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
	FCL-092269	A. BUILDING: _____ B. WING _____	01/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESERVE AT MILLS FARM VILLA #2	2010 MILLS CHASE LOOP APEX, NC 27523

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an initial survey and a COVID-19 focused infection control survey with onsite visits on 01/21/21 and 01/25/21, a desk review survey on 01/22/21, 01/26/21, and 01/27/21, with an exit conference via telephone on 01/27/21.	C 000		
C 140	10A NCAC 13G .0405(a)(b) Test For Tuberculosis 10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or living in a family care home, the administrator, all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services. Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. (b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis disease that poses a direct threat to the health or safety of others. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assure 1 of 3 sampled staff (Staff C) completed a screening tuberculosis (TB) skin test with control measures adopted by the Commission for Health Services. The findings are: Review of Staff C's, a Personal Care Assistant (PCA) personnel record reveled:	C 140	Please see attached	

Division of Health Service Regulation

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

Administrator | 02/24/21

VINSON M. BRACKOSKY

Addendum: 02/24/21
Title and Date added for Administrators signature

Reviewed and accepted 02/24/21. KG

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C 140	Continued From page 1 -Staff C was hired as a resident assistant (RA) on 11/09/20. -There was no documentation she had a TB skin test upon employment. Telephone interview with Staff C on 01/25/21 at 7:37 am revealed: -The previous business office manager (previous BOM requested her to have a TB skin test. -She had a TB skin test placed on Thursday, 11/05/20, at a local urgent care. -The nurse at the urgent care told her to come back on Saturday, 11/07/20, to have the TB skin test read. -She went back to the urgent care on 11/07/20 to have the TB skin test read, but the urgent care was closed. -She returned to work on Monday and told the previous BOM the urgent care was closed on Saturday and she did not have the TB skin test read. -She was told by the previous BOM an appointment would be made for another TB skin test, but she was not notified of an appointment before the previous BOM was no longer at the facility. Interview with the previous BOM on 01/25/21 at 1:21pm was unsuccessful. Interview with the corporate interim BOM on 01/25/21 at 12:55pm revealed: -The previous BOM was no longer at the facility. -He replaced the previous BOM on 12/01/20. -The BOM position was responsible for maintaining staff personnel records, ensuring staff qualifications and tests were documented and kept up to date. -He was in the process of auditing staff personnel records.	C 140		

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C 140	Continued From page 2 -He reviewed Staff C's records on 01/24/21 but did not find documentation for the placement and reading of TB skin testing. -He reviewed a billing statement from the local urgent care and saw documentation of Staff C's TB skin test placed on 11/05/20. -There was no documentation on the billing statement that Staff C had the TB skin test read on 11/07/20. -He did not know if Staff C returned to the local urgent care to have the TB skin test read. -TB skin testing for new employees was to be placed, read and documented in their personnel record upon employment. -The BOM was responsible for ensuring new employees' TB skin testing were completed and documented in their personnel record upon employment. Telephone interview with the Executive Director (ED) on 01/26/21 at 3:47pm revealed: -TB skin testing was required for all new employees upon employment and appointments were made by the BOM. -The BOM was responsible for maintaining documentation of TB skin testing in the staff's personnel record. -The ED monitored the audits made by the BOM to determine completeness of documentation in the records. -He did not know there was no documentation of TB skin testing upon employment in Staff C's personnel record. -The ED was not able to provide Staff C's TB test results by exit of the survey. -A different system was needed for maintaining accurate documentation of staff personnel records.	C 140		

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C 249	Continued From page 3	C 249		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to ensure implementation of a physician order for 1 of 3 sampled residents related to Thrombo-Embolic-Deterrent (TED) hose and Occupational Therapy (OT) for range of motion (ROM) exercises twice daily (Resident # 1). The findings are: Review of Resident #1's current FL2 dated 12/11/20 revealed diagnoses included Alzheimer's, dementia, subluxation of right hip, benign prostatic hyperplasia, heart disease, hypertension, depression, and atrial fibrillation. a. Review of Resident #1's FL2 dated 12/11/20 revealed an order for TED hose, on in the am and off in the pm; knee-highs. (TED hose are compression stockings used to decrease swelling and prevention of blood clots). Interview with a medication aide (MA) on 01/21/21 at 9:45am revealed there currently were no residents in the facility who wore TED hose.	C 249	Please See Attached	

