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

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on 02/17/26 through 02/19/26. The Hoke County Department of Social Services initiated this complaint on 01/14/26.	D 000		
D 226	10A NCAC 13F .0702 (d) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (d) The notices of discharge and appeal rights as required in Paragraph (c) of this Rule shall be made by the facility administrator or their designee, at least 30 days before the resident is discharged except that notices may be made as soon as practicable when: (1) the discharge is necessary to protect the welfare of the resident and the facility cannot meet the needs of the resident under Subparagraph (b)(1) of this Rule; or (2) reasons under Subparagraphs (b)(3) and (b)(4) of this Rule exist. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the requirements for a notice of discharge and appeal rights were met as soon as practicable related to a resident who was discharged for the safety of the residents in the facility (#6). The findings are:	D 226		

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Review of the facility's involuntary discharge policy dated February 2022 revealed:
-The facility may discharge a resident upon fifteen days of written notice or as required by state regulations.
-Causes for discharge included violent of antisocial behavior, harming or threatening oneself or others.

Review of Resident #6's FL-2 dated 12/16/25 revealed:
-Diagnosis included dementia, anxiety disorder, and Parkinson's disease.
-He resided in the Special Care Unit (SCU).
-He was intermittently disoriented and his recommended level of care was documented as "secured unit".

Review of Resident #6's Resident Register revealed he was admitted to the facility on 12/01/25.

Review of the facility's residency agreement signed by Executive Director (ED) and Resident #6's legal representative on 11/25/25 revealed:
-The community may discharge resident from the community and terminate this agreement by providing you with written notice made as soon as practicable when the safety of other individuals in the community were endangered.
-Notice of discharge together with an adult care home hearing request form will be delivered by hand delivery.

Review of Resident #6's secured unit admission criteria review dated 12/15/25 revealed:
-Resident #6 did express physical/abusive/combative behaviors.
-He was possibly agitated with staff at times.

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Review of Resident #6's incident report dated 12/21/25 revealed, Resident #6 was in the dining room when he walked up to a female resident, placed his hand around her neck, and forcefully pushed her head down on the table, he then struck her with a closed fist in the face.

Review of Resident #6's progress notes dated 12/21/25 revealed:
-The resident was in the dining room when he walked up to a female resident, placed his hand around her neck, and forcefully pushed her head down on the table and then struck her with a closed fist in the face.
-The resident could not return until he had a psychiatric evaluation stating that he posed no harm to himself or others.

Review of Resident #6's adult care home notice of transfer/discharge dated 12/22/25 revealed:
-Resident #6's date of discharge was immediate 12/22/25.
-He was discharged because the safety of the resident and other individuals in the facility was endangered.
-The adult care home hearing request form was on the back page of the notice of transfer/discharge.

Telephone interview with Resident #6's Power of Attorney (POA) on 02/04/26 at 6:45pm revealed:
-On 12/21/25 a facility staff member called her and informed her that Resident #6 attacked a female resident and hit her.
-When she got to the facility approximately 3 hours after the phone call, Resident #6 was in his bedroom eating lunch.
-She told facility staff that she wanted Resident #6 to go to the emergency room to make sure he did not have any injuries.

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-Emergency medical services (EMS) came to the facility and transported Resident #6 to the emergency room.
-She got a call later that evening from the hospital informing her that the facility refused to take the resident back.
-She called the facility and talked to the ED and was told Resident #6 could not return to the facility until he had a psychiatric evaluation at the hospital.
-The hospital completed the psychiatric evaluation on 12/22/26.
-After the evaluation was completed the facility still refused to readmit the resident to the facility.
-Resident #6 was in the hospital for three or four more days before he was transferred to another facility.
-The ED never told her that the resident was being discharged from the facility.
-She never received any discharge paperwork from the facility.

