Received via email on 12/05/24

Division of Health Service Regulation

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

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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		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Beverly Dee McHaffie — TITLE: administrator — (X6) DATE: 12/05/2024

Reviewed and acknowledged on 01/02/25. PD

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D 067	Continued From page 1 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	D 067		

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D 067	Continued From page 2 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	D 067		

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D 067	Continued From page 3 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	D 067		

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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	RCD checked on residents on the night On 11/14/2024. CC checks on residents the morning of 11/15/2024. Maintenance Man installed chimes/alarms on all doors that residents have access to & use. 11/15/2024	

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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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D 358	Continued From page 8 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.	D 358		

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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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D 358	Continued From page 10 -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.	D 358		

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D 358	Continued From page 11 -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.	D 358		

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D 358	Continued From page 12 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	D 358		

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

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D 358	Continued From page 13 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:	D 358		

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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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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	11/14 & 11/15 Resident Care Director did Medication Administration training w/ Medication Aides communicated orders & emphasized perimeters. Note was taped to the med cart about both medications orders. 11/15/2024 RCD auditing vitals & MAR's Daily auditing Med Cart weekly 11/15/2024 CC auditing vitals, MAR's & med cart weekly! 11/15/2024 LTC Pharmacy training all Medication Aides on Medication Administration & Vitals. 12/12/2024	

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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	RCD will continue to audit MARS VITALS & MED CARTS TWICE WEEKLY CC will continue to audit MARS VITALS & MED CARTS WEEKLY This will start on December 27 2024 for quality assurance. The frequency before that date is on the previous page.	12/27/2024