STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001169	A. BUILDING: _____ B. WING _____	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGVIEW-COOK BUILDING	715 EAST HAGGARD AVENUE ELON, NC 27244

(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 and annual survey on 11/14/24.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure outside doors had a sounding device engaged that was audible throughout the facility when the door was opened which was accessible to 3 of 3 sampled residents (#1, #2, #3) who were identified as disoriented (#1, #2, #3). The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for 12 beds.	D 067		

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Review of the facility's census on 11/14/24 revealed there were 10 residents residing in the assisted living facility.

Observation of the facility on 11/14/24 at 8:00am and 11:25am revealed:
-The main entrance to the facility was unlocked and alarmed when the door was opened.
-There was a door at the opposite end of the hallway from the main entrance that was not alarmed and was not locked.
-There was a door that exited from the resident living room that was not alarmed and was not locked.

1. Review of Resident #1's current FL-2 dated 03/12/24 revealed:
-Diagnoses included history of traumatic brain injury and schizoaffective disorder of the depressive type.
-Her recommended level of care was Assisted Living (AL).
-She was intermittently disoriented.

Interview with Resident #1 on 11/14/24 at 4:50pm revealed:
-She smoked and went outside to smoke alone.
-She could go outside at any time and did not have to tell anyone she was going outside.

Interview with a medication aide (MA) on 11/14/24 at 3:20pm revealed:
-Resident #1 was not confused but did not have a good memory.
-Resident #1 could go outside and smoke by herself and did not try to leave the facility.
-The only door the residents used was the main entrance to the facility and the door had an alarm.
-The residents could use the door in the living room and at the end of the hallway to leave the

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facility.
-She could not always see the doors to the facility because she moved about during her work day.

Interview with the Resident Care Director (RCD) on 11/14/24 at 3:45pm revealed:
-Resident #1 knew the day, date and time and where she was but got confused sometimes.
-She would forget if she took her medication or if she had eaten.
-The only door that was alarmed was the main door to the facility; that was the door the residents used.
-There were two more doors that the residents could use that were not alarmed, the door in the living room and the door at the end of a hallway.
-No one had ever said the doors needed to be alarmed; she was not aware if a resident was disoriented the doors needed to be alarmed.
-The residents were all easily redirected and none of the residents had tried to wander off.

Attempted telephone interview with Resident #1's primary care provider (PCP) on 11/14/24 at 2:45pm was unsuccessful.

Refer to the interview with the RCD on 11/14/24 at 3:45pm.

Refer to the telephone interview with the Administrator on 11/14/24 at 5:06pm.

2. Review of Resident #2's current FL-2 dated 11/08/24 revealed:
-Diagnoses included Lewy Body dementia.
-His recommended level of care was AL.
-He was constantly disorientated.

Telephone interview with Resident #2's primary care provider (PCP) on 11/14/24 at 1:58pm

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D 067	Continued From page 3	D 067		

revealed:
-Resident #2 did not wander and did not talk about leaving the facility.
-He was not a good historian and could not answer questions.

Interview with a medication aide (MA) on 11/14/24 at 3:20pm revealed:
-Resident #2 was confused and did not have a good memory.
-Resident #2 did not do much and had declined in the last few months.
-He talked about going to see his girlfriend or going to visit the local fire department, but he never tried to leave the facility.
-He could answer simple questions.
-The only door the residents used was the main entrance to the facility and the door had an alarm.
-The residents could use the door in the living room and at the end of the hallway to leave the facility.
-She could not always see the doors to the facility because she moved about during her work day.

Interview with the Resident Care Director (RCD) on 11/14/24 at 3:45pm revealed:
-Resident #2 had been in a decline for a while and had a recent diagnosis of dementia.
-He repeated what he heard and would have small tantrums.
-The week before he wanted to go to the local fire department because he claimed he had an interview and got upset when she would not take him.
-He had never tried to leave or wander away; he required assistance with standing and used either a walker or a wheelchair to move around.