Interview with a medication aide (MA) on 02/18/26 at 8:45am revealed:
-Resident #6 was sitting in the dining room along with two or three other residents on 12/21/25.
-Resident #6 got up and walked over to a female resident and grabbed her by the throat, banged her head into the table and punched her in the face.
-The incident was unprovoked.
-Staff escorted Resident #6 to his room.
-EMS came and transported the female resident to the emergency room, later Resident #6 was also transported to the emergency room.
-Resident #6 never returned to the facility.

Telephone interview with a personal care aide (PCA) on 02/18/26 at 2:00pm revealed:
-He was assigned to take the notice of discharge

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and adult care home hearing request form to Resident #6 at the hospital.
-He handed the envelope to Resident #6 in his hospital bed, Resident #6 placed the paperwork on the bed.
-He took the envelope off the bed and placed it on the table next to his food tray.
-He did not witness Resident #6 open the envelope to see what the paperwork was.
-Resident #6's responsible person was not in the hospital room when he took the paperwork.

Interview with the RCC on 02/18/26 at 9:35am revealed:
-Anytime a resident was sent out of the facility for aggressive behaviors they had to have a psychiatric evaluation before returning to the facility.
-The ED and corporate staff made the decision that Resident #6 would not be allowed to return to the facility because he was a danger to the other residents.
-A resident could be discharged immediately if they have exhibited unprovoked violence towards another resident.

Interview with the Administrator on 02/18/26 at 10:10am revealed:
-When a resident was violent with other residents they were sent out to the hospital for a psychiatric evaluation.
-The hospital did not complete a psychiatric evaluation for Resident #6.
-On 12/22/26 they decided that they were not going to allow Resident #6 to return to the facility.
-Resident #6 was a danger to other residents due to him attacking another resident unprovoked.
-The facility policy was that a resident could be discharged immediately if they were a danger to other residents.

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D 226	Continued From page 5 -She completed the notice of transfer/discharge and hearing request form on 12/22/26. -She assigned a facility staff member to take the paperwork and deliver it to Resident #6 on 12/22/26. -She did not believe the paperwork needed to be delivered to Resident #6's responsible person. -She believed it was appropriate to give the paperwork to Resident #6 even though he was a SCU resident because there was no rule against it.	D 226		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 1 of 7 sampled resident's (#7) was treated with respect, consideration, and dignity and residents' rights were maintained. The findings are: Review of Resident #7's current FL2 dated 07/15/25 revealed: -Diagnoses included neoplasm of uncertain behavior of right kidney, malignant neoplasm of brain, chronic obstructive pulmonary disease, and diabetes type I. -The resident was semi-ambulatory. -The resident was intermittently disoriented. -Recommended level of care was assisted living	D 338		

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(AL).

Review of Resident #7's Resident Register revealed he was admitted to the facility on 07/15/25.

Review of Resident #7's Licensed Health Professional Support Evaluation dated 07/26/25 revealed, Resident #7 needed assistance in transferring, toileting, showering, and dressing.

Telephone interview with Resident #7's Responsible Person (RP) on 02/17/26 at 9:15am revealed:
-Resident #7 was admitted to the facility from a rehabilitation center for a broken hip.
-He lived in the facility approximately five months in a private room.
-In December 2025, there was a water pipe that broke on the assisted living (AL) side of the facility causing water damage.
-Resident #7 was moved into a room with another resident because his room had water damage.
-The facility informed her that Resident #7 would be moved to another facility; in another city.
-She informed the facility she did not want him moved that far away from family.
-Resident #7 was moved into a private room in the Special Care Unit (SCU).
-The SCU was short staffed and did not provide personal care for Resident #7.
-When she went to visit him, he was saturated in urine and did not have any furniture in the bedroom he was in.

