STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034090	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS VILLAGE I	6401 HOLDER ROAD CLEMMONS, NC 27012

(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 completed an annual survey on May 31, 2023 and June 1, 2023.	D 000		
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: Based on observations, record reviews and interviews, the facility failed to ensure physicians' orders were implemented for 1 of 5 (# 5) sampled residents related to obtaining a thyroid stimulating hormone (TSH) laboratory test. The findings are: Review of Resident #5's current FL2 dated 03/07/23 revealed diagnoses including dementia and hypothyroidism. Review of a signed physician's order date 03/12/23 revealed an order for levothyroxine (used to treat hypothyroidism) 50 mcg at 6:30am daily and check TSH (a laboratory test for monitoring levothyroxine therapy) the week of 05/02/23. Review of Resident #5's laboratory test results revealed no TSH test results after 03/21/23 were available for review.	D 276	D 276 It is the community's policy and normal practice to assure that all physician orders are implemented accurately and completely. The community has policies and procedures designed to maintain these goals. Routine chart audits, RN, pharmacy consultant, and QA audits are all examples of the many components utilized. A stat lab draw was completed on 6/1/23 for Resident #5. An appointment calendar has been purchased where all pending lab order results will be entered by the RCD or RCD Assistant. RCD and/or RCD Assistant will continue to leave lab orders flagged on each Resident chart until the specimen has been obtained and results have been returned to the Community. Our QA Program will include an all chart audit for labs that have been	6/1/23 6/9/23

Reviewed and acknowledged 06/26/2023. C Prater

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D 276	Continued From page 1 Interview with the Resident Care Director (RCD) on 06/01/23 at 8:00am revealed: -The medication aide (MA) on duty when the primary care provider (PCP) ordered laboratory values was responsible to fax the order to the laboratory. -The PCP sent an order to the contract laboratory as well. -The MA was supposed to file the laboratory order in the resident's record by extending the order above the other papers (flagged the order) in the record. -The RCD routinely moved the laboratory request order down to the normal position in the resident's record when the laboratory test results were sent to the facility and reviewed by the PCP. -She did not know why Resident #5's TSH laboratory order was not still "flagged" and was not completed. -She called the laboratory this morning (06/01/23) and was told the order for Resident #5's TSH laboratory request for the week of 5/02/03 was never completed by the laboratory. Telephone interview with a representative for the contract laboratory on 06/01/23 at 9:50am revealed: -The laboratory received the faxed order for TSH laboratory during the week of 05/02/23 dated 03/21/23. -The laboratory's staff was responsible for adding the TSH order to the laboratory's work schedule for the week of 05/02/23. -The laboratory's staff failed to add Resident #5's name to the schedule for obtaining a TSH laboratory value the week of 05/02/23. -There was no documentation that the facility contacted the laboratory for the missed TSH check.	D 276	D 276 continued ordered each week for 4 weeks,then monthly for 3 additional months. After that time, we will continue all chart audits quarterly, thereafter. This will be the responsibility of the RN and/or RCD.	Implement 6/26/23 on-going through 10/31/23, then quarterly

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D 276	Continued From page 2 Interview with the Assistant RCD on 06/01/23 at 10:10am revealed: -She was a MA and assisted the RCD with processing residents' medication and treatment orders. -When the PCP wrote orders for laboratory (lab) checks, the MA on duty was supposed to fax the orders to the contract lab for adding to the lab's staff member's scheduled visit. -The facility did not have a system for routinely checking to ensure labs had been done except to reviewed "flagged orders" in the residents' records. -She did not know Resident #5 had an order for a TSH lab dated 03/21/23 because she did not recall seeing the order "flagged". Telephone interview with Resident #5's primary care provider (PCP) on 06/01/23 at 10:15am revealed: -She wrote an order for TSH lab on 03/12/23 after she adjusted the resident's thyroid medication. -She routinely ordered a TSH lab 6 weeks after medication dose changes to see if the therapeutic range for levothyroxine was correct. -She routinely reviewed the residents' laboratory test results with one of her weekly visits to the facility. -She did not know Resident #5's TSH lab had not been done. -She would have looked for the results the next time Resident #5 was scheduled for a routine visit. -She did not believe the delayed results created a big therapy risk. Interview with the facility's corporate (campus) Nurse on 06/01/23 at 11:00am revealed: -She routinely did quarterly audits for residents'	D 276		

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D 276	Continued From page 3 records. -She routinely checked for laboratory orders having been processed and medication orders current. -Resident #5 was scheduled in her June 2023 audit that was upcoming. -She did not know Resident #5's lab order for TSH check dated 03/21/23 had not been done. -The lab was scheduled for today 06/01/23. Interview with the Executive Director/Administrator on 06/01/23 at 11:26am revealed: -The RCD, Assistant RCD, and Nurse routinely monitored health care for the residents including Laboratory orders. -They were responsible for ensuring all orders were implemented.	D 276		