STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-092270	A. BUILDING: _____ B. WING _____	01/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESERVE AT MILLS FARM VILLA #3	2020 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 with onsite visits on 01/21/21 and 01/25/21 and a desk review survey from 01/22/21 and 01/26/21-01/28/21 and a telephone exit on 01/28/21.	C 000		
C 243	10A NCAC 13G .0901(b) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care And Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Based on record reviews, interviews and observations, the facility failed to provide supervision for 1 of 3 sampled residents (#3) who had a history of falls. The findings are: Review of the facility's Fall Management policy dated 08/27/20 revealed: -Falling is defined as an event in which a person unintentionally comes to rest on the ground or another lower level with or without injury. -All resident falls are reported to the resident's primary physician for review and any possible recommendations they may have. -Interventions are to be documented on the resident's Individualized Service Plan as well as communication to the appropriate caregivers. Review of Resident #3's current FL-2 dated 12/28/20 revealed: -Diagnoses included dementia, kidney stone and hematuria.	C 243	Please see attached	2/18/21

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Linda G Duncan, RN. AED
3/4/21

Vinson Bonasky 3/4/21
POC reviewed and accepted
3/4/2021
D. Morrison-Rogers

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 243	Continued From page 1 -Resident #3 was ambulatory. Review of Resident #3's Resident Register revealed an admission date of 10/06/20. Review of Resident #3's current care plan dated 10/14/20 revealed: -Resident #3 was ambulatory, and he had a steady gait. -Resident #3's bed was moved and reposition due to a previous fall. -Resident #3 was independent with ambulation. Review of Resident #3's Incident and Accident Report dated 11/18/20 revealed: -On 11/18/20 at 1:44pm, Resident #3 was found on the bedroom floor by the window between the table and the swivel chair. -He had no skin tears, bruising or redness. -Resident #2 remained in the facility. -The facility's Director of Clinical Services (DCS) was notified on 11/18/20 at 2:05pm. Review of Resident #3's electronic progress note dated 11/18/20 at 3:07pm revealed: -The MA walked by room #601 and saw the resident on the floor by the window between the table and a swivel chair. -The MA checked the resident, and she found no skin tears, no bruising, or redness. Telephone interview with the MA who completed the previous report on 01/27/21 at 4:04pm revealed: -She worked on 11/18/20. -She did not remember the incident on 11/18/20 when Resident #3 was found on the floor in another resident's room. -She did not remember who she notified of the incident or the interventions after the incident.	C 243		

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C 243	Continued From page 2 -The process for a fall was to check the resident for injury and to take vital signs (VS). -If the resident complained of pain or hit their head, the staff should not move the resident and call 911. -The family member, Resident Care Coordinator (RCC) or DCS should be notified and the incident report should be faxed to the PCP. -An incident report, post fall report should be filled out, and a progress note should be documented in the resident's record and the shift report for the next 24 hours. -Resident #3 was checked between 30 minutes to an hour for the next 72 hours and documented in the progress notes. -The residents were normally monitored between one to two hours. Telephone interview with the RCC on 01/28/21 at 10:02am revealed: -She knew about the fall on 11/18/20 when Resident #3 was found on the floor in another resident's room. -Resident #3 should be engaged in activities to keep him from wandering into other residents' rooms. -The intervention put in place after this fall on 11/18/20 was Resident #3 should be monitor every 30 minutes to an hour for 72 hours. -The information was placed in Resident #3's progress notes. Telephone interview with the DCS on 01/27/21 at 7:25pm revealed: -She knew about the fall on 11/18/20 when Resident #3 was found on the floor in another resident's room. -The intervention put in place after this fall on 11/18/20 was Resident #3 should be monitor every 30 minutes to an hour for 72 hours.	C 243		

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C 243	Continued From page 3 -There was no documentation of the 30 minute or hourly checks for 72 hours. -This was a facility policy. Review of Resident #3's Incident and Accident Report dated 12/19/20 revealed: -On 12/19/20 at 2:27pm, Resident was found between his bed and the chair. -Resident #3 had no apparent injury, but he appeared weak and tired. -The personal care aide (PCA) and the MA picked the resident up and sat him on his bed. -The DCS was notified on 12/19/20 at 2:30pm. -Resident #2 remained in the facility. Review of Resident #3's electronic progress note dated 12/19/20 at 3:19pm revealed: -Resident #3 was found between his bed and chair. -Resident #3 had no apparent injuries, but he was weak and tired. Telephone interview with a MA who completed the previous report on 01/27/21 at 8:30am revealed: -She worked on 12/19/20 when Resident #3 was found on the floor in his bedroom. -Resident #3 complained of no pain, and he was able to get up on his own. -Resident #3 had no injury. -She notified the DCS, family member and faxed the incident report to the PCP on 12/19/20 (no time). -The intervention put in place was the bed was moved against the wall and 2 of the 4 locks on the bed was hard to lock. The locks on the two wheels had to be loosened to make it easier to push the lock down. -The process for a fall was to check the resident for injury and to take vital signs (VS). -If the resident complained of pain or hit their	C 243		