Second Interview with Resident #7's RP on 02/18/26 at 1:00pm revealed:
-Resident #7 was admitted to the facility on 07/15/25.
-The facility had a water pipe break on the AL on

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12/15/25.
-On 12/27/25 the family visited Resident #7 and found him in a room on the SCU with no furniture sitting in his wheelchair saturated with urine.
-On the evening of 12/27/25 the facility brought Resident #7 his bed in his room on the SCU.
-He began to develop bed sores due to the lack of personal care provided to him on the SCU.
-The resident told her that other residents in the SCU would wander into his room regularly.
-The resident informed her that confused residents would get into the bed with him.
-The resident informed her that there was a female resident that used us bathroom regularly.
-She reported that she decided to transfer the resident to another facility because she was not satisfied with the care he received and that he was not appropriately placed in the SCU.
-She reported that the resident appeared to be unhappy while he was residing in the SCU.

Interview with a personal care aide (PCA) on 02/19/26 at 9:25am revealed:
-Resident #7 was on the SCU approximately three weeks.
-He was getting the same personal care as the other residents on the SCU.
-He received sponge baths in the bed as needed.
-He was being checked on at least every two hours by the PCAs.
-A PCA left Resident #7 unattended in his bedroom and did not provide personal care for him on 12/27/25.
-The staff member that did not provide him with personal care was no longer employed at the facility.
-The former staff member told her that she thought Resident #7 was independent since he came from the AL side of the facility.

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-On 12/27/25 Resident #7 was soaked with urine, she was not sure of how long he was in his room unattended.

Interview with a medication aide (MA) on 02/19/26 at 11:00am revealed:
-Resident #7 was in the SCU approximately two weeks.
-He was moved to the SCU from the AL side due to water damage in his room.
-He was moved into the room of a resident that had just left the facility.
-The former resident's furniture was still in the room when Resident #7 moved in.
-The family of the former resident came to the facility to get his furniture and his bed.
-Once they left Resident #7 was placed back into the room in his wheelchair.
-She was not aware of how long it took the facility to get Resident #7's furniture moved into the room.
-Resident #7 had the flu at the time so he was always in his room and was served meals in his room.
-She believed his personal care was not being completed because staff was not made aware of the level of care he needed.
-Staff members thought he was independent because he was from AL.
-Staff should have checked on him every two hours and provided personal care.
-It was concerning that Resident #7 was not provided personal care for an extended period of time.
-She was not aware of Resident #7 getting any bed sores while he was in the SCU.

Interview with the Special Care Coordinator (SCC) on 02/19/26 at 2:00pm revealed:
-Resident #7 was moved to the SCU from AL due

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D 338	Continued From page 9 to water damage in his room. -He was placed in a room that a resident was recently discharged from. -A former staff member did not provide personal care to Resident #7 during her shift. -It was a resident rights issue for the staff member not to check on the resident or provide incontinent care during her shift. Interview with the Administrator on 02/19/26 at 1:04 pm revealed: -Resident #7 was left in his room and was not provided personal care on 12/27/25. -The staff member that was assigned to him and responsible for his personal care was no longer employed at the facility. -Staff members not providing personal care and checking on residents regularly was unacceptable. -She believed it was gross misconduct by the staff member to leave the resident in his room and not check on him. Telephone interview with primary care provider (PCP) on 02/19/26 at 4:40pm revealed: -She expected staff to check on all residents regularly and provide personal care as needed. -She was not concerned about Resident #7 being admitted to the SCU temporarily. -She was concerned that lack of personal care could result in skin breakdown. -She was not aware of Resident #7 having any bed sores.	D 338		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration	D 367		

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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,
(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 observations, interviews, and record reviews, the facility failed to ensure medication administration records were accurate for 1 of 5 sampled residents (#5) including documentation of insulin.

The findings are:

Review of Resident #5's current FL-2 dated 06/10/25 revealed diagnoses included Multiple Sclerosis (MS), insulin dependent diabetes, incomplete bladder emptying, hypertension, hyperlipidemia, depression, and anxiety.

Review of Resident #5's Resident Register

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revealed she was admitted to the facility on 06/24/25.

