

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL-092269	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/22/2022
NAME OF PROVIDER OR SUPPLIER THE RESERVE AT MILLS FARM VILLA #2		STREET ADDRESS, CITY, STATE, ZIP CODE 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 annual survey on 09/22/22.	C 000		
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, interviews and record reviews, the facility failed to ensure physician orders were implemented for 1 of 3 sampled residents (#1) with an order for weekly blood pressure. The findings are: Review of Resident #1's current FL-2 dated 05/03/22 revealed diagnoses included Alzheimer's dementia, anxiety, post-traumatic stress disorder and Parkinson's disease. Review of Resident #1's physician order dated 05/18/22 revealed an order to start checking blood pressure weekly. Review of Resident #1's electronic weights and vitals for July 2022 revealed there was one entry for the resident's blood pressure. Review of Resident #1's electronic weights and	C 249		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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C 249	Continued From page 1 vitals for August 2022 revealed there was one entry for the resident's blood pressure. Review of Resident #1's electronic weights and vitals for September 2022 revealed there was one entry for the resident's blood pressure. Interview with a representative from the pharmacy on 09/22/22 at 3:30pm revealed the facility was responsible for putting orders for blood pressures in the electronic medication administration record (eMAR). Interview with the Resident Care Coordinator (RCC) on 09/22/22 at 3:53pm revealed: -She became the RCC of the facility in July 2022. -She was not aware Resident #1 had an order for weekly blood pressure checks. -The order should have been tracked using the facility's order tracking system. -She and the Administrator were responsible to ensure blood pressure orders were implemented. -She had not conducted a record review audit for Resident #1. Interview with the Administrator on 09/22/22 at 3:50pm revealed: -She thought orders for blood pressure checks were put in the eMAR by the pharmacy. -She was not aware the pharmacy did not put blood pressure orders in the eMAR, until today, 09/22/22, when she spoke with a representative from the pharmacy. -She was not aware Resident #1 had an order for weekly blood pressures.	C 249		