

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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(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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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	<p>Oxygen tanks in the community. The ED reached out to all hospice DME companies and informed them any oxygen tanks that were needed by the residents had to come with metal storage containers for safety, and if they could not secure them in that manner, they could not bring oxygen tanks.</p> <p>The ROD/RCC/CCD/Designee will review all oxygen orders that come into the community and ensure that once delivered, it has the appropriate secured storage container and is stored in a safe, secured manner.</p> <p>The ED/Designee will complete weekly oxygen checks to ensure</p>	<p>10/8/25 and ongoing</p> <p>11/27/25</p> <p>11/27/25</p>
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the the oxygen is stored correctly and secured.

Spring Arbor of Sandhills

License# HAL-047-016

County: Hoke

It is the policy and standard practice of Spring Arbor of Sandhills to comply with all North Carolina Adult Care rules and state regulations.

State Rule # and Rule: 10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings

(a) Adult care homes shall:

(5) Be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards.

Plan of Correction:

It shall always be the process of Spring Arbor Sandhills to ensure that the home is maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards. 10/8/25

The community immediately removed the oxygen tanks during survey, when it was brought to our attention. 10/8/25

The community also immediately conducted a check of all apartments to ensure that there were no unsecured oxygen tanks in the community. 10/8/25

The ED reached out to all hospice DME companies and informed them that any oxygen tanks that were needed by the residents had to come with metal storage containers for safety, and if they could not be secured in that manner, they would not be allowed to bring the oxygen tanks to the community.10/8/25

Prevention of Re-occurrence:

The RCD/RCC/CCD/Designee will review all oxygen orders that come into the community and ensure that once delivered, it has the appropriate secured storage container and is stored in a safe secured manner. 11/27/25

Monitoring Responsibility & Frequency:

The ED/Designee will complete weekly oxygen monitoring to ensure that the oxygen has been stored correctly and secured. 11/27/25

Correction Completion Date:

On or before 11/27/25 and ongoing until substantial compliance is obtained.

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D 079	Continued From page 2 -She was responsible to call the supply company about a secure crate for all oxygen cylinders. Interview with the Administrator on 10/01/25 at 4:30pam revealed: -She was not aware that oxygen cylinders were not secured in a resident's room on the SCU. -The MA and the RCD did walk through the SCU every day to ensure oxygen cylinders were secured. -The Resident Care Coordinator (RCC), the RCD, and the memory care coordinator (MCC) were responsible for ensuring the oxygen cylinders were secured. Based on observations, interviews, and record reviews it was determined the resident who resided in room 411 was not interviewable.	D 079		
(D 358)	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to 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),	(D 358)	Spring Arbor Sandhills will assure that the preparation and administration of medications, prescription and non prescription, and treatments by staff are in accordance with: orders by a licensed prescribing practitioner which are maintained in the residents record; and rules in this Section and the facility's policies and procedures	

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{D 358}	Continued From page 3 dementia symptoms (#7). The findings are: 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. a. Review of Resident #6's current FL-2 dated 11/20/24 revealed diagnoses including vascular dementia, hypertension, and hyperthyroidism. 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. Observation of the 8:00am medication pass on 10/01/25 revealed: -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). Review of Resident #6's October 2025 electronic medication administration record (eMAR) revealed: -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. Interview with the MA on 10/01/25 at 8:07am	(D 358)	The Med-Techs and leadership of Spring Arbor Sandhills were immediately educated on identifying appropriate orders and following the orders as written. The Med-Techs and leadership were also immediately educated on documentation of any exceptions charted and the reasons why they became exceptions. An audit of all residents' medication, FL-2, orders and MAR was begun on 11/11/25 by the AL and Cottage leaders to ensure that all medications are appropriate and match orders written by the physicians and will be completed by 11/30/25. The Med-Techs will be educated on 11/11/25 on ensuring all medication doses as ordered are given to the residents.	11/11/25 11/11/25 11/30/25 11/11/25

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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}	<p>The New order Tracking tool will be utilized on all new orders starting on 11/11/25. The order and confirmation will be attached to the new order tracking form and placed in the RCD/RCC/CCD/Designee's box. The RCD/RCC/CCD/Designee will then review that order and approve said order in 11/11/25 yardi, and check to ensure that medication has come into the community, the directions on the medication match the order and the old medication when applicable has been removed from the MAR and removed from the cart.</p>	

