STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESERVE AT MILLS FARM	3000 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
D 000	Initial Comments The Adult Care Licensure Section conducted a follow up survey on May 10-11, 2023.	D 000		
D 161	10A NCAC 13F .0504(a & b) Competency Eval & Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task. (b) The licensed health professional shall evaluate the staff person's knowledge, skills, and abilities that relate to the performance of each personal care task. The licensed health professional shall validate that the staff person has the knowledge, skills, and abilities and can demonstrate the performance of the task(s) prior to the task(s) being performed on a resident. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 personal care aides (Staff A) had been competency validated for licensed health professional support (LHPS) tasks by return demonstration including applying and removing bandages.	D 161		

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D 161	Continued From page 1 The findings are: Observations of Resident #1 on 05/10/23 at 9:27am revealed: -She was lying on her back with her eyes closed in her bed. -There was a large yellow, beige, and brown stain over the front left chest of her gown extending to her left arm from her shoulder to her elbow and onto the sheet and pillow underneath her. -The center of the stained area was moist and the area towards her arm and on the sheet was dried. -There was a musty odor of decay within 3 feet of her. -There were several 4 inch square gauze pads in a basket by her bed. -There were 2 plastic totes of wound care supplies in her bathroom which included an opened package of 4 inch gauze pads, abdominal pads, wound cleansers and tape. Review of Resident #1's current FL-2 dated 09/16/22 revealed: -Diagnoses included dementia, psychotic/mood disturbances, anxiety, abnormal gait and mobility, hypothyroidism, and generalized muscle weakness. -There was an order for foam dressing pad bordered apply to chest mass as needed (PRN) when dressing is soiled Review of Resident #1's Order Summary Report dated 02/01/23 and signed by the primary care provider (PCP) revealed an order for foam dressing pad bordered apply to chest mass PRN when dressing is soiled Review of Resident #1's hospice orders dated 04/11/23 revealed:	D 161		

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-There was an order for the hospice nurse (HN) to perform/provide instruction/reinforcement to patient/caregiver the procedure of wound care.
-Cleanse the left scapula area with wound cleanser, apply Vaseline gauze dressing, and cover with a foam dressing using clean technique.
-There was an order for the HN to change the dressing twice weekly.

Review of Staff A's personnel record revealed:
-She was hired on 01/24/23 as a personal care aide (PCA).
-There was no documentation she completed an LHPS Competency Validation to perform clean dressing changes.

Interview with Staff A on 05/10/23 at 9:27am revealed:
-Resident #1's wound had been draining large amounts of some kind of fluid daily for more than a month.
-Many times she was left to care for the wound and saturated bandage because the MAs would tell her they were waiting for the Hospice Nurse (HN).
-No one had shown her how to remove the old dressing, clean the wound and apply clean gauze and pads to Resident #1's left chest wound.
-The current dressing had been in place since yesterday (05/09/23) when she had changed the dressing.

Interview with Staff A on 05/11/23 at 8:41am revealed:
-She had not been trained on changing Resident #1's dressing when it became soiled and saturated.
-She cleaned the area and changed the dressing as best she could when the dressing was heavily

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D 161	Continued From page 3 soiled. Interview with the Resident Care Coordinator (RCC) on 05/11/23 at 3:55pm revealed: -The Clinical Management was responsible to ensure staff were validated as new tasks were ordered for residents in the facility. -All direct care staff should be LHPS validated before they were allowed to work on the floor on their own. -Staff A was a PCA working the floor without supervision. -She did not have documentation that Staff A was LHPS competency validated for dressing changes. Telephone interview with Corporate Operations staff on 05/11/23 at 2:40pm revealed: -She was a registered nurse (RN) although that was not her hired role with the facility's corporate office. -She had been contacted to come and verify skills with Staff A at the facility on 05/11/23. -Resident #1 had a dressing on her left chest area below her clavicle and on her left lower leg shin area. -She demonstrated the dressing changes with Staff A present and completed the check skills list regarding dressing changes. -The PCA did not do a return demonstration of the dressing change, she only observed the RN change the dressings. Telephone interview with the facility's LHPS RN on 05/11/23 at 2:02pm revealed: -She had started in March 2023 coming in twice a week to help get the residents' LHPS reviews completed and completing skills checklists for the new hires. -At the end of March or the first part of April 2023,	D 161		