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C 243	Continued From page 4 head, the staff should not move the resident and call 911. -The family member, RCC or DCS should be notified and the incident report faxed to the resident's PCP. -An incident report, post fall report should be filled out, and a progress note should be documented in the resident's record and shift report for the next 24 hours. -Resident #3 was checked between 30 minutes to an hour for the next 72 hours and documented in the progress notes. -The residents were normally monitored between one to two hours. Telephone interview with the RCC on 01/28/21 at 10:02am revealed: -She knew about the fall on 12/19/20 when Resident #3 was found on the floor in his room. -The bed was pushed away from the wall which caused him to lean back on the bed and lose his balance. -The intervention put in place after this fall on 12/19/20 was Resident #3's bed was move close to the wall, so it could be in a more secure location. Telephone interview with the DCS on 01/27/21 at 7:25pm revealed: -She knew about the fall on 12/19/20 when Resident #3 was found on the floor in his room. -The intervention put in place after the fall on 12/19/20 was that Resident #3's bed was move closer to the wall. -There was no documentation of the 30 minute or hourly checks for 72 hours. -This was a facility policy. Review of Resident #3's Incident and Accident Report dated 12/22/20 revealed:	C 243		

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C 243	Continued From page 5 -On 12/22/20 at 7:30 pm, Resident #3 was found on the floor behind his bed. -Resident #3 was weak and looked pale. -He was unable to verbalize any pain. -Resident #3 did not sustain any injury. -Resident #3 remained in the facility. -The RCC was notified on 12/22/20 at 8:08pm. Resident #3's electronic progress note dated 12/22/20 at 10:19pm revealed: -Resident #3 was found on the floor behind his bed in his bedroom. -Resident #3 was unable to verbalize any pain. -There was no signs of injury. Interview with a MA who completed the previous report on 01/27/21 at 5:26pm revealed: -She worked on 12/22/20 when Resident #3 was found on the floor in his room. -The PCA notified her on 12/22/20 (no time). -She checked Resident #3 and took his vital signs (VS) and found the resident had no injury. -Resident #3 was unable to verbalize any injuries. -She notified the RCC, family member and faxed the incident report to the PCP on 12/22/20. -The process for a fall was to check the resident for injury and to take VS. -If the resident complained of pain or hit their head, the staff should not move the resident and call 911. -The family member, RCC or DCS should be notified and the incident report faxed to the PCP. -An incident report, post fall report should be filled out, and a progress note should be documented in the resident's record and shift report for the next 72 hours. -Resident #3 was checked between 30 minutes to an hour for the next 72 hours and documented in the progress notes. -The residents were normally monitored between	C 243		

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C 243	Continued From page 6 one to two hours. Telephone interview with a PCA on 01/27/21 at 5:50pm revealed: -She worked on 12/22/20 when she found Resident #3 on the floor between the bed and the table. -She notified the MA on 12/22/20 (no time) of the incident. The residents were normally monitored between one to two hours. Telephone interview with the RCC on 01/28/21 at 10:02am revealed: -She knew about the fall on 12/22/20 when Resident #3 was found on the floor in his room. -There was no new intervention put in place after the fall on 12/22/20. -The process for a fall was to check the resident for injury and to take VS. -If the resident complained of pain or hit their head, the staff should not move the resident and call 911. -The family member, RCC or DCS should be notified and the incident report should be faxed to the resident's PCP. -The RCC or DSC should be notified within 30 minutes of the incident. -An incident report, post fall report should be filled out, and a progress note should be documented in the resident's record and shift report for the next 72 hours. -Resident #3 was checked between 30 minutes to an hour for the next 72 hours and documented in the progress notes. -The residents were normally monitored between one to two hours. Telephone interview with the DCS on 01/28/21 at 7:25pm revealed:	C 243		