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C 249	Continued From page 4 Observation on 01/21/21 at 11:35am revealed Resident #1 was not wearing TED hose and his right ankle area was swollen with his right ankle protruding over the top sides of his tennis shoe. Interview with Resident #1 on 01/21/21 at 11:35am revealed he did not wear TED hose; "I wear regular socks." Review of Resident #1's December 2020 electronic medication administration record (eMAR) revealed there was no entry for applying knee-high TED hose in the morning and remove the TED hose in the evening. Review of Resident #1's January 2021 eMAR there was no entry for applying knee-high TED hose in the morning and remove them in the evening. Telephone interview with the Director of Nursing at Resident #1's skilled nursing facility (SNF) on 01/22/21 at 2:48pm and 4:21pm revealed: -On 12/11/20 Resident #1 had noted swelling to his left ankle. -An order was written by the facility's medical provider for a one-time dose of Lasix (fluid pill), TED hose on in the am and off in the pm, and try to keep the resident's legs elevated as much as the resident would tolerate. -Resident #1 was discharged from the SNF to the current facility on 12/16/20. -Resident #1's TED hose were applied prior to discharge on 12/16/20. -If Resident #1's current facility staff had any questions about the FL-2 and the orders for the TED hose, they could have clarified the order. -No one had contacted the facility staff for clarification about Resident #1's TED hose order.	C 249		

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C 249	Continued From page 5 Observation on 01/25/21 9:45am and 11:55am revealed Resident #1 was not wearing TED hose. Interview with a pharmacy technician at the facility's contract pharmacy on 01/25/21 at 11:02am revealed: -The pharmacy had received Resident #1's FL2 and the orders were entered into the eMAR by the pharmacy. -TED hose would be entered on the eMAR if there was an order. -She did not see an order for Resident #1's TED hose on the FL2. -The facility had not contacted the pharmacy about the TED hose order. -If she missed entering in an order, the facility staff could enter the order into the eMAR system. -Orders entered by the pharmacy were approved by the facility staff. Interview with a MA on 01/25/21 at 11:38am revealed: -The MA on duty was responsible for faxing the FL2 and physician summaries to the pharmacy. -The pharmacy entered the orders on the resident's eMARs, and the orders would be verified by the MA and accepted as entered if they were correct; if there was a discrepancy, she would contact the pharmacy for clarification. -The order on the FL-2 was for compression stockings; it was the "thing" Resident #1's was wearing on his arm. -When she reported no one wore TED hose on 01/21/21, she meant no one wore them on their legs, she did not think about Resident #1's compression stocking he was wearing on his arm under his elbow brace. -Resident #1's compression stocking was removed from his arm when he took a bath 2-3 times per week.	C 249		

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C 249	Continued From page 6 Interview with the facility's Licensed Practical Nurse (LPN) on 01/25/21 at 12:47 pm revealed: -Resident #1's order for TED hose was missed on the FL-2. -The FL-2 was faxed to the pharmacy and then the eMAR entries had to be accepted by the MA or Resident Care Coordinator (RCC). -The RCC should have caught the order for Resident #1's TED hose. -Resident #1 did not have TED hose. -If there was an order for TED hose, it was missed. -It was concerning that Resident #1 had not been wearing TED hose as ordered because he could experience edema, increased risk of falls, and hypotension. Observation on 01/25/21 at 1:00pm revealed: -Resident #1 was sitting on the side of his bed with both feet placed on the floor. -Resident #1 had on loose fit calf height cotton socks. -The facility nurse removed Resident #1's sock, and had noticeable indentions mid-calf on both legs and around the ankle of the right foot. Interview with the facility's Licensed Practical Nurse (LPN) on 01/25/21 at 1:00pm revealed she did not think the indentions on Resident #1's legs were caused by the socks he currently had on, but by a different pair that may have been too tight. Telephone interview with the Licensed Health Professional Support (LHPS) nurse on 01/25/21 at 1:40pm revealed: -She completed an initial LHPS evaluation on Resident #1 on 12/31/20. -She saw the order for TED hose for Resident #1.	C 249		