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D 161	Continued From page 4 she had completed the LHPS information on all the residents and was validating staff on their clinical skills. -She had not checked off any staff for competency for Resident #1's dressing change as hospice was the agency caring for that resident. Interview with the Director of Clinical Services (DCS) on 05/11/23 at 4:35pm revealed: -Before staff could work on the floor on their own they must be LHPS validated as competent. -It was the clinical management staff's job to follow up and get staff LHPS competency validated. -New staff should be LHPS competency validated after about a week or two of hire date. -All direct care staff get LHPS training. -She did not know Staff A was not LHPS competency validated for dressing changes. Interview with the Administrator on 05/11/23 at 4:50pm revealed: -She was not aware LHPS validation was not previously completed for Staff A. -It was the DCS's and RCC's responsibility to ensure all staff were competency validated for LHPS tasks. Attempted telephone interview with the second LHPS nurse on 05/11/23 at 2:30pm was unsuccessful.	D 161		
D 255	10A NCAC 13F .0801(c)(1) Resident Assessment 10A NCAC 13F .0801Resident Assessment (c) The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition	D 255		

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D 255	Continued From page 5 using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living; (B) change in ability to walk or transfer; (C) change in the ability to use one's hands to grasp small objects; (D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic; (E) no response by the resident to the treatment for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) threat to life such as stroke, heart condition, or metastatic cancer; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher; (I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being such as initial diagnosis of Alzheimer's disease or diabetes; (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed; (K) new onset of impaired decision-making; (L) continence to incontinence or indwelling catheter; or (M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident.	D 255		

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This Rule is not met as evidenced by:
The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule

Based on observations, interviews and record reviews, the facility failed to assure an assessment of a resident was completed within 10 days following a significant change in the resident's condition for 1 of 3 sampled residents (Resident #2) who required assistance with transferring, toileting and had a history of falling.

The findings are:

Review of Resident #2's current FL2 dated 01/13/23 revealed diagnoses included hemiplegia and hemiparesis, congestive heart failure, generalized muscle weakness, and unsteadiness on feet.

Review of Resident #2's care plan dated 09/28/22 revealed:
-She required extensive assistance with bathing.
-She required limited assistance with toileting and dressing.
-She was independent with transferring, eating, ambulation, and grooming.

Review of Resident #2's licensed health professional support (LHPS) evaluation dated 03/27/23 revealed she required staff assistance with transfers.

Review of Resident #2's resident assessment tool dated 03/29/23 revealed she was a fall risk,

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required hands on physical assist of one person on a regular basis, and required physical assistance of 2 or more staff members for transfers.

Observation of Resident#2 in her room on 05/11/23 revealed:
-She was in a wheelchair
-She needed assistance from staff for transfers from the wheelchair.

Review of Resident #2's April 2023 progress notes revealed:
-On 04/05/23, at 11:40am, she was found on her bathroom floor, unwitnessed fall.
-The Power of Attorney (POA) was called and vitals were taken.
-Resident #2 did not complain of pain.
-On 04/18/23, at 7:45am, Resident #2 had an unwitnessed fall in her bathroom and was found on her left side.
-She complained of shoulder pain.
-Emergency Medical Services (EMS) was called and she was sent to hospital for observation.

Review of Resident #2's incident and accident reports revealed:
-On 04/05/23, Resident #2 rang her call bell and was found her on the bathroom floor
-Resident #2 stated she fell trying to get into her wheelchair.
-No injuries were observed, and she did not complain of pain.

Interview with Resident #2 on 05/10/23 at 9:30am revealed:
-She had 2 falls in the past 30 days (April 2023).
-She fell transferring from the toilet to her wheelchair, without any assistance from staff.
-She reported that she should have waited for

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D 255	Continued From page 8 staff to assist her with transfer. Interview with a PCA on 05/10/23 at 4:00pm revealed: -She learned about the level of care each resident needed from watching other staff members provide care. -Each resident had a care plan in a folder at the staff desk. -Resident #2's care plan was outdated. -Resident #2 had two unwitnessed falls in April. Interview with Med-aide on 05/10/23 at 4:10pm revealed: -It was documented in the care plan dated 09/28/22, Resident #2 needed no assistance during transferring. -If new staff or agency staff looked at her care plan they would not know she needed assistance with transferring. -Resident #2 needed assistance for transfers. -Resident #2 had two unwitnessed falls in her bathroom in April 2023. -She knew Resident #2 needed assistance transferring from talking with other PCA's. Interview with the Director of Clinical Services (DCS) on 05/10/23 at 3:20pm revealed: -All new staff were told to look at the resident care plans in the folder at the staff desk in order to know each residents' level of care. -Resident care plans should be updated if there was a significant change to the residents' level of care. -Resident #2's level of care changed and she needed increased supervision and assistance with transfers since her return from rehabilitation in January 2023. -There were no measures implemented and communicated to staff about increased	D 255		