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C 243	Continued From page 7 -She knew about the fall on 12/22/20 when Resident #3 was found on the floor in his room. -There was no new intervention put in place after the fall on 12/22/20. -The process for a fall was to check the resident for injury and to take VS. -If the resident complained of pain or hit their head, the staff should not move the resident and call 911. -The family member, RCC or DCS should be notified and the incident report should be faxed to the resident's PCP. -An incident report, post fall report should be filled out, and a progress note should be documented in the resident's record and shift report for the next 72 hours. -Resident #3 was checked between 30 minutes to an hour for the next 72 hours and documented in the progress notes. -The residents were normally monitored between one to two hours. Telephone interview with the Executive Director (ED) on 01/28/21 at 1:37pm revealed: -He knew about the fall on 11/18/20 when Resident #3 was found on the floor in another resident's room. -The intervention put in place after this fall on 11/18/20 was Resident #3 should be monitor every 30 minutes to an hour for 72 hours. -He knew about the fall on 12/19/20 when Resident #3 was found on the floor in his room. -The intervention put in place after this fall on 12/19/20 was new footers were placed on the bed, and the bed was moved to the wall. -He knew about the fall on 12/22/20 when Resident #3 was found on the floor in his room. -There was no new intervention put in place after the fall on 12/22/20 for Resident #3.	C 243		

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C 243	Continued From page 8 Based on observations, interviews, and record review, it was determined Resident #3 was not interviewable.	C 243		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure referral and follow-up for 1 of 3 sampled residents related to three unwitnessed falls (#3). The findings are: Review of the facility's Fall Management policy date 08/27/20 revealed: -Falling is defined as an event in which a person unintentionally comes to rest on the ground or another lower level with or without injury. -All resident falls are reported to the resident's primary physician for review and any possible recommendations they may have. -Interventions are to be documented on the resident's Individualized Service Plan as well as communication to the appropriate caregivers. Review of Resident #3's current FL-2 dated 12/28/20 revealed: -Diagnoses included dementia, kidney stone and hematuria. -Resident #3 was ambulatory. Review of Resident #3's Resident Register revealed an admission date of 10/06/20.	C 246	Please see attached 3/8/21 This will be completed by date specified.	

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C 246	Continued From page 9 Review of Resident #3's current care plan dated 10/14/20 revealed: -Resident #3 was ambulatory, and he had a steady gait. -Resident #3's bed was moved and reposition due to a previous fall. -Resident #3 was independent with ambulation. Telephone interview with Resident #3's primary care provider (PCP) on 01/28/21 at 12:23pm revealed: -She did not know Resident #3 had falls on 11/18/20, 12/19/20 and 12/22/20. -She did not receive notification from the facility regarding Resident #3's falls on 11/18/20, 12/19/20 and 12/22/20. -She expected staff to notified her about Resident #3's falls on 11/18/20, 12/19/20 and 12/22/20. -If she had known about the falls on 11/18/20, 12/19/20 and 12/22/20 she would have made recommendations. Telephone interview with a medication aide (MA) on 01/28/21 at 2:32 pm revealed: -She could not recall the incident on 11/18/20, so she could not say if she fax an incident report to Resident #3's PCP on 11/18/20. She faxed an incident report to Resident #3's PCP on 12/19/20 related to Resident #3 being found on the floor in his bedroom. -The fax machine did not provide a confirmation sheet. Telephone interview with a second MA on 01/28/21 at 3:16pm revealed: -She faxed an incident report to Resident #3' PCP on 12/22/20 related to Resident #3 being found on the floor in his bedroom. -The fax machine did not provide a confirmation	C 246		

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C 246	Continued From page 10 sheet. Telephone interview with the RCC on 01/28/21 at 2:32 pm revealed: -The process for notifying the resident's PCP about a fall was to fax an incident report to the resident's PCP and then attached a confirmation sheet to the incident report. -This would be proof the MA sent the incident report to the PCP. -She just found out on 01/28/21 that the fax machine did not always provide a fax confirmation sheet. Telephone interview with the Executive Director (ED) on 01/28/21 at 1:37pm revealed: -The process for notifying the resident's PCP about a fall was to fax an incident report to the resident's PCP and then attached a confirmation sheet to the incident report. -The MAs were responsible for faxing the incident reports to the resident's PCP. Based on observations, interviews, and record review, it was determined Resident #3 was not interviewable.	C 246		
C 284	10A NCAC 13G .0904(e)(4) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (e) Therapeutic Diets in Family Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by:	C 284	Please see attached	