New Order Tracking Form

Date _____

Resident Name: _____

*This form is to be completed for **All New Orders***

Date	Initial	Date & Initial when each task is completed
		New order(s) received
		Order faxed to Pharmacy or, if it is a referral, faxed to Home Health & Therapy and/or Hospice (circle which one)
		Make a copy of New Order & staple to this Tracking Form
		Place the copy of the New Order attached to the Tracking Form in the 24 hr. Shift-to -Shift binder behind the current date
		Staple the Confirmation from fax to the ORIGINAL New Order
		File New Order w/fax confirmation attached under "Physician Orders" in resident medical record
		Pharmacy called for "Back Up", if needed (i.e. antibiotics)
		Document "Back Up" on Shift-to-Shift report & in Resident record
		Follow up appointment or labs scheduled, if applicable
		RP/POA notified, if applicable, then document communication
Date	Initial	Date & Initial when each task is completed
		Medication has been delivered & verified to be correct
		Pending Order Accepted in EMAR
		All D/C'd medications removed from med cart and returned to pharmacy/family/destroyed in Drug Buster

Comments/Follow Up needed:

RCD/ARCC/CCC/Designee Reviewed/ Sign: _____ Date: _____

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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}	<p>On 11/11/25 the RCD/RCC/CCD/Designee will file that new order tracking form.</p> <p>The ED/Designee will review New order Tracking forms 11/11/25 weekly for 3 months or until completion until significant compliance is obtained.</p>	2/11/26

Spring Arbor of Sandhills

License# HAL-047-016

County: Hoke

It is the policy and standard practice of Spring Arbor of Sandhills to comply with all North Carolina Adult Care rules and state regulations.

State Rule # and Rule: 10A NCAC 13F .1004 (a) Medication Administration

(a) Adult care homes 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.

Plan of Correction:

Spring Arbor Sandhills will assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with orders by a licensed prescribing practitioner, which are maintained in the resident's chart. 11/11/25

The med-techs and leadership of Spring Arbor of Sandhills were immediately educated on identifying appropriate orders and following the orders as written. The med-techs and leadership were also immediately educated on documentation of any exceptions charted and the reasons why they became exceptions. 11/11/25

An Audit of all residents' medications, FL-2s, orders and MARs was begun on 11/11/25 by the AL and Cottage leaders to ensure that all medications are appropriate and match orders written by the physicians and will be completed by 11/30/25.

The Med-Techs will be educated on 11/11/25 on ensuring all medication doses as ordered are given to the residents. 11/22/25

Prevention of Re-occurrence:

The new order tracking tool will be utilized on all new orders starting on 11/11/25. The order and confirmation will be attached to the new order tracking form and placed in the box RCD/RCC/CCD/Designee's box. 11/11/25

Monitoring Responsibility & Frequency:

The RCD/RCC/CCD/Designee will review all orders and approve said order in Yardi and check to ensure that medication has come into the community, the directions on the medication match the order and the old medication, when applicable, has been removed from the cart. That order will then be filed by the RCD/RCC/CCD/Designee.

The ED/Designee will review New Order Tracking forms weekly X3 months or until significant compliance is obtained. 11/11/25 -2/11/26

Correction Completion Date:

On or before 11/11/25 and 11/11/25-2/11/26 and ongoing until substantial compliance is obtained.

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{D 358}	Continued From page 6 Alzheimer's dementia, type II diabetes mellitus, hypertension, osteoarthritis knees, and hyperlipidemia. 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. 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). 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. 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.	{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:</p> <ul style="list-style-type: none"> -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>Interview with the MA on 10/01/25 at 11:40am revealed:</p> <ul style="list-style-type: none"> -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>Telephone interview with a pharmacist at the facility's contracted provider pharmacy on 10/01/25 at 2:59pm revealed:</p> <ul style="list-style-type: none"> -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>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}	Continued From page 9 Refer to the interview with the Administrator on 10/01/25 at 12:07pm. Interview with the Resident Care Director (RCD) on 10/01/25 at 4:10pm revealed: -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. Interview with the Administrator on 10/01/25 at 12:07pm revealed: -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}		