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D 255	Continued From page 9 supervision for Resident #2. Interview with a Resident Care Coordinator (RCC) on 05/11/23 at 3:55pm revealed: -Resident #2's care plan should have been updated by herself or the DCS. -Resident #2 needed increased supervision and assistance with transfers upon returning from rehabilitation (January 2023). -Resident #2 had a couple of falls since returning from rehabilitation on 01/13/23. Attempted telephone interview with Resident #2's family member on 05/11/23 at 11:40am was unsuccessful.	D 255		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .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: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to implement as needed wound care as ordered by the primary care provider (PCP) for 1 of 3 sampled residents (#1) who had a chronic nonhealing mass on her chest with progressive growth and a steady increase in drainage.	D 276		

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D 276	Continued From page 10 The findings are: Observations of Resident #1 on 05/10/23 at 9:27am revealed: -She was lying on her back with her eyes closed in her bed. -There was a large yellow, beige, and brown stain over the front left chest of her gown extending to her left arm from her shoulder to her elbow and onto the sheet and pillow underneath her. -The center of stained area was moist and the area towards her arm and on the sheet was dried. -There was a musty odor of decay within 3 feet of her. -There were several 4 inch square gauze pads in a basket by her bed. -There were 2 plastic totes of wound care supplies in her bathroom which included an opened package of 4 inch gauze pads, abdominal pads, wound cleansers and tape. Review of Resident #1's current FL-2 dated 09/16/22 revealed: -Diagnoses included dementia, psychotic/mood disturbances, anxiety, abnormal gait and mobility, hypothyroidism, and generalized muscle weakness. -There was an order for a foam dressing pad bordered apply to chest mass as needed (PRN) when dressing was soiled. Review of Resident #1's Order Summary Report dated 02/01/23 and signed by the primary care provider (PCP) revealed an order for foam dressing pad bordered apply to chest mass PRN when dressing is soiled. Review of Resident #1's hospice orders dated 04/11/23 revealed: -There was an order for the hospice nurse (HN)	D 276		

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to perform/provide instruction/reinforcement to patient/caregiver the procedure of wound care.
-Cleanse the left scapula area with wound cleanser, apply Vaseline gauze dressing, and cover with a foam dressing using clean technique.
-There was an order for the HN to change the dressing twice weekly.

Review of Resident #1's current care plan dated 10/03/22 revealed:
-She was totally dependent on staff for assistance with bathing, dressing, ambulation, transfers and toileting.
-She had a mass on the left outside area of her chest.
-She was seen and treated by hospice for the left chest mass.

Review of Resident #1's March, April and May 2023 electronic medication administration records (eMAR) revealed:
-There was an entry for foam dressing pad bordered apply to the chest mass PRN when dressing was soiled.
-There was no documentation a foam dressing was applied to the resident from 03/01/23 through 05/09/23.
-On 05/10/23 at 10:33am, there was documentation that a foam dressing was placed on Resident #1's chest mass by the Director of Clinical Services (DCS).

Review of Resident #1's electronic progress note dated 04/27/23, 04/28/23 and 04/30/23 revealed:
-The MA documented the resident was warm to touch and had an axillary body temperature of 99.1 degrees Fahrenheit (F).
-The MA notified hospice of the resident's temperature and the "smell of resident area".

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D 276	Continued From page 12 -The HN told the MA he would see about starting antibiotic treatments on the wound. -The MA contacted hospice for wound care and the resident was being monitored for fevers. Review of Resident #1's electronic progress note dated 05/02/23 revealed the resident was receiving antibiotics for a skin infection. Interview with a personal care aide (PCA) on 05/10/23 at 9:27am revealed: -She was unable to get Resident #1 up and to the dining room for breakfast because of the large amount of drainage and odor from the dressing on the resident's chest. -She could not take Resident #1 to the dining room with the saturated dressing and odor. -She assisted the resident with eating breakfast in her room that morning (05/10/23). -The resident's wound had been draining large amounts of some kind of fluid daily for more than a month. -She reported the condition of the dressing to the MAs daily when she worked. -Many times, she was left to care for the wound and saturated bandage because the MAs would tell her they were waiting for the HN. -She did not know what to do for Resident #1. -No one had shown her how to remove the old dressing, clean the wound and apply clean gauze and pads to Resident #1's left chest wound. -She reported the condition of Resident #1's dressing, drainage, and odor to the Resident Care Coordinator (RCC) within the last week. -Yesterday (05/09/23) she had reported the concern to the Administrator and today to one of the corporate nurses. -She was told the HN was scheduled to change Resident #1's dressing around 11:00am on 05/10/23.	D 276		