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C 284	Continued From page 11 Based on observations, interviews and record reviews, the facility failed to assure therapeutic diets were served as ordered for 1 of 3 sampled residents (#2) who had an order for a nutritional supplement. The findings are: Review of Resident #2's current FL-2 dated 10/28/20 revealed: -Diagnoses included dementia with behavioral disturbance, essential hypertension, coronary artery disease, chronic kidney disease, vitamin D deficiency, senile osteoporosis, mixed hyperlipidemia and anxiety disorder. -There was an order for a nutritional supplement entree three daily. Observation of the facility's refrigerator on 01/21/21 at 12:20pm revealed no nutritional supplement was available. Review of Resident #2's current care plan dated 11/30/20 revealed: -Resident #2 required reminders to eat and complete meals -Resident #2 required supervision with eating. Telephone interview with Resident #2's primary care provider (PCP) on 01/28/21 at 12:23pm revealed: -She did not know Resident #2 had not been provided a nutritional supplement to drank. -The purpose of a nutritional supplement was to help Resident #2 maintain a healthy weight. -If she had been aware, she would have recommended the staff to provide a nutritional supplement and record Resident #2's weights. Review of Resident #2's monthly weight record	C 284		

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C 284	Continued From page 12 revealed she weighed 115.2 in November 2020, 120.0 in December 2020 and121.8 in January 2021. Telephone Interview with a representative from the contracted pharmacy on 01/28/21 at 9:43am revealed: -The FL-2 for Resident #2 had been faxed to the pharmacy. -She was responsible for putting all the information from the orders on the FL-2 for Resident #2 into the system. -The pharmacist checked the data entry on the Electronic Medication Records (eMARs). -The facility was responsible for verifying the orders in the system and then confirm the order before it would down load on the eMAR. -She did not know a nutritional supplement had to be put into the system as an order. -She was learning the process during the audit. -She had not been putting nutritional supplements in the system if it was not related to a medication order. Review of Resident #3's November 2020, December 2020 and January 2021 eMARs revealed there was no entry for a nutritional supplement. Interview with a medication aide (MA) on 01/25/21 at 10:45am revealed: -She did not know about the nutritional supplement order for Resident #2 on the FL-2 dated 10/28/20. -The process for an order was to fax the order to the pharmacy, to make copies of the order and attach a copy of the order to the 24 hour report and to make a copy for the Resident Care Coordinator (RCC) and to put a note in the resident's progress note and to put the original	C 284		

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	FCL-092270	A. BUILDING: _____ B. WING _____	01/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESERVE AT MILLS FARM VILLA #3	2020 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 284	Continued From page 13 order in the resident's record. -A new tracking sheet was attached to all orders expect the FL-2 and the MAs were responsible for verifying the order in the system, and the RCC or the Director of Clinical Services (DCS) was responsible for auditing the order within 24 hours. Telephone interview with a second MA on 01/27/21 at 5:26pm revealed: -She did not work at the facility when Resident #2 was admitted. -The process for an order was to fax the order to the pharmacy, the pharmacist put the orders into the computer. -The MA verified the orders with the orders on the eMAR and the medication on hand. -If all the information was correct the MA confirmed the order and then the RCC or DSC will audit the order within 24 hours. Telephone with the RCC on 01/28/21 at 10:01am revealed: -She did not know Resident #3 had an order for a nutritional supplement on her FL-2 dated 10/28/20. -The order went unnoticed. -The MA who should have verified the order and then confirmed the orders no longer worked at the facility. -The order should have been audited within 24 hours by the RCC. -The process for an order was to fax the FL-2 to the pharmacy and the information was put in the system by the pharmacist. -The MA had to verify the information with Resident #2's FL-2 then confirm it, if okay. -The MA should notify the pharmacist or the RCC if there was a concern. Telephone interview with the DCS on 01/27/21 at	C 284		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-092270	A. BUILDING: _____ B. WING _____	01/28/2021

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THE RESERVE AT MILLS FARM VILLA #3	2020 MILLS CHASE LOOP APEX, NC 27523