Review of Resident #5's physician's order dated 01/06/26 revealed:
-There was an order for Insulin Aspart U-100 7 units subcutaneously before meals (breakfast, lunch, dinner) (3 times a day before meals), hold if the patient is not eating by mouth (NPO) or blood glucose (BG) less than 80. (Insulin Aspart is the generic name for Novolog and is used to treat diabetes.)
-There was an order for correction scale Insulin Aspart U-100 before meals (AC) and bedtime (HS) (4 times a day per sliding scale 60-200 = 0 units; 201-250 = 2 units; 251-300 = 4 units; 301-350 = 6 units; 351-400 = 8 units; 401-450 = 10 units; 451 = 15 units recheck in 1 hour; if still greater than 451, notify the doctor. HS =Give correction only, no fixed mealtime dose.
-There was an order to check blood glucose (BG) before meals (AC) and bedtime (HS).

Review of Resident #5's physician's order dated 02/10/26 revealed:
-There was an order for Insulin Aspart 100 unit/mL, check fingerstick blood sugar (FSBS) AC and HS then inject subcutaneously per sliding scale 60-200 = 0 units; 201-250 = 2 units; 251-300 = 4 units; 301-350 = 6 units; 351-400 = 8 units; 401-450 = 10 units; 451 = 15 units recheck in 1 hour; if above 451, notify the doctor. Cover all mealtime blood sugars if they fall in sliding scale range, the set time dose, and sliding scale. Only give the corrective sliding scale scheduled insulin dose at bedtime 7 units. (Insulin Aspart is the generic name for Novolog and is used to treat diabetes.)
-There was an order for Insulin Aspart Flexpen Subcutaneous Solution Pen-injector 100 unit/mL,

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7 units subcutaneously 3 times a day every day at 7:30am, 11:30am and 5:30pm. Hold if the patient is nothing by mouth (NPO) or BG less than 80.

Review of Resident #5's January 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for Insulin Aspart 100 unit/mL, check fingerstick blood sugar (FSBS) AC and HS then inject subcutaneously per sliding scale 60-200 = 0 units; 201-250 = 2 units; 251-300 = 4 units; 301-350 = 6 units; 351-400 = 8 units; 401-450 = 10 units; 451 = 15 units recheck in 1 hour; if above 451, notify the doctor. Cover all mealtime blood sugars if they fall in sliding scale range, the set time dose, and sliding scale. Only give the corrective sliding scale scheduled insulin dose at bedtime 7 units.
-Insulin Aspart was documented as administered daily at 7:30am, 11:30am, 5:30pm and 8:00pm from 01/09/26 to 01/31/26.
-There was an entry for FSBS checks four times daily scheduled for 7:30am, 11:30am, 5:30pm and 8:00pm from 01/09/26 to 01/31/26.
-Resident #5's FSBS was documented daily at 7:30am, 11:30am, 5:30pm and 8:00pm from 01/09/26 to 01/31/26.
-There was no documentation of the units of Insulin Aspart administered to Resident #5.

Review of Resident #5's January 2026 progress notes revealed Insulin Aspart dose administered was documented 55 times from 01/07/26 to 01/31/26.

Review of Resident #5's February 2026 eMAR revealed:
-There was an entry for Insulin Aspart 100 unit/mL, FSBS AC and HS then inject subcutaneously per sliding scale 60-200 = 0

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units; 201-250 = 2 units; 251-300 = 4 units; 301-350 = 6 units; 351-400 = 8 units; 401-450 = 10 units; 451 = 15 units recheck in 1 hour; if above 451, notify the doctor. Cover all mealtime blood sugars if they fall in sliding scale range, the set time dose, and sliding scale. Only give the corrective sliding scale scheduled insulin dose at bedtime 7 units.
-Insulin Aspart was documented as administered daily at 7:30am, 11:30am, 5:30pm and 8:00pm from 02/01/26 to 02/16/26.
-There was an entry for FSBS checks four times daily scheduled for 7:30am, 11:30am, 5:30pm and 8:00pm.
-Resident #5's FSBS was documented daily at 7:30am, 11:30am, 5:30pm and 8:00pm from 02/01/26 to 02/16/26.
-There was no documentation of the units of Insulin Aspart administered to Resident #5.