Based on observations, interviews, and record reviews it was determined Resident #2 was not

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D 067	Continued From page 4 interviewable. Refer to the interview with the RCD on 11/14/24 at 3:45pm. Refer to the telephone interview with the Administrator on 11/14/24 at 5:06pm. 3. Review of Resident #3's current FL-2 dated 11/08/24 revealed: -Diagnoses included history of traumatic brain injury with post traumatic left frontal encephalopathy and Alzheimer's disease. -She was intermittently confused. Interview with a medication aide (MA) on 11/14/24 at 3:20pm revealed: -Resident #3 was not confused, could answer some simple questions but could not tell you where she was or the date. -She could carry on a conversation with someone for a little while. -She had never talked about leaving and had never tried to leave the facility. -The only door the residents used was the main entrance to the facility and the door had an alarm. -The residents could use the door in the living room and at the end of the hallway to leave the facility. -She could not always see the doors to the facility because she moved about during her work day. Interview with the Resident Care Director (RCD) on 11/14/24 at 3:45pm revealed: -Resident #3 knew her birthday and where she was, she had a recent diagnosis of dementia. -She could carry a conversation with anyone. -She had never talked about leaving the facility or tried to leave; she had family that took her out of the facility frequently and she was fine to return.	D 067		

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D 067	Continued From page 5 Attempted telephone interview with Resident #3's PCP on 11/14/24 at 2:45pm was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable. Refer to the interview with the RCD on 11/14/24 at 3:45pm. Refer to the telephone interview with the Administrator on 11/14/24 at 5:06pm. _____ Interview with the RCD on 11/14/24 at 3:45pm revealed: -The only door that was alarmed was the main door to the facility; that was the door the residents used to go in and out of the facility. -There were two more doors that the residents could use that were not alarmed, the door in the living room and the door at the end of a hallway. -No one had ever said the doors needed to be alarmed; she was not aware doors needed to be alarmed when a resident was disoriented. -The residents were all easily redirected and none of the residents had tried to wander off. Telephone interview with the Administrator on 11/14/24 at 5:06pm revealed: -Only one door to the facility was alarmed because that was the way it was when she acquired the facility. -She had only found out today, 11/14/24 that the exit doors were not chimed [alarmed]. -She was aware there were residents who were disoriented. -She was responsible for ensuring the doors that the residents could use were alarmed; she just did not realize they were not alarmed.	D 067		

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D 067	Continued From page 6 The facility failed to ensure the two doors that were accessible for residents were alarmed with an audible sounding device when the doors were opened to prevent 3 of 3 residents who were identified as disoriented (#1, #2, #3) from leaving without staff knowledge. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/14/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 29, 2024	D 067		
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 B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 sampled residents (#2) for a laxative medication and a medication for low blood pressure.	D 358		

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D 358	Continued From page 7 The findings are: Review of Resident #2's current FL-2 dated 11/08/24 revealed diagnoses included schizoaffective disorder, bipolar, dyslipidemia, hyperlipidemia, Lewy Body dementia, and hypothyroidism. a. Review of Resident #2's current FL-2 dated 11/08/24 revealed there was an order for midodrine 2.5mg (used to treat low blood pressure) twice daily as needed (PRN) administer for systolic blood pressure less than 100. Review of Resident #2's physician order dated 08/27/24 revealed an order for midodrine 2.5mg twice daily PRN for systolic blood pressure (BP) less than 100. Review of Resident #2's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for BP checks twice daily see PRN order for midodrine scheduled at 8:00am and 8:00pm. -Blood pressure checks were documented twice daily from 09/01/24 to 09/30/24. -Resident #2's systolic BP was documented as lower than 100 twenty-four times from 09/01/24 to 09/30/24. -Resident #2's systolic BP was documented at 8:00am as 95 on 09/02/24, 92 on 09/04/24, 86 on 09/07/24, 86 on 09/09/24, 80 on 09/10/24, 94 on 09/12/24, 98 on 09/14/24, 90 on 09/15/24, 85 on 09/17/24, 92 on 09/18/24, 99 on 09/19/24, and 74 on 09/21/24. -Resident #2's systolic BP was documented at 8:00pm as 96 on 09/01/24, 90 on 09/02/24, 90 on 09/04/24, 86 on 09/07/24, 97 on 09/09/24, 99 on	D 358		