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C 249	Continued From page 7 -She did not see a discontinue order for the TED hose. -Resident #1 was not wearing TED hose at the time of her evaluation. -She talked to the MA who told her Resident #1 did not have TED hose but "they were working on it." -She did not recall the name of the MA she had talked to about the TED hose. Telephone interview with the Resident Care Coordinator (RCC) on 01/25/21 at 3:11pm revealed: -Orders were faxed to the pharmacy and the orders would be entered into the system by the pharmacy. -The MA, RCC or LPN, could verify orders were entered correctly and accept the order as entered. -Resident #1 did not wear TED hose. -She did not recall seeing an order for TED hose. -The LHPS nurse talked to the facility nurse after she had completed her assessment. -"We missed it." -She was concerned Resident #1 did not have TED hose because it was a provider's order and the order should have been followed. Telephone interview with a MA on 01/25/21 at 3:35pm revealed: -She had noticed Resident #1's socks were leaving indentions on his legs on Saturday, 01/23/21. -She had not told anyone, but she did contact Resident #1's family member and asked them to bring in different socks. Telephone interview with Resident #1's family member on 01/26/21 at 4:06pm revealed: -Resident #1 did not wear TED hose "as far as	C 249		

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C 249	Continued From page 8 she knew." -A MA had contacted her the weekend of 01/16/21 and asked her to bring different socks for Resident #1 because the ones he had were too tight. Telephone interview with Resident #1's Primary Care Provider (PCP) on 01/22/21 at 5:04pm revealed: -Anything written on the FL-2 was considered to be an order. -If there was an order for Resident #1 to wear TED hose, she would expect the order to have continued. -TED hose were ordered for a reason by the PCP at the SNF for Resident #1 and the TED hose should have been applied as ordered. -If Resident #1 did not wear the TED hose, he would have continued swelling, which could cause discomfort and pain. Telephone interview with the Associate Executive Director (ED)on 01/26/21 at 12:02pm revealed: -She was not aware Resident #1 had an order for TED hose. -She would need to look into the reason why the TED hose were not ordered so she could inform the staff of the result of the action. -The MAs were the first point of contact for all orders. -The RCC was responsible for reviewing the tracking form, and if it was correct, the RCC would sign off on the form. Refer to the telephone interview with the Administrator on 01/26/21 at 11:24am. b. Review of Resident #1's orthopedic physician's summary dated 12/29/20 revealed: -Resident #1 had a diagnosis of a displaced	C 249		

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C 249	Continued From page 9 fracture of the olecranon process with intraarticular extension of the left ulna, subsequent to closed fracture with routine healing. -There was an order for Occupational Therapy (OT) for left elbow gentle range of motion (ROM) exercises twice daily. -Resident may remove splint for ROM exercises and showering. Review of Resident #1's record on 01/21/21 revealed there was no documentation of Resident #1 receiving occupational therapy services. Observation on 01/21/21 at 11:35am revealed Resident #1 his left arm was in a hard-plastic splint from approximately 3-4 inches above the elbow extended to 3-4 inches below the elbow. Interview with Resident #1 on 01/21/21 at 11:35am revealed: -He was not receiving therapy on his arm. -He did not take the splint off his arm. -He was not having any pain in the arm. Telephone interview with a medical assistant at Resident #1's orthopedic provider on 01/22/21 at 12:56pm revealed: -No one from the facility had contacted their office related to Resident #1's OT referral. -The order for OT had not been discontinued. -Resident #1's orders for OT and range of motion (ROM) should have been implemented when he returned to the facility on 12/29/20. -Without the ordered ROM, Resident #1 would "stiffen up" and lose range of motion in his left elbow. Telephone interview with Resident #1's PCP on 01/22/21 at 5:04pm revealed:	C 249		