Review of Resident #5's February 2026 progress notes revealed Insulin Aspart dose administered was documented 43 times from 02/01/26 to 02/16/26.

Interview with a medication aide (MA) on 02/19/26 at 2:03pm revealed:
-She determined how much insulin to administer to Resident #5 based on the sliding scale numbers on the eMAR.
-She documented Resident #5's FSBS on the eMAR.
-The eMAR system only had a section to add the FSBS reading.
-The eMAR system did not have a section to add the units administered to Resident #5 so staff had to document the units administered in the progress notes.
-At one point, the MAs were not documenting the units administered.

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-The previous Special Care Coordinator (SCC) told staff to document the units of insulin administered in the progress notes.
-She sometimes documented the units of insulin she administered to Resident #5 in the progress notes and other times she did not.
-She did not think she needed to document the units administered because the eMAR told them how much to administer.
-She felt that when she signed off on administering Resident #5's insulin, that meant she administered the medication and administered the correct amount based on the sliding scale.
-If the eMAR gave instructions on how to administer the insulin, there was no reason to document the units given in the progress notes.
-She had not been told the importance of taking the extra step to document the units administered in the progress notes.

Interview with a second MA on 02/19/26 at 3:19pm revealed:
-She used the instructions on the eMAR to administer the insulin to Resident #5.
-After administering the insulin, she documented Resident #5's FSBS reading on the eMAR and the units administered in the progress notes.
-Staff had been told to document the units of insulin administered in the progress notes and she did so each time.
-She was unsure why some units of insulin administered to Resident #5 were not documented in the progress notes.

Interview with the facility's contracted pharmacy on 02/19/26 at 12:38pm revealed:
-The pharmacy entered the medication orders on the eMARs.
-The orders put on the eMAR came from

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e-scripts or verbal orders.
-The facility approved the orders as the pharmacy entered the orders on the eMAR
-Adding space on the eMAR to document the units of insulin given depended on the facility's eMAR system.
-She was unable to see what the facility saw on the eMAR.

Interview with Resident #5's primary care provider (PCP) on 02/19/26 at 4:30pm revealed:
-She did not have access to the facility's progress notes but was provided with Resident #5's FSBS.
-She used the FSBS readings to help her understand how to manage Resident #5's FSBS.
-She was okay with getting the FSBS readings and not the units of insulin administered.
-The units of insulin administered should have been documented because that told the provider how much insulin Resident #5 received over time and helped manage the medication.
-She never asked for documentation of the units of insulin administered.
-She did not need the units of insulin administered to evaluate Resident #5 unless her FSBS was not controlled.

Interview with the Resident Care Coordinator (RCC) on 02/19/26 at 2:31pm revealed:
-The MAs were responsible for administering medication and documenting on the eMAR.
-The eMAR system the facility used did not have a space to document the units of insulin administered.
-She found out in the past 3 to 4 weeks there was no place to document the units of insulin administered on the eMAR.
-The MAs were told to document the units of insulin given in the progress notes prior to her becoming the RCC.

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-She was not aware all units administered to Resident #5 were not documented in the progress notes.
-She did not know why units administered for Resident #5 were not documented all the time.
-She expected the MAs to document the units administered in the progress notes all the time.
-MAR audits were done often but she was unsure when they were done.
-The facility contacted the pharmacy about how space could be added to the eMAR to document the units of insulin administered.