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09/11/24, 91 on 09/12/24, 85 on 09/14/24, 91 on 09/17/24, 91 on 09/19/24, 95 on 09/22/24 and 96 on 09/28/24.
-There was an entry for midodrine 2.5mg twice daily PRN for systolic BP less than 100.
-Midodrine was documented as administered 4 of 24 opportunities from 09/01/24 to 09/30/24 on 09/04/24, 09/09/24, 09/10/24 and 09/17/24.

Review of Resident #2's October 2024 eMAR revealed:
-There was an entry for BP checks twice daily see PRN order for midodrine scheduled at 8:00am and 8:00pm.
-Blood pressure checks were documented twice daily from 10/01/24 to 10/31/24.
-Resident #2's systolic BP was documented as lower than 100 twenty-eight times from 10/01/24 to 10/31/24.
-Resident #2's systolic BP was documented at 8:00am as 73 on 10/01/24, 91 on 10/04/24, 90 on 10/06/24, 80 on 10/09/24, 91 on 10/13/24, 94 on 10/14/24, 98 on 10/16/24, 94 on 10/17/24 98 on 10/19/24, 99 on 10/20/24, 94 on 10/21/24, 98 on 10/22/24, 97 on 10/23/24, 99 on 10/24/24, 94 on 10/25/24, 94 on 10/26/24, 86 on 10/27/24 92 on 10/28/24, 96 on 10/29/24, 98 on 10/30/24, and 95 on 10/31/24.
-Resident #2's systolic BP was documented at 8:00pm as 90 on 10/05/24, 98 on 10/06/24, 98 on 10/13/24, 98 on 10/16/24, 92 on 10/17/24, 88 on 10/28/24 and 93 on 10/31/24.
-There was an entry for midodrine 2.5mg twice daily PRN for systolic blood pressure less than 100.
-Midodrine was documented as administered 8 of 28 opportunities from 10/01/24 to 10/31/24 on 10/04/24, 10/09/24, twice on 10/17/24, 10/21/24, 10/25/24, 10/26/24, and 10/27/24.

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D 358	Continued From page 9 Review of Resident #2's November 2024 eMAR from 11/01/24 to 11/14/24 revealed: -There was an entry for BP checks twice daily see PRN order for midodrine scheduled at 8:00am and 8:00pm. -Blood pressure checks were documented twice daily from 11/01/24 to 11/13/24 and once at 8:00am on 11/14/24. -Resident #2's systolic BP was documented as lower than 100 eleven times from 11/01/24 to 11/14/24. -Resident #2's systolic BP was documented at 8:00am as 96 on 11/02/24, 94 on 11/06/24, 93 on 11/07/24 94 on 11/11/24, and 96 on 11/13/24. -Resident #2's systolic BP was documented at 8:00pm as 97 on 11/02/24, 97 on 11/03/24, 89 on 11/05/24, 96 on 11/06/24, 93 on 11/11/24 and 99 on 11/12/24. -There was an entry for midodrine 2.5mg twice daily PRN for systolic BP less than 100. -Midodrine was documented at administered 3 of 11 opportunities from 11/01/24 to 11/14/24 on 11/03/24, 11/05/24 and 11/12/24. Observation of Resident #1's medication on hand on 11/14/24 at 1:22pm revealed: -There was a medication card with 30 tablets of midodrine 2.5mg that was dispensed on 10/25/24. -There were 23 tablets of midodrine available for administration. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/14/24 at 1:47pm revealed: -Resident #2 had a current order for midodrine 2.5mg PRN twice daily for systolic BP less than 100. -Thirty tables of midodrine were dispensed on 07/30/24 and 10/25/24.	D 358		

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-Midodrine was used to treat low BP and was only given when a resident's BP was low.
-Potential outcomes of not administering the medication as ordered included low BP which could cause dizziness.