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-The HN did not come in to change Resident #1's dressing on the weekends so there was frequently no dressing change on Saturdays and Sundays.

Interview with the medication aide (MA) on 05/10/23 at 9:45am revealed:
-Resident #1's left chest wound was a tumor and MAs did not change those kinds of dressings.
-The HN came three times a week to change Resident #1's left chest dressing.
-There was a lot of drainage from the left chest wound or tumor.
-PCAs washed Resident #1 and changed her clothing each day.
-PCAs did the best they could do to clean the area around the left chest dressing.
-There were supplies in the resident's room to change the dressing, but the HN applied medication to the wound.
-She was responsible for removing the saturated dressing, cleaning the area, and applying a clean and dry dressing while waiting for the HN, but normally the PCA did it.
-She did not have a response for why the PCA was changing Resident #1's left chest dressing.

Interview with a second MA on 05/11/23 at 8:47am revealed:
-The HN was responsible for wound care of Resident #1's left chest.
-She only placed a new dressing on Resident #1's left chest because the resident had pulled off the old dressing.
-After placing the dressing, she called hospice to provide wound care for Resident #1.
-She did not remember when that happened.

Telephone interview with a third MA on 05/11/23 at 2:53pm revealed:

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-She documented Resident #1's electronic progress note dated 04/27/23.
-Resident #1's left chest wound normally had an odor but on 04/27/23 she noticed there was a stronger odor.
-Resident #1 was placed on an antibiotic after hospice was notified on 04/27/23 that the resident was warm to touch and there was a stronger odor from the wound on her left chest.

Telephone interview with Resident #1's family member on 05/11/23 at 10:11am revealed:
-There was a time that the wound on Resident #1's left chest drained more.
-Then hospice increased the wound care visits to 3 times a week about 8 weeks ago.
-Staff said they could not change Resident #1's left chest dressing and that hospice had to be called.

Interview with the Director of Clinical Services (DCS) on 05/10/23 at 9:51am revealed:
-The PCAs were responsible for assisting Resident #1 with washing and getting dressed.
-MAs were responsible for contacting hospice when Resident #1's left chest dressing needed to be changed.
-The HN was responsible for changing the resident's left chest dressing three times a week.
-If there were written orders then the MA could apply a clean, dry dressing to Resident #1's left chest in the absence of a HN.
-She did not know how long it had taken for Resident #1's dressing to saturate the dressing, her gown, the bed sheets, and her pillow.
-She had not taught staff how to remove the saturated dressing, clean Resident #1's left chest area and apply clean and dry gauze and padding.

Interview with Resident #1's HN on 05/10/23 at

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D 276	Continued From page 15 12:10pm revealed: -She had been seeing Resident #1 for approximately 5 months for some of the resident's wound care visits. -She was not Resident #1's primary HN. -Resident #1 was receiving comfort care for Alzheimer's dementia which included HN visits three times weekly for wound care and hospice aide visits twice weekly for assistance with activities of daily living (ADLs). -HNs visited Resident #1 as needed if staff called for assistance.. -The wound on Resident #1's left chest went from just beneath the clavicle and extended down toward the breast. -The wound was raised at the center with red, nonhealing tissue like a tumor and measured 11.5cm by 8cm by 2cm. -Excessive bleeding and drainage from the wound on Resident #1's left chest started as a leak 2 to 4 months ago and has steadily gotten worse. -There was a hospice order for staff to replace a soiled or dislodged dressing to Resident #1's left chest with a dry dressing. -Staff could also call hospice and request a PRN visit for wound care. -Lying in saturated bandages, clothing, and linen increased Resident #1's risk of infection and further skin breakdown. -Staff were expected to call hospice and follow treatment orders. Interview with the Resident Care Coordinator (RCC) on 05/11/23 at 3:55pm revealed: -She saw Resident #1 with a saturated dressing on occasion in the past. -It did not happen often and usually occurred because the resident had slept on her left side. -Resident #1 should not eat meals with a	D 276		