Interview with the Administrator on 02/19/26 at 3:05pm revealed:
-The MAs were responsible for administering insulin and documenting on the eMAR.
-MAs were supposed to check the FSBS, document the FSBS reading, administer the insulin based on the sliding scale and document the units administered.
-The eMAR system the facility used did not have a space to document the units of insulin administered.
-She saw in Resident #5's progress notes on yesterday, 02/18/26, where some units administered had been documented but not all units administered had been documented.
-She did not know if all MAs were told where to document the units administered.
-There was nothing on the eMAR to prompt the MAs to document the units administered.
-The units administered should have been documented to show proof of what had been done.
-She expected the units administered to Resident #5 to be documented in the progress notes until the eMAR system was fixed to allow for documentation on the eMAR.

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D 371 — 10A NCAC 13F .1004 (n) Medication Administration — D 371

10A NCAC 13F .1004 Medication Administration
(n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered in accordance with infection control measures by a medication aide, who did not sanitize her hands prior to the preparation and administration of medications and reached into a bottle of medication with her bare finger to retrieve a tablet for administration to the resident.

The findings are:

Review of the facility's Policy and Procedure: Infection Prevention and Control (IPCP) dated 03/23/20 revealed education compliance: all team members will receive training on the IPCP within 30 days of hire including competency demonstration and sign off as required for hand hygiene and personal protective equipment (PPE) donning and doffing.

Observation of a medication aide (MA) administering medications during the 8:00am medication pass on 02/18/26 from 8:25am - 8:30am revealed:
-There was a bottle of hand sanitizer on the

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medication cart.
-At 8:25am, the MA opened a drawer of the medication cart, retrieved, and prepared medications for a resident.
-The MA did not sanitize or wash her hands prior to preparing medications for the resident.
-The MA picked up and pushed medications from 3 bubble packed medications into a plastic medication cup.
-The MA opened a bottle of lanthanum carbonate chewable tablets.
-The MA inserted her ungloved bare finger into the bottle to retrieve one tablet and placed it into the plastic medication cup with the other medications and placed the lid back onto the bottle.
-The MA picked up and pushed medications from 3 remaining bubble packed medications into a plastic medication cup.
-The MA administered the medications to the resident in the dining room.
-The MA returned to the medication cart and used her hands to enter documentation into the computer system.
-The MA began to prepare another resident's medication and never washed or sanitized her hands.
-The MA continued with the morning medication pass.

Interview with the MA on 02/19/26 at 2:40pm revealed:
-There was hand sanitizer available on the medication carts.
-She thought she sanitized her hands before she began the medication pass.
-She should have poured the chewable tablets from the bottle into the bottle cap and then into the medication cup or worn gloves to get the medication out of the bottle.

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-She was nervous being watched.
-She was trained in infection control and knew what she did was a potential risk for spreading infections.

Interview with the Resident Care Coordinator (RCC) on 02/19/26 at 2:45pm revealed:
-The MAs should wash or sanitize their hands between each resident during the medication pass.
-The MA should have used a gloved hand to get the medication out of the bottle, but best practice would have been to pour the medication from the bottle into the bottle cap or another medication cup.
-It was important for the MAs to wash or sanitize their hands because of cross-contamination and passing of germs from one resident to another.

Interview with the Executive Director on 02/18/26 at 2:35pm revealed:
-She was a MA.
-She was surprised it was the MA, "she's a good MA".
-The MAs received training on infection control.
-There was hand sanitizer on the medication carts.
-She had a lot of concerns about the MAs not sanitizing or washing their hands.
-The MAs should wash their hands between each resident or use hand sanitizer.
-The MA should have used a gloved hand to get the medication out of the bottle or pour the medication from the bottle into the bottle cap and then put it in the medication cup.
-It was important for the MAs to wash or sanitize their hands because of cross-contamination.

Telephone interview with the facility's contracted primary care provider (PCP) on 02/19/26 at

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4:20pm revealed:
-Not washing or sanitizing hands during the medication pass could put residents at risk of infections.
-The MA should have washed hands, put on gloves, poured the medication into a medication cup or into the bottle lid and then into the medication cup.
-Residents could get bacterial infections from contamination from their hands not being washed or sanitized.