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C 249	Continued From page 10 -She was not aware Resident #1's orthopedic provider had ordered occupational therapy for Resident #1's left arm. -No one had talked to her about the order; she would not make a change in another provider's order. -If OT was ordered for Resident #1, "he should have it." Telephone interview with a representative at the facility's contracted therapy office on 01/25/21 at 10:32am revealed a referral was received for Resident #1 on 01/21/21 and the start of care was also started on 01/21/21. Telephone interview with the RCC on 01/25/21 at 3:11pm revealed: -Resident #1 was discussed in the facility's comprehensive resident review the week of 01/11/21 and she asked the therapy provider why Resident #1 was not receiving therapy and she was told the therapist had not been able to reach Resident #1's orthopedic provider. -She had not contacted Resident #1's Orthopedic provider to discuss the delay in OT services because the "therapy staff handled that." Telephone interview with Resident #1's physical therapist on 01/25/21 at 12:27pm revealed: -She completed the therapy start of care for Resident #1 on 01/21/21. -Resident #1 could have increased pain in his elbow because he had been immobilized for so long. -Resident #1's range of motion (ROM) in his left arm was "about" 20 degrees off compared to his right arm. -She and the occupational therapist would be working with Resident #1 to obtain the full range of motion.	C 249		

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C 249	Continued From page 11 -Resident #1 would "definitely" benefit from receiving therapy on his left arm. Telephone interview with the Program Manager for the facility's contracted therapy on 01/25/21 at 4:11pm revealed: -The order for Resident #1's OT was "stuck under" the therapy office door on 12/31/20. -She tried calling Resident #1's Orthopedic provider for two-weeks to get a signed order. -After two weeks, she reached out to Resident #1's PCP (01/16/21) to obtain signed orders. -She then obtained a "delay" of the orders on 01/18/21 due to COVID-19 and the new orders were to begin services on 01/21/21. -No one had told her the therapist could not provide services because of COVID-19, but she was being cautious. -She left two voicemails at the Orthopedic provider's office trying to obtain an order for therapy services. -Between 12/31/20 and 01/20/21, she had not notified the facility staff Resident #1's OT was pending in writing but thought she had mentioned it in passing. Telephone interview with the Associate Executive Director on 01/26/21 at 12:02pm revealed: -She was aware the facility's contracted therapist was trying to obtain an order for therapy from Resident #1's Orthopedic provider. -Resident #1's therapy order was discussed at the weekly reviews they had with all contracted services. -She did not feel it was the facility's responsibility to contact the Orthopedic provider because the facility's contracted therapist was working on the order. Refer to the telephone interview with the	C 249		

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C 249	Continued From page 12 Administrator on 01/26/21 at 11:24am. _____ Telephone interview with the Administrator on 01/26/21 at 11:24am revealed: -Orders started with the MA who received them. -The RCC was responsible for oversight of the "Villas" and was responsible to make sure all the orders had gone through. -The facility's LPN would also validate to make sure the orders had been processed. -The Associate ED was ultimately over the process. -The staff had morning meetings where new orders were discussed and updates on the status of those orders. -Reviewing, clarifying, and implementing orders was the responsibility of whoever was involved to carry out that service. _____ The facility failed to ensure implementation of a physician's order for TED hose for over 40 days for a resident who had been ordered the TED hose secondary to swelling and was observed to have swelling beyond the top of his tennis shoe on 01/21/20 and then on 01/25/21 both legs had swelling as evidenced of indentions left by socks that he had removed for an unknown amount of time, prior to the observation. The facility failed to ensure implementation of an order for three weeks for OT for daily ROM exercises secondary to an injury to his left elbow that had required the elbow to be in a fixated position and required therapy to ensure the resident did not lose his range of motion in the elbow. This failure was detrimental to the health and safety of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/26/21 for this violation.	C 249		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESERVE AT MILLS FARM VILLA #2	2010 MILLS CHASE LOOP APEX, NC 27523

(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
C 249	Continued From page 13 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 25, 2021.	C 249		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered to 1 of 3 sampled residents (#1) including a stool softener that was ordered as needed (prn) but was scheduled and administered twice a day and a medication that was ordered to be administered sublingual was administered by mouth with other medications and a beverage. The findings are: Review of Resident #1's current FL2 dated 12/11//20 revealed diagnoses included Alzheimer's, dementia, subluxation of right hip, benign prostatic hyperplasia, heart disease, hypertension, depression, and atrial fibrillation. a. Review of Resident #1's FL-2 revealed an	C 330	Please see attached.	

