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 _____	R 03/27/2023

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 a follow up survey on March 27, 2023.	{C 000}	The Regional Directors of Clinical Services completed retraining for Med Tech's on the proper process of approving orders in the eMAR system.	April 26th, 2023
{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: FOLLOW-UP TO TYPE B VIOLATION Noncompliance continues with increased severity resulting in residents placed at substantial risk for serious physical harm or neglect will occur. THIS IS A TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to administer a narcotic pain reliever used to control severe pain and a narcotic antianxiety medication used to manage shortness of breath in end-of-life care as ordered by the hospice provider for 1 of 3 sampled residents (#1) who was experiencing acute, unmanaged pain. The findings are: Review of Resident #1's current FL-2 dated 02/14/23 revealed diagnoses included acute	{C 330}	The Executive Director and Director of Clinical Services met with all 3rd party vendors that service our residents and explained they must give a report prior to exiting the facility post assessment of a resident. The Regional Director of Clinical Services and Director of Clinical Services completed full MAR to Cart audits by two separate nurses a week apart. The DCS/Designee will continue to monitor new orders and medications on hand ongoing. The facility completed retraining to Med Tech's regarding meds on hand and the new order approval process. The DCS/RCC/Regional Director of Clinical Services is reviewing eMAR reports daily (Monday – Friday) for 3 weeks, then decrease to weekly for 2 weeks, and then as needed ongoing. The Regional Director of Clinical Services is working with the pharmacy when issues arise with a delay in order entry and following up. In the absence of the Regional Director of Clinical Services onsite, the DCS/RCC notifies the pharmacy when there is a delay in order entry. In this process we have found concerns with our current pharmacy with the order entry process. We have made the agreement to give notice to our current pharmacy, and switch to a long-term care pharmacy in the near future. The Regional Director of Clinical Services completed retraining for the Med Tech's on documenting in the progress notes on residents as indicated. The Regional Director of Clinical Services has completed training with the Med Tech's on proper documentation of narcotics on both the control substance count log and the medication administration record. The DCS/RCC are completing daily Narc Log to Mar Audits (Monday – Friday) for 3 weeks, then decrease to weekly for 2 weeks, and then as needed ongoing.	April 26th, 2023 April 26th, 2023 April 26th, 2023 April 26th, 2023 April 26th, 2023 April 26th, 2023

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

Reviewed and acknowledged. 8 May 2023

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{C 330}	Continued From page 1 cystitis, benign prostatic hyperplasia, stage 3 chronic kidney disease, dementia, and hypertension. Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 08/11/22. Review of Resident #1's Hospice Physician's Orders and Care Plan dated 03/02/23 revealed the resident was admitted to hospice on 03/02/23. a. Review of Resident #1's hospice order dated 03/21/23 revealed an order for morphine 0.25ml (5mg) every 6 hours for pain or shortness of breath and every 2 hours as needed (PRN) for pain or shortness of breath. (Morphine is a narcotic medication used to treat severe pain.) Review of Resident #1's March 2023 electronic medication administration record (eMAR) revealed: -There was an entry for morphine 0.25ml (5mg) every 6 hours scheduled for 12:00am, 6:00am, 12:00pm, and 6:00pm with a start date of 03/21/23. -There was no documentation that morphine 5mg was administered at 12:00am, 6:00am, 12:00pm and 6:00pm on 03/21/23. -There was no documentation that morphine 5mg was administered at at 12:00am, 6:00am, 12:00pm and 6:00pm on 03/22/23. -There was no documentation that morphine 5mg was administered at 12:00am and 6:00am on 03/23/23. -There was documentation the first dose of morphine was administered at 12:00pm on 03/23/23. -There was an entry for morphine 5mg every 2 hours PRN.	{C 330}		

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{C 330}	Continued From page 2 -There was no documentation morphine 5mg every 2 hours PRN was documented as administered on 03/21/23 and 03/22/23. -There was an entry for morphine 5mg every 3 hours PRN. -There was documentation morphine 5mg every 3 hours PRN was administered on 03/21/23 at 3:18pm and 10:03pm and 03/22/23 at 4:50am and 10:39am. Observations of Resident #1's medications on hand on 03/27/23 at 3:36pm revealed: -There was a brown plastic bag with a pharmacy label which had Resident #1's name and instructions for morphine 5mg to be administered every 6 hours. -The pharmacy label indicated 32 prefilled syringes of morphine 5mg were ordered and dispensed on 03/21/23. -There were 15 prefilled syringes of morphine 5mg remaining on hand. Review of Resident #1's controlled substance records (CSRs) revealed: -There was a CSR with a pharmacy label which had Resident #1's name and instructions for morphine 5mg every 6 hours. -The pharmacy label indicated 8ml or 32 prefilled syringes of morphine 5mg were ordered and dispensed on 03/21/23. -The first entry on the CSR was undated and documented 32 syringes remained on hand. -The second entry on the CSR documented 1 syringe was removed and 31 remained on 03/23/23 at 11:42am. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/27/23 revealed: -The pharmacy received the order for morphine	{C 330}		