Telephone interview with Resident #2's primary care provider (PCP) on 11/14/24 at 1:58pm revealed:
-Midodrine was ordered for Resident #2 because sometimes he had low BP.
-He had parameters with his midodrine because she did not want his BP to go too low or too high.
-If Resident #2 was not administered his midodrine when his systolic BP dropped lower than the parameters, he could experience low BP which could cause dizziness and place him at a risk for a fall.
-He had not had any falls due to low BPs.
-She expected the staff to administer Resident #2's midodrine as ordered every time his systolic was lower than 100.

Interview with a medication aide (MA) on 11/14/24 at 3:20pm revealed:
-She checked Resident #2's BPs twice a day; once in the morning and once at night.
-His BP "ran" on the lower side.
-There were specific numbers on the top of his BPs [systolic] she had to look at.
-If his BP was too low, she was supposed to administer the midodrine.
-She administered the midodrine and documented when his BPs was low.
-There were times on the eMAR the midodrine was not documented as administered.
-The staff were not always administering his midodrine every time his BP was low.
-If Resident #2 had low BPs and needed the midodrine the staff should have administered it.

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-Resident #2 was never dizzy but he was sleepy a lot.

Interview with the Resident Care Director (RCD) on 11/14/24 at 3:45pm revealed:
-Resident #2 had BP checks twice a day because of low BP.
-When his top [systolic] BP number was less than 100, he was supposed to receive a dose of midodrine.
-The staff had not told her the systolic BP reading was low.
-She looked at his BP results last week and the previous week; she had not checked the eMAR to see if the midodrine was administered.
-She would like for the staff to tell her when his BP was low.
-The staff needed to administer Resident #2 his midodrine when his BP was low and document the administration.
-She was concerned he was having low BPs and was at risk for a fall because he could become dizzy.

Telephone interview with the Administrator on 11/14/24 at 5:06pm revealed:
-Resident #2's midodrine should have been administered when his systolic BP was lower than 100 and documented on the eMAR.
-The BPs and midodrine orders should have been discovered during eMAR audits; the BP results should have been compared to the midodrine administration.
-She expected the staff to take Resident #2's BP twice a day and administer the midodrine as ordered.

Based on observations, interviews and record reviews it was determined Resident #2 was not interviewable.

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b. Review of Resident #2's current FL-2 dated 11/08/24 revealed an order for polyethylene glycol (used to treat constipation) 32gm per 8 oz of fluid once daily.

Review of Resident #2's FL-2 dated 03/23/24 revealed there was an order for polyethylene glycol 32gm per 8 oz of fluid once daily.

Observation of Resident #2 on 11/14/24 at 10:04am revealed:
-He told the RCD and the MA his stomach hurt.
-The RCD asked him if he drank all the polyethylene glycol when it was administered that morning, 11/14/24.
-He said he did not know, and the MA told the RCD he did drink it all.

Review of Resident #2's September 2024 eMAR revealed:
-There was an entry for polyethylene glycol 32gm once daily scheduled at 8:00am.
-Polyethylene glycol was documented as administered 30 of 30 opportunities form 09/01/24 to 09/30/24.

Review of Resident #2's October 2024 eMAR revealed:
-There was an entry for polyethylene glycol 32gm once daily scheduled at 8:00am.
-Polyethylene glycol was documented as administered 31 of 31 opportunities form 10/01/24 to 10/31/24.

Review of Resident #2's November 2024 eMAR from 11/01/24 to 11/14/24 revealed:
-There was an entry for polyethylene glycol 32gm once daily scheduled at 8:00am.
-Polyethylene glycol was documented as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001169	A. BUILDING: _____ B. WING _____	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGVIEW-COOK BUILDING	715 EAST HAGGARD AVENUE ELON, NC 27244

(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 358	Continued From page 13	D 358		

administered 14 of 14 opportunities form 11/01/24 to 11/14/24.