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saturated dressing, gown, and bed linens.
-The MA should have reinforced the dressing and assisted the PCA with cleaning and dressing Resident #1 while waiting for hospice.
-MAs were supposed to document any clean dressing changes completed in the resident's progress notes.
-She was made aware on 05/11/23 there was no documentation of clean dressing changes in Resident #1's electronic progress notes or on the eMARs.
-She was not sure if staff had been trained to remove a saturated or soiled dressing, cleanse the wound area, and placed a clean, dry dressing to Resident #1's left chest.
-MAs were able to apply Band-aids but for anything else they normally called hospice.

Interview with the Administrator on 05/10/23 at 9:56am revealed:
-Resident #1 and her family had chosen non-aggressive treatment for wound care of the resident's left chest wound.
-The wound drainage from the resident's left chest had increased over the past couple of days and hospice would need to be consulted about the appropriateness of Resident #1's care.
-The HN changed the dressing to Resident #1's left chest a couple times a week.
-Due to increased drainage hospice was called on 05/10/23 to change the dressing.
-MAs and PCAs were not permitted to change Resident #1's left chest dressing.
-She was made aware of the increased drainage on 05/09/23.
-She did not know the increased drainage had been occurring for more than a month.
-She was new as the campus Administrator and had not been at the facility long enough to know if staff had been taught how to clean Resident #1's

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D 276	Continued From page 17 wound and apply a clean dressing in the absence of and while waiting for a HN. Upon request on 05/10/23 and 05/11/23, Resident #1's hospice order for staff to replace soiled or dislodged dressings was not provided for review Attempted interview with Resident #1's primary care provider (PCP) on 05/11/23 at 2:46pm was unsuccessful. Attempted interview with Resident #1's Hospice Provider on 05/10/23 at 10:05am and 05/11/23 at 2:00pm were unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. _____ The facility failed to implement as needed wound care as ordered by the primary care provider (PCP) for 1 of 3 sampled residents (#1) who had a chronic nonhealing mass on her chest with progressive growth and a steady increase in drainage. The facility's failure to implement as needed wound care for Resident #1 resulted in a bandage saturated with body fluids and a decaying odor which increased the risk of infection and further skin breakdown and was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. _____ THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 25, 2023.	D 276		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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10A NCAC 13F .1004 Medication Administration
(a) An adult 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 A2 VIOLATION.

The Type A2 violation was abated.
Non-compliance continues.

Based on observations, interviews and record reviews, the facility failed to administer medications including a medication used to treat hypothyroidism, and iron and vitamin D deficiencies as ordered by the provider for 1 of 3 sampled residents (#1).

The findings are:

Review of Resident #1's current FL-2 dated 09/16/22 revealed diagnoses included dementia, psychotic/mood disturbances, anxiety, abnormal gait and mobility, hypothyroidism, and generalized muscle weakness.

a. Review of Resident #1's current FL-2 dated 09/16/22 revealed an order for levothyroxine 125mcg daily.

Review of Resident #1's primary care provider (PCP) order dated 02/01/23 revealed an order to decrease levothyroxine from 112mcg to 100mcg daily.

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D 358	Continued From page 19 Review of Resident #1's hospice orders dated 04/11/23 revealed an order for levothyroxine 112mcg daily. Review of Resident #1's April 2023 electronic medication administration record (eMAR) revealed: -There was an entry for levothyroxine 100mcg every morning at 6:00am. -There was documentation levothyroxine 100mcg was administered daily from 04/01/23 through 04/30/23. Review of Resident #1's May 2023 eMAR revealed: -There was an entry for levothyroxine 100mcg every morning at 6:00am. -There was documentation levothyroxine 100mcg was administered daily from 05/01/23 through 05/11/23. Observations of Resident #1's medications on hand on 05/11/23 at 12:05pm revealed: -There was a bubble pack with a pharmacy label that had Resident #1's name and instructions for levothyroxine 100mcg every morning. -The pharmacy label indicated 28 tablets were dispensed on 04/17/23 and there were 9 tablets remaining. b. Review of Resident #1's current FL-2 dated 09/16/22 revealed an order for vitamin D3 5000 units daily. Review of Resident #1's primary care provider (PCP) order dated 03/21/23 revealed an order for vitamin D3 5000 units twice weekly. Review of Resident #1's hospice orders dated	D 358		