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{C 330}	Continued From page 3 5mg every 6 hours on 03/21/23. -The pharmacy processed the order at 7:50pm on 03/21/23, added the order on the eMAR system and dispensed the medication for delivery. -The pharmacy dispensed 32 prefilled syringes of morphine 5mg, a total of 8ml on 03/21/23 which went out to the facility the same night around 9:00pm. -Facility staff were responsible for confirming new orders on the eMAR. b. Review of Resident #1's hospice order dated 03/21/23 revealed an order for lorazepam 0.5mg every 6 hours scheduled for restlessness or agitation and every 2 hours as needed (PRN) for restlessness or agitation. (Lorazepam is a narcotic medication used to treat anxiety.) Review of Resident #1's March 2023 electronic medication administration record (eMAR) revealed: -There was an entry for lorazepam 0.5mg every 6 hours scheduled for 12:00am, 6:00am, 12:00pm, and 6:00pm with a start date of 03/21/23. -There was no documentation that lorazepam 0.5mg was administered at 12:00am, 6:00am, 12:00pm and 6:00pm on 03/21/23. -There was no documentation that lorazepam 0.5mg was administered at at 12:00am, 6:00am, 12:00pm and 6:00pm on 03/22/23. -There was no documentation that lorazepam 0.5mg was administered at 12:00am and 6:00am on 03/23/23. -There was documentation the first dose of lorazepam was administered at 12:00pm on 03/23/23. -The was an entry for lorazepam 0.5mg every 2 hours PRN. -There was no documentation lorazepam 0.5mg every 2 hours PRN was documented as	{C 330}		

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{C 330}	Continued From page 4 administered on 03/21/23 and 03/22/23. -There was an entry for lorazepam 0.5mg every 4 hours PRN. -There was documentation 1 dose of lorazepam every 4 hours PRN was administered at 3:21pm on 03/21/23. -There was no documentation lorazepam 0.5mg every 4 hours PRN was documented as administered on 03/22/23. Observations of Resident #1's medications on hand on 03/27/23 at 3:36pm revealed: -There was a bubble pack with a pharmacy label with Resident #1's name and instructions for lorazepam 0.5mg every 6 hours scheduled. -The pharmacy label indicated 30 tablets were ordered and dispensed on 03/21/23. -There were 14 tablets remaining in the bubble pack. Review of Resident #1's controlled substance records (CSRs) revealed: -There was a CSR with a pharmacy label which had Resident #1's name and instructions for lorazepam 0.5mg every 6 hours. -The pharmacy label indicated 30 tablets were ordered and dispensed on 03/21/23. -The first entry on the CSR documented 30 tablets remained on hand on 03/21/22. -The second entry on the CSR documented 1 tablet was removed and 29 remained on 03/23/23 at 11:42am. -The third entry on the CSR documented 1 tablet was removed and 28 remained on 03/23/23 at 11:15pm. -There was no documentation a tablet was removed on 03/23/23 between 11:42am and 11:15pm for the scheduled 6:00pm dose. -The last entry on the CSR documented 14 tablets remained on 03/27/23 at 12:00pm.	{C 330}		

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{C 330}	Continued From page 5 Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/27/23 revealed: -The pharmacy received the order for lorazepam 0.5mg every 6 hours on 03/21/23. -The pharmacy processed the order at 7:50pm on 03/21/23, added the order on the eMAR system and dispensed the lorazepam for delivery. -The pharmacy dispensed 30 lorazepam 0.5mg tablets on 03/21/23 which went out to the facility that night around 9:00pm. Review of Resident #1's electronic progress notes dated 03/21/23 and 03/22/23 revealed: -On 03/21/23 at 7:04am, there was documentation the resident experienced shortness of breath at 6:20am. -Hospice was contacted and the medication aide (MA) was instructed to administer PRN morphine and await the arrival of the hospice nurse (HN). -On 03/21/23 at 8:29am, there was documentation the MA was instructed to call emergency medical services (EMS) by the Director of Clinical Services (DCS) because Resident #2's blood oxygen saturation level (O2 sat) was 74% (normal levels are 90-100%). -EMS was at the facility at 7:45am and provided supplemental oxygen (O2) to the resident. -The resident's family member did not want the resident taken to the emergency room (ER). -On 03/21/23 at 3:18pm, there was documentation morphine 5mg every 3 hours PRN was administered for shortness of breath and documentation at 4:08pm the morphine was effective. -On 03/21/23 at 3:21pm, there was documentation lorazepam 0.5mg every 4 hours PRN was administered for anxiety and documentation at 4:08pm the lorazepam was	{C 330}		

