none"> -Resident #6's medications that could be crushed were crushed prior to administration. -She administered medications based on what was transcribed on the electronic medication administration record (eMAR). -She looked at the eMAR before removing the medication from the pharmacy dispensed medication packaging to ensure the right medication and dosage was administered. <p>Second interview with the MA on 10/01/25 at 11:37am revealed:</p> <ul style="list-style-type: none"> -She was supposed to have administered Resident #6 Acetaminophen 500mg two tablets instead of Acetaminophen 500mg one tablet. -She realized after administering medications that she administered Resident #6 the wrong amount of Acetaminophen. -She had not done anything to correct the error but should have notified the Resident Care Director (RCD) and reported the error. <p>Third interview with the MA on 10/01/25 at 11:53am revealed:</p> <ul style="list-style-type: none"> -Resident #6 received hospice services. -Resident #6 complained of pain "every now and then". -The last time she heard Resident #6 complain of pain was about one month ago. <p>Interview with Resident #6 on 10/01/25 at 11:51am revealed:</p> <ul style="list-style-type: none"> -She was not feeling that good. -She did not know what was wrong but just did not feel good. <p>Telephone interview with Resident #6's nurse representative for the hospice agency on 10/01/25 at 10:44am revealed:</p>	{D 358}		

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{D 358}	<p>Continued From page 5</p> <ul style="list-style-type: none"> -Resident #6 was prescribed Acetaminophen 500mg two tablets three times a day beginning 05/06/25. -There had not been any changes to the physician's order for the acetaminophen since 05/06/25. -Resident #6's physician orders were recertified for the period of 07/09/25 through 10/06/25 by the hospice provider. -All of Resident #6's medications were packaged through the facility contracted provider pharmacy. -Resident #6 might be a little more uncomfortable, have aches and pains if the correct amount of acetaminophen was not administered because Resident #6 had arthritis. <p>Telephone interview with a pharmacist at the facility's contracted provider pharmacy on 10/01/25 at 2:40pm revealed:</p> <ul style="list-style-type: none"> -There was a current physician's order for Resident #6 dated 09/25/25 for Acetaminophen 500mg take two tablets three times a day. -The facility did not get resident medications "double bubble packaging". -The MAs should be punching out two tablets of the Acetaminophen 500mg tablet for administration to Resident #6. -The lower dose administered to Resident #6 was therapeutic, but the resident could experience more arthritic pain if not administered the prescribed dose. <p>Refer to the interview with the Resident Care Director (RCD) on 10/01/25 at 4:10pm.</p> <p>Refer to the interview with the Administrator on 10/01/25 at 12:07pm.</p> <p>b. Review of Resident #7's current FL-2 dated 05/12/25 revealed diagnoses including</p>	{D 358}		

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{D 358}	<p>Continued From page 6</p> <p>Alzheimer's dementia, type II diabetes mellitus, hypertension, osteoarthritis knees, and hyperlipidemia.</p> <p>Review of a signed physician order review dated 05/12/25 revealed there was an order for Memantine HCL (used to treat memory disorders such as Alzheimer's) 10mg take one tablet every day.</p> <p>Observation of the 8:00am medication pass for Resident #7 on 10/01/25 at 8:01am revealed the medication aide (MA) prepared and administered Memantine 5mg one tablet, instead of Memantine 5mg two tablets (10mg).</p> <p>Review of Resident #7's October 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Memantine HCL 5mg take two tablets to equal 10mg by mouth every day for Alzheimer's scheduled at 8:00am. -Memantine HCL 5mg take two tablets(10mg) was documented as administered at 8:00am on 10/01/25.</p> <p>Interview with the MA on 10/01/25 at 11:37am revealed: -She was supposed to have administered Resident #7 Memantine 5mg two tablets instead of Memantine 5mg one tablet. -She misread the instructions printed on the medication label and eMAR indicating that Resident #7 was supposed to have been administered Memantine 5mg two tablets instead of Memantine 5mg one tablet daily. -She had not done anything to correct the error but should have notified the Resident Care Director (RCD) and reported the error.</p>	{D 358}		