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10A NCAC 13F .1501 (d) Use Of Physical Restraints And Alternatives

10A NCAC 13F .1501 Use Of Physical Restraints And Alternatives

(d) The following applies to the restraint order as required in Subparagraph (a)(2) of this Rule:
(1) The order shall indicate:
(A) the medical need for the restraint based on the assessment and care plan;
(B) the type of restraint to be used;
(C) the period of time the restraint is to be used; and
(D) the time intervals the restraint is to be checked and released, but no longer than every 30 minutes for checks and no longer than two hours for releases.
(2) If the order is obtained from a physician other than the resident's physician, the facility shall notify the resident's physician or physician extender of the order within seven days.
(3) The restraint order shall be updated by the resident's physician or physician extender at least every three months following the initial order.
(4) If the resident's physician changes, the physician or physician extender who is to attend

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the resident shall update and sign the existing order.
(5) In an emergency, where the health or safety of the resident is threatened, the administrator or their designee, shall make the determination relative to the need for a restraint and its type and duration of use until a physician or physician extender is contacted. Contact with a physician shall be made within 24 hours and documented in the resident's record. For the purpose of this Rule, an "emergency" means a situation where there is a certain risk of physical injury or death to a resident.
(6) The restraint order shall be kept in the resident's record.

This Rule is not met as evidenced by:
Based on observations, interviews and record review, the facility failed to ensure there was a primary care provider's (PCP) order for a restraint for 1 of 1 sampled resident related to use of a geri- chair (#2).

The findings are:

Review of the facility's Policy on Physical Restraints revealed:
-It was the policy to only use restraints on an emergency basis.
-No resident requiring physical restraints would be admitted to the facility.
-It was the responsibility of the Executive Director and Resident Care Director/Cottage Care Director to be aware of state licensure regulations on restraints.
-By licensure a physical restraint was considered to be any physical or mechanical device attached

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or adjacent to the resident's body that the resident could not remove easily or restricted freedom of movement or normal access to one's body.
-In the unlikely event that an emergency situation arose and there was a temporary need for a physical restraint to limit the resident's movement for safety or protective reasons, this would be conducted in accordance with the licensure rules for restraints and documented in the resident's record, if needed, EMS or police would be contacted if the resident's safety or the safety of other residents or team members was at risk to arrange for the resident to be transferred for appropriate care.
-When a resident's need changed, the Resident Care Director/Cottage Care Director would explore the least restrictive safety options within the parameters of state licensure and the resident's specific needs.
-All state regulations would be followed regarding the use of any restraints.

Review of Resident #2's current FL-2 dated 11/17/25 revealed:
-Diagnoses included dementia and neurocognitive disorder with Lewy Body Dementia.
-Resident #2 was documented as being intermittently disoriented.
-Resident #2 was documented as semi-ambulatory.

Observation of Resident #2 on 02/18/26 at 2:09pm revealed:
-Resident #2 was sitting in a geri-chair.
-The geri-chair was reclined in the common area.
-Resident #2 rocked back and forth in an attempt to get out of the geri-chair and was unsuccessful.

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Observation on the Special Care Unit (SCU) on 02/18/26 from 2:00pm to 3:00pm revealed:
-The Special Care Coordinator (SCC) moved Resident #2, in the reclined geri-chair, from one side of the common area to a spot in front of the television in the common area.
-After the medication aide (MA) told the SCC that Resident #2 could not be in the geri-chair without a primary care provider's (PCP) order, the SCC stated she knew Resident #2 could not be reclined in the geri-chair.
-The SCC set the geri-chair up and assisted Resident #2 to his wheelchair.
-Staff moved the geri-chair off the SCU.

Review of Resident #2's current care plan dated 12/19/25 revealed:
-Resident #2 required extensive assistance with ambulation and transferring
-There was no documentation Resident #2 used of a geri-chair.