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{C 330}	Continued From page 6 effective. -On 03/21/23 at 10:03pm, there was documentation morphine 5mg every 3 hours PRN was administered for shortness of breath, documentation on 03/22/23 at 2:05am the morphine was not effective and the resident had a pain score of 9 out of 10. -On 03/21/23 at 10:13pm, there was documentation the resident was seen by the HN, there were medication order changes, lorazepam and morphine had been administered per the HN and the resident was on supplemental O2. -On 03/22/23 at 4:50am, there was documentation that PRN morphine was given at 2:00am for continuous wheezing and shortness of breath. (There was no documentation on Resident #1's eMAR that morphine 5mg PRN was administered at 2:00am). -On 03/22/23 at 6:15am, there was documentation morphine 5mg every 3 hours PRN administered at 4:50am was effective. -On 03/22/23 at 10:39am, there was documentation morphine 5mg every 3 hours PRN was administered for an unspecified reason and documentation at 10:39am the morphine was effective. -On 03/22/23 at 9:43pm, there was documentation PRN morphine was administered on first shift for shortness of breath. -On 03/23/23 at 7:36am, there was documentation the order for morphine 5mg every 6 hours was initiated. -On 03/24/23 at 8:40pm, there was documentation the order for morphine 5mg every 2 hours PRN was initiated. Interview with a MA on 03/27/23 at 3:35pm revealed: -Medications were delivered to the facility sometimes in the afternoon and sometimes at	{C 330}		

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{C 330}	Continued From page 7 night depending on when the order was written. -She was not working in the facility on 03/21/23 when Resident #1's morphine and lorazepam were delivered. -The CSR documented 30 lorazepam tablets were delivered on 03/21/23 and there was no date on the morphine CSR, but it most likely came on 03/21/23. -MAs could not see orders on the eMAR which were pending approval in the electronic system. -The nurse or the Director of Clinical Services were responsible for approving orders on the eMAR. Interview with Resident #1's family member on 03/27/23 at 4:21pm revealed: -The care provided for Resident #1 had been up and down and awful about one week ago (03/21/23). -Staff at the facility were having difficulty determining how much medication to give the resident for his pain. -There were new hospice orders written one week ago and it took 2 days for the facility to administer the new medications to the resident. -The first night she stayed with him until 1:00am because he was in a great deal of pain. -He was restless and shouted out in pain during the night. -It was very difficult to watch him in so much pain. -Those were "a rough two days" because he was in pain the entire two days. -She was never told why the medications were not administered. Telephone interview with Resident #1's HN on 03/23/23 at 2:59pm revealed: -The orders for morphine 5mg every 6 hours and lorazepam 0.5mg every 6 hours were written by the hospice medical provider on 03/21/23.	{C 330}		

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{C 330}	Continued From page 8 -The order was sent electronically to the pharmacy and the facility on 03/21/23. -The morphine 5mg every 3 hours PRN and lorazepam 0.5mg every 4 hours PRN were both increased to every 2 hours PRN . -The scheduled doses of morphine 5mg every 6 hours and lorazepam 0.5mg every 6 hours were newly added because the resident's pain and shortness of breath were unmanaged with the previous orders. -She discussed the medication changes with the Memory Care Coordinator (MCC) on 03/21/23 before leaving the facility. -She visited the facility on 03/22/23 and was told by staff that the orders written on 03/21/23 had been implemented. -She did not know the name of the staff. -Resident #1 was more uncomfortable with pain and shortness of breath when she visited him on 03/23/23. -She was then told by staff on 03/23/23 that the orders for scheduled morphine 5mg every 6 hours and lorazepam 0.5mg every 6 hours were not implemented until 03/23/23. -She did not know the name of the staff. -She contacted the Hospice provider due to concern for the resident related to unmanaged pain and shortness of breath and the delay in initiating the orders written on 03/21/23. -The resident was placed on hospice watch which involved ensuring the orders for scheduled morphine and lorazepam were administered and educating staff on administering PRN morphine and lorazepam to relieve pain and shortness of breath. -She visited the resident on 03/24/23 and his pain and shortness of breath were managed and he was receiving the morphine 5mg and lorazepam 0.5mg every 6 hours. -Staff were expected to contact hospice	{C 330}		