Observation of Resident #1's medication on hand on 11/14/24 at 1:22pm revealed:
-There was a bottle of polyethylene glycol dispensed on 07/30/24 and labeled 1 of 2.
-There was two thirds of the bottle available for administration.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/14/24 at 1:47pm revealed:
-Resident #2 had a current order for polyethylene glycol 34gm once daily.
-Two bottles of polyethylene glycol were dispensed on 07/30/24; the two bottles were a thirty-day supply.
-There were no other dispensed dates.
-Polyethylene glycol was not on a cycle fill and had to be ordered by staff from the facility.
-Polyethylene glycol was used to treat constipation and a potential out come of not administering it as ordered could be constipation.

Telephone interview with Resident #2's PCP on 11/14/24 at 1:58pm revealed:
-Resident #2 had a long history of gastrointestinal issues and abdominal pain.
-He would complain of abdominal pain, but he could not relate it to constipation.
-He was ordered the polyethylene glycol to manage his constipation.
-There were no orders to hold for loose stools.
-A potential outcome if Resident #2 was not administered his polyethylene glycol as ordered could be increased risk of constipation.

Interview with a MA on 11/14/24 at 3:20pm revealed:

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	HAL001169	A. BUILDING: _____ B. WING _____	11/14/2024

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D 358	Continued From page 14 -Resident #2 sometimes had loose bowel movements (BM) and sometimes he was constipated. -Resident #2 had a BM at least once a day. -He was frequently constipated because it was hard to get him to drink his fluids. -She did not always administer Resident #2 his polyethylene glycol because it was hard to get him to drink it. -He had an order to drink it once a day, but he would leave it and not want to drink it like he was supposed to. -The last time he drank it all was about a day or so ago. -She could usually get him to drink all the polyethylene glycol which was about two days ago. -She did not document when he refused to drink it all. -The polyethylene had to be ordered by the facility staff when it was low; the pharmacy did not automatically send it and it had been a while since it had been ordered. Interview with the RCD on 11/14/24 at 3:45pm revealed: -Resident #2 was seen by a gastroenterologist. -He had constipation issues one or two times a month. -He would tell the staff his tummy hurt, and they would give him the polyethylene glycol. -He had regular BM the last two to three months. -She did not know why he still had a bottle of polyethylene glycol unless the staff were administering from another resident's bottle. -Polyethylene glycol was not on a cycle fill and needed to be ordered from the pharmacy when it was running low. -There was no documentation on the eMAR that he refused his polyethylene glycol.	D 358		

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	HAL001169	A. BUILDING: _____ B. WING _____	11/14/2024

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D 358	Continued From page 15 -Staff had not reported Resident #2 refusing his polyethylene glycol. -He complained of a stomach ache and said he did not get his polyethylene glycol because he overheard her and the MA asking another resident if they were still constipated. -He had a BM earlier today, 11/14/24, it was firm, but it was not hard. Telephone interview with the Administrator on 11/14/24 at 5:06pm revealed: -Resident #2 had constipation issues and sometimes he had issues with his stools being too loose. -Resident #2 would not say in so many words that he was constipated he would complain about stomach pain. -The staff were supposed to administer [residents'] medications and document the medication administration. -She was not aware of his polyethylene not being administered and she did not know if he had missed any doses of his polyethylene glycol. -The RCD conducted cart audits and would need to start watching the dates on medications. -She expected residents' medications to be administered consistently and as ordered. Attempted telephone interview with Resident #2's gastroenterologist on 11/14/24 at 4:50pm was unsuccessful. Based on observations, interviews and record reviews it was determined Resident #2 was not interviewable. _____ The facility failed to administer medications as ordered for 1 of 3 residents (#2) related to a medication with parameters for low BP readings which increased the risk for dizziness and falls,	D 358		

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D 358	Continued From page 16 and a medication for constipation due to a history of gastrointestinal issues and constipation. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-32 on 11/14/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 29, 2024.	D 358		