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C 330	Continued From page 14 order for Docusate Sodium (stool softener)100mg twice daily as needed for constipation. Review of Resident #1's December 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Docusate Sodium 100mg twice daily with a scheduled administration time of 8:00 am and 8:00 pm. -There was documentation Docusate Sodium 100mg was administered at 8:00am and 8:00pm from 12/16/20-12/31/20. Review of Resident #1's January 2021 eMAR revealed: -There was an entry for Docusate Sodium 100mg twice daily with a scheduled administration time of 8:00 am and 8:00 pm. -There was documentation Docusate Sodium 100mg was administered at 8:00am and 8:00pm from 01/01/21-01/21/21. Observation of Resident #1's medication on hand on 01/21/21 at 11:01am revealed a punch card dispensed 01/11/21 for Docusate Sodium administer one capsule by mouth twice daily; there were 49 of 60 tablets available for administration. Interview with Resident #1 on 01/21/21 at 12:13pm revealed asking about his stools was a "personal" question. Interview with a pharmacy technician at the facility's contract pharmacy on 01/25/21 at 11:02am revealed: -Orders were entered into the eMAR by the pharmacy. -She had entered Docusate Sodium 100mg twice daily onto Resident #1's eMAR.	C 330		

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C 330	Continued From page 15 -She failed to enter the order for Docusate Sodium as prn. -The facility accepted the order as it was entered and did not notify the pharmacy staff of the error. Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/25/21 at 12:16pm revealed Resident #1 had an order for a daily laxative, Senna, and to combine that with a stool softener being administered twice daily, could cause the resident to have diarrhea. Interview with a medication aide (MA) on 01/25/21 at 11:38am revealed: -Resident #1's FL-2 was faxed to the pharmacy. -When medications were delivered to the facility, she looked at the FL-2, the eMAR, and the actual medication on hand to make sure they all "matched up." -If there was a discrepancy, she would contact the pharmacy for clarification. -She had not noticed the Docusate Sodium order on the FL-2 was documented as prn and the order on the eMAR and medication package was documented as twice daily. -If she had noticed the prn on the FL-2 she would have contacted the pharmacy. Interview with the facility's Licensed Practical Nurse (LPN) on 01/25/21 at 12:47pm revealed: -When Resident #1's Docusate Sodium 0.125mg was delivered to the facility, the medication should have been compared to the FL-2 and when the order did not match, the MA should have called the pharmacy. -The MA was not following through making sure the information in the eMAR system matched the FL-2. -Administering Resident #1's Docusate Sodium twice daily was a medication error when the order	C 330		

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C 330	Continued From page 16 should have been administered as needed. Telephone interview with the Resident Care Coordinator (RCC) on 01/25/21 at 3:11pm revealed: -Orders were faxed to the pharmacy and the orders would be input into the system by the pharmacy. -The MA, RCC or LPN, could verify orders were entered correctly and accept the order as entered. -She was not aware Resident #1's Docusate Sodium being administered did not match the order on the FL-2. -She was concerned "that it was a medication error." -Resident #1 had not had any reported diarrhea. Telephone interview with a MA on 01/25/21 at 3:35pm revealed Resident #1 had not had any episodes of loose stools. Telephone interview with a medical assistant for Resident #1's primary care provider (PCP) on 01/26/21 at 1:12pm revealed: -Anything written on the FL-2 was considered to be an order. -Administering Docusate Sodium to Resident #1 twice daily instead of prn could cause Resident #1 to experience diarrhea. Refer to the telephone interview with the Associate Executive Director (ED)on 01/26/21 at 12:02pm. Refer to the telephone interview with the Administrator on 01/26/21 at 11:24am. b. Review of Resident #1's FL-2 revealed an order for Clonazepam (antipsychotic) 0.125mg	C 330		