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{D 358}	<p>Continued From page 7</p> <p>Telephone interview with a pharmacist at the facility's contracted provider pharmacy on 10/01/25 at 2:55pm revealed:</p> <ul style="list-style-type: none"> -There was a current physician's order for Resident #7 dated 08/08/25 for Memantine 10mgs daily. -The pharmacist talked to the PCP (named) on 08/08/25 and the dosage for the Memantine was not changed from Memantine 10mg daily, but the instructions were changed to Memantine 5mg two tablets to equal 10mg daily. -The facility did not get resident medications "double bubble packaging". -The MAs should be punching out two tablets of the Memantine 5mg tablet for administration to Resident #7. <p>Refer to the interview with the Resident Care Director (RCD) on 10/01/25 at 4:10pm.</p> <p>Refer to the interview with the Administrator on 10/01/25 at 12:07pm.</p> <p>c. Review of Resident #7's current FL-2 dated 05/12/25 revealed diagnoses including Alzheimer's dementia, type II diabetes mellitus, hypertension, osteoarthritis knees, and hyperlipidemia.</p> <p>Review of a signed physician order review dated 05/12/25 revealed there was an order for Sertraline HCL (used to treat mood disorders) 50mg tablet every day.</p> <p>Observation of the 8:00am medication pass for Resident #7 on 10/01/25 at 8:01am revealed the medication aide (MA) prepared and administered Sertraline 100mg one tablet, instead of Sertraline 50mg one tablet.</p>	{D 358}		

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{D 358}	<p>Continued From page 8</p> <p>Review of Resident #7's October 2025 eMAR revealed: -There was an entry for Sertraline HCL 100mg take one tablets by mouth every day for mood scheduled at 8:00am. -Sertraline 100mg take one tablet was documented as administered at 8:00am on 10/01/25.</p> <p>Interview with the MA on 10/01/25 at 11:40am revealed: -She administered the Sertraline 100mg one tablet on 10/01/25 because those were the instructions on the eMAR and the Sertraline 100mg tablet was in the medication cart for the resident. -Medication orders were transcribed to the eMAR by the contracted provider pharmacy and approved by the Resident Care Director (RCD), Assistant Resident Care Director (ARCD), or Resident Care Coordinator (RCC) prior to the MAs being able to administer the medication. -She administered medication based on the instructions on the eMAR.</p> <p>Telephone interview with a pharmacist at the facility's contracted provider pharmacy on 10/01/25 at 2:59pm revealed: -They were responsible for transcribing physician orders to the eMARs. -There was an electronic prescription dated 05/08/25 with instructions for Sertraline 100mg tablet daily and a note for "dose increase". -There was no copy of an FL-2 dated 05/12/25 for Resident #7 in the pharmacy profile with a physician's order for Sertraline HCL 50mg tablet every day.</p> <p>Refer to the interview with the Resident Care Director (RCD) on 10/01/25 at 4:10pm</p>	{D 358}		

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{D 358}	<p>Continued From page 9</p> <p>Refer to the interview with the Administrator on 10/01/25 at 12:07pm.</p> <p>Interview with the Resident Care Director (RCD) on 10/01/25 at 4:10pm revealed:</p> <ul style="list-style-type: none"> -The RCD, Assistant Resident Care Director (ARCD), and Resident Care Coordinator (RCC) were responsible for reviewing and approving physician orders. -When a new physician order review was printed for physician signature, the physician order copy should be reviewed by the RCD, ARCD, or RCC to ensure the physician order review included all current physician's order. -All signed physician orders should be checked against the eMAR instructions and the medication on hand. <p>Interview with the Administrator on 10/01/25 at 12:07pm revealed:</p> <ul style="list-style-type: none"> -Medications were to be administered as ordered. -New physician orders were to be approved by the RCC, RCD, or ARCD prior to administration. -She expected the RCC, RCD, and ARCD to approve physician orders by comparing the instructions transcribed on the eMAR by the provider pharmacy, to the physical order in hand. -If there was a discrepancy in the order transcribed to the eMAR and the physician order, the order was not to be approved and clarification of the order was needed. 	{D 358}		