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D 358	Continued From page 20 04/11/23 revealed an order for vitamin D3 5000 units daily. Review of Resident #1's April 2023 electronic medication administration record (eMAR) revealed: -There was an entry for vitamin D3 5000 units 2 days per week (Tuesday and Friday) at 8:00am. -There was documentation vitamin D3 5000 units was administered every Tuesday and Friday between 04/01/23 and 04/30/23. Review of Resident #1's May 2023 eMAR revealed: -There was an entry for vitamin D3 5000 units 2 days per week (Tuesday and Friday) at 8:00am. -There was documentation vitamin D3 5000 units was administered every Tuesday and Friday between 05/01/23 and 05/11/23. Observations of Resident #1's medications on hand on 05/11/23 at 12:05pm revealed: -There was a bubble pack with a pharmacy label that had Resident #1's name and instructions for vitamin D3 5000 units 2 days per week. -The pharmacy label indicated 8 capsules were dispensed on 04/17/23 and there was 1 capsule remaining. c. Review of Resident #1's Order Summary Review dated 02/01/23 revealed an order for ferrous sulfate 325mg twice daily. Review of Resident #1's primary care provider (PCP) order dated 03/21/23 revealed an order to change ferrous sulfate to ferrous gluconate 324mg every other day. Review of Resident #1's hospice orders dated 04/11/23 revealed an order for ferrous sulfate	D 358		

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D 358	Continued From page 21 325mg twice daily. Review of Resident #1's April 2023 electronic medication administration record (eMAR) revealed: -There was an entry for ferrous gluconate 324mg every other day at 8:00am. -There was documentation ferrous gluconate was administered every other day from 04/01/23 through 04/29/23. Review of Resident #1's May 2023 eMAR revealed: -There was an entry for ferrous gluconate 324mg every other day at 8:00am. -There was documentation ferrous gluconate was administered every other day from 05/01/23 through 05/11/23. Observations of Resident #1's medications on hand on 05/11/23 at 12:05pm revealed: -There was a bubble pack with a pharmacy label that had Resident #1's name and instructions for ferrous gluconate 324mg every other day. -The pharmacy label indicated 14 tablets were dispensed on 04/21/23 and there were 3 tablets remaining. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 05/11/23 at 2:30pm revealed: -Most of the hospice orders from the facility were faxed by the facility. -There were a few electronic prescriptions sent by the hospice provider that were mostly for controlled substances. -The pharmacy did not have Resident #1's hospice orders dated 04/11/23. -The Resident Care Coordinator (RCC) had contacted the pharmacy on 05/11/23 regarding	D 358		

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those orders.
-There was no record of the pharmacy ever receiving Resident #1's 04/11/23 hospice orders.
-The pharmacy had an order for levothyroxine 100mcg daily dated 01/12/23 for Resident #1.
-The pharmacy had an order for vitamin D3 5000 units twice weekly dated 03/22/23 for Resident #1.
-The pharmacy had an order for ferrous gluconate 324mg every other day dated 03/22/3 for Resident #1 because the enteric coated ferrous sulfate previously ordered was not crushable.

Telephone interview with Resident #1's hospice nurse (HN) on 05/11/23 at 3:30pm revealed:
-She did not see Resident #1 regularly but was covering the interview for the resident's primary HN.
-Hospice orders that were electronically signed by the hospice provider were effective and active orders.

Interview with the RCC on 05/11/23 at 3:55pm revealed:
-Hospice normally faxed Resident #1's updated care plan and orders to the facility.
-She did not know how often hospice updated care plans and orders and then faxed them to the facility.
-The medication aides (MAs), she and the Director of Clinical Services (DCS) were responsible for receiving orders faxed to the facility and faxing them to the pharmacy.
-Orders faxed to the pharmacy were also scanned to her for review.
-She did not have Resident #1's hospice orders dated 04/11/23 in her scans folder.
-She checked with the pharmacy, and they did not have the hospice orders dated 04/11/23 for

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Resident #1 either.
-She did not know what happened with Resident #1's 04/11/23 hospice orders.