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C 330	Continued From page 17 dis tab SL (sublingual) twice daily. Review of Resident #1's December 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Clonazepam 125mg take one tablet by mouth twice daily with a scheduled administration time of 8:00 am and 8:00 pm. -There was documentation Clonazepam 125mg was administered at 8:00am and 8:00pm from 12/16/20-12/31/20. Review of Resident #1's January 2021 eMAR revealed: -There was an entry for Clonazepam 125mg take one tablet by mouth twice daily with a scheduled administration time of 8:00 am and 8:00 pm. -There was documentation Clonazepam 125mg was administered at 8:00am and 8:00pm from 01/01/21-01/21/21. Observation of Resident #1's medication on hand on 01/21/21 at 11:01am revealed: -There was a punch card for Clonazepam ODT (orally disintegrating tablet) 0.125mg give one table by mouth twice daily. -There was a yellow sticker below the order with the directions of place medicine on tongue and allow to disintegrate. Interview with Resident #1 on 01/21/21 at 11:34am revealed he was doing fine and had not concerns. Interview with a pharmacy technician at the facility's contract pharmacy on 01/25/21 at 11:02am revealed: -Resident #1 was dispensed Clonazepam 0.125mg ODT. -The pharmacy failed to make the entry specific	C 330		

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C 330	Continued From page 18 to administer sublingually. -The facility accepted the order as it was entered and did not ask for clarification. Interview with a medication aide (MA) on 01/25/21 at 11:38am revealed: -Resident #1 took all his medications by mouth with a glass of water. -Resident #1 did not have any medications that he did not swallow. -Resident #1's FL-2 was faxed to the pharmacy. -When medications were delivered to the facility, she looked at the FL-2, the eMAR, and the actual medication on hand to make sure they all "matched up." -If there was a discrepancy, she would contact the pharmacy for clarification. -She had not noticed the Clonazepam order on the FL-2 was ordered as SL and the order on the eMAR and medication package was documented as by mouth. -If she had noticed the directions on the FL-2 she would have contacted the pharmacy. Interview with the facility's Licensed Practical Nurse (LPN) on 01/25/21 at 12:47pm revealed: -The MA should have known to administer the Clonazepam sublingual because the order was written as SL and the MA should know what the abbreviation stood for. -The MA should have read the entire medication label for Resident #1's Clonazepam punch card. Telephone interview with the Resident Care Coordinator (RCC) on 01/25/21 at 3:11pm revealed: -Orders were faxed to the pharmacy and the orders would be input into the system by the pharmacy. -The MA, RCC or LPN, could verify orders were	C 330		

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C 330	Continued From page 19 entered correctly and accept the order as entered. -Resident #1 had an order for Clonazepam 0.125mg ODT. -She thought ODT meant sublingual. -She was concerned Resident #1's Clonazepam was not administered correctly. Telephone interview with a medical assistant for Resident #1's primary care provider (PCP) on 01/26/21 at 1:12pm revealed: -Anything written on the FL-2 was considered to be an order. -Clonazepam ODT was less effective if it was swallowed and not allowed to disintegrate. -Resident #1 could experience increased anxiety or agitation if the Clonazepam was not disintegrated for maximum effectiveness. Refer to the telephone interview with the Associate Executive Director (ED)on 01/26/21 at 12:02pm. Refer to the telephone interview with the Administrator on 01/26/21 at 11:24am. Telephone interview with the Associate Executive Director (ED)on 01/26/21 at 12:02pm revealed: -The MAs were the first point of contact for all orders. -The facility had implemented an order tracking form that was initiated by the MA when new orders were received. -Orders were faxed to the pharmacy, and each section of the tracking form would be completed and signed off on. -The RCC was responsible for reviewing the tracking form, and if it was correct, the RCC would sign off on the form. -The RCC and the Facility's LPN should have	C 330		

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C 330	Continued From page 20 reviewed the FL-2 with the eMARs. -The facility staff had been working on auditing resident records; she thought the audits started in December 2020 or January 2021. Telephone interview with the Administrator on 01/26/21 at 11:24am revealed: -Orders started with the MA who received them. -The RCC was responsible for oversight of the MAs and was responsible to make sure all the orders were accurate. -The facility's LPN would also validate to make sure the orders had been processed and accurate. -The facility's Associate ED was ultimately over the process. -The staff had morning meetings where new orders were discussed and updates on the status of those orders. -Reviewing, clarifying, and implementing orders was the responsibility of whoever was involved to carry out that service. -The facility staff had started internal audits on the residents records for the past three weeks.	C 330		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state	C 912	Please see attached	