Review of Resident #2's Licensed Health Professional Support (LHPS) dated 12/19/25 revealed there was no LHPS task documentation that Resident #2 used a geri-chair.

Review of Resident #2's record revealed:
-There was no documentation of a order for use of a geri-chair.
-There was no documentation of a restraint assessment.

Interview with a personal care aide (PCA) on 02/19/26 at 9:00am revealed:
-She knew Resident #2 was not supposed to be in a geri-chair because he did not have an order.
-Resident #2 may have been assisted to the geri-chair because he always got up out of his wheelchair, but stayed in the geri-chair because

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he could not get out of the geri-chair.
-She did not notice Resident #2 in the geri-chair because she was busy with her assignments.
-The SCC always reminded staff that Resident #2 was not supposed to be in the geri-chair.
-Resident #2 was in the geri-chair about 2 months ago and the previous SCC told them Resident #2 could not be in the geri-chair.
-Resident #2 was using the geri-chair 2 months ago because he was getting out of his wheelchair and falling or dragging his catheter bag.

Interview with a MA on 02/18/26 at 2:14pm revealed:
-Resident #2 did not have an order for a geri-chair.
-She was unsure why Resident #2 was in the geri-chair today, but one of the PCAs must have assisted him to the geri-chair.
-She did not know who assisted Resident #2 in the geri-chair or how long he had been in the geri-chair.
-The geri-chair reclined was considered a restraint.
-The geri-chair Resident #2 was using belonged to a previous resident.
-Resident #2 was placed in the geri-chair a couple of weeks ago and the Administrator informed staff at that time that he could not be in the geri-chair without a PCP's order.
-Resident #2's family member liked for Resident #2 to use the geri-chair but she informed her that he could not be in the geri-chair without an order.

Interview with the SCC on 02/18/26 at 2:51pm revealed:
-Resident #2 enjoyed the geri-chair and treated it like a recliner.
-She spoke with Resident #2's family member about the geri-chair because Resident #2 was

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more relaxed in the geri-chair.
-Resident #2 did not have an order for a geri-chair.
-She did not know Resident #2 was not supposed to be in the geri-chair until the MA told her today, 02/18/26.
-She was unsure who assisted Resident #2 in the geri-chair but it was most likely a PCA.
-She did not know when Resident #2 was assisted to the geri-chair.
-She did not know why Resident #2 was in the geri-chair.
-She was unsure if the PCAs knew Resident #2 was not supposed to be in the geri-chair.

Interview with the Administrator on 02/19/26 at 8:15am revealed:
-Resident #2 did not have an order for a geri-chair.
-Resident #2 was not supposed to be in the geri-chair.
-She was not aware Resident #2 was in the geri-chair until the MA informed her yesterday, 02/18/26.
-Once she was informed that Resident #2 had been in the geri-chair yesterday, 02/18/26, she had the geri-chair moved off the SCU.
-The geri-chair was considered a restraint.
-She did not know who put Resident #2 in the geri-chair.
-Staff informed her that Resident #2 was put in the geri-chair because he was "here and there."
-She was unsure if the SCC knew Resident #2 was not supposed to be in the geri-chair.
-She was unsure if Resident #2 had been in the geri-chair in the past, but she was previously asked about residents using geri-chairs by staff and she told them residents could not use a geri-chair without an order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047016	A. BUILDING: ______ B. WING ______	R 02/19/2026

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 485	Continued From page 26 Interview with Resident #2's primary care provider (PCP) on 02/19/26 at 4:20pm revealed: -Resident #2 did not have an order for a geri-chair. -If the facility wanted an order for Resident #2 to use a geri-chair, she would have written an order for a geri-chair if physical therapy (PT) recommended it. Attempted telephone interview with Resident #2's family member on 02/19/26 at 8:50am was unsuccessful.	D 485		