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C 284	Continued From page 14 7:25pm revealed: -She did not know Resident #3 had an order for a nutritional supplement on her FL-2 dated 10/28/20. -The resident's original FL-2 order was placed in the resident's record after faxed to the pharmacy. -The pharmacist typed the order on the eMARs. -The pharmacist only typed in the medications on the eMARs. -The MA had to type in supplements and other non-medications. -First, the staff verify the orders typed on the eMAR. -Second, the staff compare the medications sent from the pharmacy to the type orders on the eMARs. -If there was an issue the MA could notify the pharmacist and get the order reprofile or notify the RCC. -There was no tracking sheet attached to the FL-2. -The RCC was responsible for auditing new orders within 24 hours of the order and the end of the month. -The RCC should notify the DCS if there was a problem with the orders. Telephone interview with the Executive Director (ED) 01/28/21 at 1:37pm revealed: -He did not know Resident #2 had an order for a nutritional supplement, and it had been left off the eMAR. -He expected the eMARs to be complete and accurate. -He expected the MA to verify and confirm the orders on eMARs. -The RCC should audit the orders on the eMARs within two to four hours of the order. -He really did not know what happened or why the order for the nutritional supplement fell through	C 284		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-092270	A. BUILDING: _____ B. WING _____	01/28/2021

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THE RESERVE AT MILLS FARM VILLA #3	2020 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 284	Continued From page 15 the cracks. Based on observations, interviews, and record review, it was determined Resident #2 was not interviewable.	C 284		

- The New Order Tracking Forms will be reviewed by the AED/DCS/RCC/Designee daily when in the community for accurateness of eMAR.

Linda G Duncan RN. AED 3/4/21

The following is a summary of the Plan of Correction for The Reserve at Mills Farm Villa 3. This Plan of Correction is in regards to the Corrective Action Report dated February 16, 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.

10A NCAC 13G .0901 (b) Personal Care and Supervision

- Each resident residing in Villa 3(C) was reassessed using Navion's Resident Assessment Tool by the Associate Executive Director (AED)/Director of Clinical Services (DCS)/ Resident Care Coordinator (RCC)/Designee no later than 2/18/21.
- A Fall Risk Review was completed for each resident residing in Villa 3(C) by the AED/DCS/RCC/Designee no later than 2/18/21.
- Each Care Plan for residents residing in Villa 3(C) was reviewed and updated, as indicated, with above findings by the AED/DCS/RCC/Designee no later than 2/18/21.
- When a resident who resides in Villa 3(C) has had a fall, that resident's monitoring will be increased to assist with the resident's care needs.
- The increased supervision will be reassessed by the AED/DCS/Designee to determine the need for additional interventions.
- Associates assigned to Villa 3(C) will be re-educated on Fall Prevention program utilizing Slip, Trip and Fall Prevention training by the AED/DCS/Designee
- A "weekly" Thera Care/Comprehensive Resident Review (CRR) meeting was implemented on 1/29/21, and will be led by the AED/DCS/Designee.
- Residents residing in Villa 3(C) with any falls since the last meeting will be reviewed to include the effectiveness of interventions discussed.
- Notes from that meeting will be maintained by the AED/Designee for ~~review~~ and follow up.
- System fully implemented 2/17/21 (LGD)

10A NCAC 13G .0902 (b) Health Care Referral and Follow Up

- Associates scheduled to work in Villa 3(C) will be reeducated on appropriate documentation regarding incidents and follow up with the Health Care Provider no later than 3/8/21 by the AED/DCS/RCC/Designee.
- As each incident occurs the Incident will be relayed to the Primary Care Provider to include call or fax with documentation of a Physician Communication regarding the incident for their review.
- A "weekly" Thera Care/Comprehensive Resident Review (CRR) meeting will be implemented reviewing any follow up instructions as indicated by ~~Health~~ Care Provider led by the AED/DCS Designee. Initiated 1/29/21 (LGD)
- Shift to Shift Report will be reviewed on a daily basis reviewing any incidents and appropriate follow up daily for the next 30 days when in the community, and then at least weekly there after, by the AED/DCS/RCC/Designee.

10A NCAC 13G .0904 € (4) Nutrition and Food Services

- A resident chart audit was completed by the AED/DCS/RCC/Designee no later than 2/19/21. Chart audits completed on 2/17/21 Daily chart audits are completed daily (Goal 4 per day) by RCC, DCS, AED/Designee
- Appropriate follow up was completed with the residents Healthcare Provider of any issues that were discovered at that time in regards to ordered supplements.
- Associates (MED TECHS) working in Villa 3(C) will be reeducated on the use of the New Order Tracking form and it's usage for all orders and appropriate follow up no later than 3/9/21 by the AED/DCS/RCC/Designee. Fully implemented by 2/17/21 (LGD)
- MED TECHS working in Villa 3(C) will be reeducated on appropriate documentation regarding new orders no later than 3/9/21 by the AED/DCS/RCC/Designee. re-implemented re-education occurred by 2/17/21 (LGD)

Linda Duncan RN. AED
2/4/21