

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: fc1032171	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/06/2025
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NAME OF PROVIDER OR SUPPLIER SPRINGDAILE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 4315 HOLDER ROAD DURHAM, NC 27703
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C 000	Initial Comments The Adult Care Licensure section conducted an annual and follow-up survey survey on 02/06/2025.	C 000		
C 315	<p>10A NCAC 13G .1002(a) Medication Orders</p> <p>10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments:</p> <p>(1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;</p> <p>(2) if orders are not clear or complete; or</p> <p>(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.</p> <p>The facility shall ensure that this verification or clarification is documented in the resident's record.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify an order for 1 of 3 residents sampled (#1) including an anti-psychotic medication.</p> <p>The findings are:</p> <p>Review of Resident #1's current FL-2 dated 01/23/25 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included schizoaffective disorder, obsessive compulsive disorder, depression, and mild intellectual disabilities. -There was an order for clozapine 100mg (used to manage hallucinations and delusions related to schizophrenia) 2 tablets at bedtime. -The FL-2 was received by the facility on 	C 315		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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C 315	<p>Continued From page 1</p> <p>01/30/25.</p> <p>Review of Resident #1's signed physician's order dated 01/14/25 revealed there was an order to increase clozapine 100mg to 3 tablets at bedtime.</p> <p>Review of Resident #1's January 2024 medication administration record (MAR) from 01/15/25 to 01/31/25 revealed: -There was an entry for clozapine 100mg take 3 tablets every night. -There was documentation clozapine 3 tablets was administered each night.</p> <p>Review of Resident #1's February 2024 MAR from 02/01/25 to 02/06/25 revealed: -There was an entry for clozapine 100mg take 3 tablets every night. -There was documentation clozapine 3 tablets was administered every night.</p> <p>Review of Resident #1's record revealed there was no documentation the primary care provider (PCP) was contacted to clarify the dosage of clozapine.</p> <p>Observation of Resident #1's medication on hand on 02/06/25 at 10:30am revealed there was a bottle containing 116 of 180 clozapine 100mg tablets available for administration with a dispensed date of 01/14/25.</p> <p>Telephone interview with the Pharmacist at the facility's contracted pharmacy on 02/06/25 at 11:04am revealed: -Resident #1 had an order for clozapine 100mg 3 tablets at night dated 01/14/25. -The pharmacy did not receive the FL-2 dated 01/23/25 for Resident #1. -The pharmacy accepted FL-2s as orders.</p>	C 315		

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C 315	<p>Continued From page 2</p> <p>-If the pharmacy had received the FL-2 dated 01/23/25 and noticed the discrepancy in the clozapine, they would have notified the PCP for clarification.</p> <p>Telephone interview with a representative from Resident #1's mental health provider (MHP) on 02/06/25 at 10:15am revealed:</p> <p>-Resident #1's clozapine 100mg was increased to 3 tablets at night on 01/14/25.</p> <p>-Resident #1 should take clozapine 100mg 3 tablets every night to help control her thought process.</p> <p>-The MHP did not complete the FL-2s, the PCP would complete them.</p> <p>-The PCP could see all medication changes made by the MHP in the computer system when completing the FL-2.</p> <p>Interview with a medication aide (MA) on 2/06/25 at 10:45am revealed:</p> <p>-When he received the FL-2 he compared the medications on the FL-2 with the MAR for accuracy.</p> <p>-If he noticed a discrepancy, he would look in the chart for the current order.</p> <p>-He would notify the administrator for discrepancies.</p> <p>-He did not fax FL-2s to the pharmacy.</p> <p>-He was not working when Resident #1's FL-2 dated 01/23/30 was faxed to the facility.</p> <p>Interview with the Administrator on 02/06/24 at 10:50am revealed:</p> <p>-The FL-2 was sent to the PCP on 09/03/24 to be completed and returned to the facility.</p> <p>-The FL-2 was faxed to the facility on 01/30/25.</p> <p>-The order to increase the clozapine was received from the MHP before the FL-2 was completed.</p>	C 315		

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C 315	<p>Continued From page 3</p> <ul style="list-style-type: none"> -The MAs should compare the FL-2 with the MAR to ensure they were the same. -The MA should notify the PCP if there was a discrepancy for clarification. -The MA should fax the FL-2 to the pharmacy. <p>Attempted telephone interview with Resident #1's PCP on 02/06/25 at 10:43am was unsuccessful.</p>	C 315		