Interview with the DCS on 05/11/23 at 4:30pm revealed:
-MAs were responsible for faxing orders received on the fax machine to the pharmacy and scanning the orders to her and the RCC.
-Not all hospice orders were received by fax, some were brought to the facility by the HN.
-She did not know Resident #1's hospice orders dated 04/11/23 existed before today (05/11/23).
-Hospice did not notify her of hospice recertification and updated care planning and orders.
-There was no collaboration with hospice.
-Once orders were received and faxed to the pharmacy, the pharmacy entered the order on the eMAR and she or the RCC approved the order.

Interview with the Administrator on 05/11/23 at 4:53pm revealed:
-The orders provided for review were sent to her by hospice on 05/11/23.
-Orders should be sent to the facility by hospice for faxing to the pharmacy, review, and implementation.
-Copies of electronic prescriptions should be left in the facility by hospice staff.
-She was going to have meet with hospice to figure out what happened with Resident #1's hospice orders dated 04/11/23.

Attempted interview with Resident #1's primary care provider (PCP) on 05/11/23 at 2:46pm was unsuccessful.

Attempted interview with Resident #1's Hospice Provider on 05/10/23 at 10:05am and 05/11/23 at

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D 358	Continued From page 24 2:00pm were unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.	D 358		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure incident and accident reports involving emergency room (ER) evaluations after a fall for 2 of 3 sampled residents (#1 and #2) were sent to the Department of Social Services (DSS) within 48 hours of the event. The findings are: 1. Review of Resident #1's current FL-2 dated 09/16/22 revealed diagnoses included dementia, psychotic/mood disturbances, anxiety, abnormal gait and mobility, hypothyroidism, and generalized muscle weakness. Review of Resident #1's electronic progress note dated 03/11/23 revealed the resident was sent to the emergency room (ER) at 4:34pm for an	D 451		

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unwitnessed fall and had sutures placed over her left eye.

Review of Resident #1's incident and accident report dated 03/11/23 revealed:
-It was not specified what time the resident was found on the floor with blood coming from the top of her head.
-The resident was unable to say what happened.
-There was no documentation of who found the resident.
-There was no documentation of what was done for the resident.
-The resident was sent to the ER by unspecified means.
-The report was not signed by the Administrator.

Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.

Refer to interview with the Resident Care Coordinator (RCC) on 05/11/23 at 3:55pm.

Refer to interview with the DCS on 05/11/23 at 4:30pm.

Refer to interview with the Administrator on 05/11/23 at 11:23am.

2. Review of Resident #2's current FL2 dated 01/13/23 revealed diagnoses included hemiplegia and hemiparesis, congestive heart failure, generalized muscle weakness, and unsteadiness on feet.

Review of Resident #2's 04/18/23 progress notes revealed:
-On 04/18/23, at 7:45am, the resident had an unwitnessed fall in her bathroom and was found

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on her left side.
-Resident #2 complained of shoulder pain.
-EMS was called and she was sent to hospital for observation.

Review of Resident #2's incident and accident report dated 04/18/23 revealed:
-It was not specified what time the resident was found on the floor.
-The resident said she fell transferring from the toilet to the wheelchair.
-There was no documentation of who found the resident.
-The report was not signed by the Administrator.

Refer to interview with the Resident Care Coordinator (RCC) on 05/11/23 at 3:55pm.

Refer to interview with the DCS on 05/11/23 at 4:30pm.

Refer to interview with the Administrator on 05/11/23 at 11:23am.

_____

Interview with the Resident Care Coordinator (RCC) on 05/11/23 at 3:55pm revealed:
-She was responsible for prompting staff to complete incident and accident reports.
-The Director of Clinical Services (DCS) was responsible for faxing completed incident and accident reports to the Department of Social Services (DSS).

Interview with the DCS on 05/11/23 at 4:30pm revealed:
-She was responsible for faxing completed incident and accident reports to DSS.
-She kept a binder with fax confirmations of incident and accident reports faxed to DSS.
-She did not have fax confirmations for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-092221	A. BUILDING: _____ B. WING _____	R 05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESERVE AT MILLS FARM	3000 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
D 451	Continued From page 27 sampled incident and accident reports. -She did not know if the sampled incident and accident reports were faxed to DSS. -She did not know what happened. Interview with the Administrator on 05/11/23 at 11:23am revealed: -There was a binder for fax confirmations of incident and accident reports faxed to the DSS. -She could not find the binder with confirmations the sampled incident and accident reports had been sent to DSS. -She did not know what happened because she was not the Administrator when the incidents occurred. Attempted telephone interview with the DSS representative on 05/11/23 at 11:00am was unsuccessful.	D 451		