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{C 330}	Continued From page 9 immediately with any issues implementing new and changed medication orders whether it was with the written order or getting the medication from the pharmacy. -There was no record of the staff contacting hospice regarding the changed orders for morphine and lorazepam written on 03/21/23. Interview with the DCS on 03/27/23 at 4:53pm revealed: -She, the new MCC, the nurse and the Administrator were responsible for processing provider orders for multiple sister facilities. -There was no system to identify which staff was responsible for processing new orders in the facility and sister facilities. -Electronic prescriptions sent directly to the pharmacy showed up on the eMAR system as a pending order. -Upon seeing the pending order on the eMAR system, one of us (DCS, MCC, nurse or Administrator) contacted the pharmacy for a copy of the order. -Once medications arrived in the facility one of us(DCS, MCC, nurse or Administrator) approved the order on the eMAR. -She verified medications were in the building by asking the MA to fax the pharmacy delivery slip or coming to the facility and checking the medication. -Resident #1's orders for morphine 5mg every 6 hours and lorazepam 0.5mg every 6 hours were not faxed to the facility until 03/22/23 at 10:11am. -She did not have a response for why the morphine and lorazepam were not implemented until 12:00pm on 03/23/23. -Some HNs told the MA what orders they were implementing, and some did not. -MAs were responsible for notifying the DCS, the nurse, MCC or Administrator when medications	{C 330}		

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{C 330}	Continued From page 10 arrived in the facility that were not on the eMAR. -Orders that were pending on the eMAR were not visible to MAs when they viewed the eMAR. -She was not aware of Resident #1's condition on 03/21/23 and 03/22/23. -She did not know he experienced a "decline." -She did not know hospice changed the morphine and lorazepam orders due to uncontrolled pain. -If the medications were in the facility, they should have been administered as ordered. -There must have been an electronic prescription that she did not know about. -Resident #1's family member did tell her the resident had pain, but she could not remember when that conversation occurred because she talked to her every day. Interview with the Administrator on 03/27/23 at 5:29pm revealed: -The DCS made her aware on 03/27/23 of the delay in implementing Resident #1's hospice orders for morphine 5mg and lorazepam 0.5mg every 6 hours. -The records indicated hospice wrote the orders on 03/21/23, the order was not in the facility until 03/22/23 and was not implemented until 03/23/22. -If the start date was not changed when the order was approved in the system, then the eMAR grid to document administration of medication remained blank until the order was approved by one of the supervisors. -She saw discrepancies in the timeline of Resident #1 experiencing a change of condition, when hospice came to the facility, and when the orders were written based on the resident's electronic progress notes. -She did not have a response for documentation on the CSR for lorazepam 0.5mg every 6 hours that showed 30 tablets were in the facility on	{C 330}		

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{C 330}	Continued From page 11 03/21/23 and the morphine 5mg every 6 hours was delivered on 03/21/23 as reported by the pharmacy. -She could not identify where or how in the order processing system that Resident #1's morphine 5mg every 6 hours and lorazepam 0.5mg every 6 hours orders dated 03/21/23 were missed. -It was important to implement hospice orders for end-of-life care and comfort. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. The facility failed to administer a narcotic pain reliever used to control severe pain (morphine) and a narcotic antianxiety medication used to manage shortness of breath in end-of-life care (lorazepam) as ordered by the hospice provider for Residents #1 who was experiencing acute unmanaged pain for 2 days. The facility's failure to administer morphine and lorazepam as ordered by the hospice provider resulted in substantial risk of serious harm and neglect and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/12/23 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 26, 2023.	{C 330}		

Washington, Bynithia T

From: Olivia Jenkins <olivia.jenkins@navionsl.com>
Sent: Tuesday, May 2, 2023 2:04 PM
To: Washington, Bynithia T
Cc: Jan Garihan; Mark Kane; Jennifer Price Penn
Subject: [External] Updated POC RMF 3/27/2023
Attachments: The Reserve at Mills Farm #3 2023-03-27 SOD ZKFL13 - COMPLETED.docx

Hello Bynithia,

Please see the updated SOD. Please let me know if you need anything further.

Thank you!

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