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C 912	Continued From page 21 laws and rules related to health care. The findings are: Based on observations, record reviews, and interviews the facility failed to ensure implementation of a physician order for 1 of 3 sampled residents related to Thrombo-Embolic-Deterrent (TED) hose and Occupational Therapy (OT) for range of motion (ROM) exercises twice daily (Resident # 1). [Refer to Tag C 0249 10A NCAC 13G .0902(c) (3-4) Health Care (Type B Violation)].	C 912		

The following is a summary of the Plan of Correction for The Reserve at Mills Farm. This Plan of Correction is regarding the Corrective Action Report dated 1/27/2021, This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors.

0405 (a) (b) Test for Tuberculosis

An associate file review was completed for the presence of 1st & 2nd Step PDD's on 2/10/21 by the Business Office Manager (BOM)/Designee.

A list of associates that were missing either the 1st Step &/or 2nd Step PPD was developed on 2/10/21 by the BOM/Designee.

This list will be reviewed on a weekly basis by the Executive Director (ED)/BOM/Designee until testing is completed for those associates missing either the 1st and/or 2nd Step PPD's.

1st Step PPD's will be completed for those designated associates no later than 2/28 or they will be removed from the schedule until complete.

2nd Step PPD's will be completed for those designated associates no later than 3/12/21 or they will be removed from the schedule until complete.

If an associate is unable to receive a PPD due to a history of an allergic reaction or past positive testing a chest x-ray result stating they are free of Tuberculosis will be placed in their file.

An associate tracker will be developed for required items at hire, to include PPD documentation.

There after a weekly review of the associate compliance tracker will be completed by the ED/BOM/Designee for completion of the 1st & 2nd Step PPD's.

Any associate that has not completed a 1st and/or 2nd Stepp PDD within 30 days will be removed from the schedule until completed.

Going forward- At hire a review for completion of a 1st Step PPD's will be completed by the BOM/Designee.

.0902 (c)(3) (4) Health Care

A comprehensive order review was completed for current residents on 1/28/21 by the Regional Director of Clinical Services/Resident Care Coordinator (RCC).

Healthcare Providers were contacted for any needed clarifications noted regarding orders not followed up on appropriately at that time.

Associates will be re-trained on using the New Order Tracking Form (NOTF) for all orders obtained on residents no later than 2/26/21 by the Associate Executive Director (AED)/Director of Clinical Services (DCS)/RCC/Designee.

The NOTF will be reviewed on a daily basis by the AED/DCS/RCC/Designee when in the community with appropriate follow up as indicated.

The NOTF will be reviewed following the Daily Stand Up by the ED/AED when in the community to include follow up documentation.

.1004 (a) Medication Administration

A comprehensive order review was completed for current residents on 1/28/21 by the Regional Director of Clinical Services/Resident Care Coordinator (RCC).

Healthcare Providers were contacted for any needed clarifications noted regarding orders not followed up on appropriately at that time.

Associates will be re-trained on using the New Order Tracking Form (NOTF) for all orders obtained on residents no later than 2/26/21 by the Assistant Executive Director (AED)/Director of Clinical Services (DCS)/RCC/Designee.

Associates will be retrained regarding medication administration and following administration orders no later than 2/28/21 by the Assistant Executive Director (AED)/Director of Clinical Services (DCS)/RCC/Designee.

The NOTF will be reviewed on a daily basis by the AED/DCS/RCC/Designee when in the community with appropriate follow up as indicated.

The NOTF will be reviewed following the Daily Stand Up by the ED/AED when in the community to include follow up documentation.

131D-21 (2) Declaration of Resident Rights

Associates will be re-educated regarding Resident Rights no later than 2/26/21 by the AED/DCS/RCC/Designee.

Linda G. Duncan, RN AED

2/24/21