STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049033	A. BUILDING: _____ B. WING _____	R 02/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CREEK MANOR	1902 ORA DRIVE STATESVILLE, NC 28625

(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 an follow-up survey on Febuary 5-6, 2020.	{D 000}		
{D 234}	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 2 of 5 sampled residents (Resident #2 and #5) had completed tuberculosis testing upon admission in compliance with the control measures for the Commission for Health Services. The findings are: 1. Review of Resident #2's current FL2 dated 12/19/19 revealed diagnoses included left subdural hematoma, history of cerebrovascular accident, history of dementia, history of hypertension and history of chronic obstructive pulmonary disease. Review of Resident #2's Resident Register	{D 234}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049033	A. BUILDING: _____ B. WING _____	R 02/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CREEK MANOR	1902 ORA DRIVE STATESVILLE, NC 28625

(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 234}	Continued From page 1 revealed an admission date of 11/21/19. Review of Resident #2's resident record revealed there was no documentation of any tuberculosis (TB) skin testing. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable. Refer to interview with the Resident Care Director (RCD) on 02/06/20 at 3:38pm. Refer to interview with the Administrator on 02/06/20 at 5:33pm. 2. Review of Resident #5's current FL2 dated 10/14/19 revealed diagnoses included atrial fibrillation, localized edema, muscle weakness, major depressive disorder, and viral hepatitis. Review of Resident #5's Resident Register revealed an admission date of 10/15/19. Review of Resident #5's resident record revealed there was no documentation of any tuberculosis (TB) skin testing. Interview with Resident #5 on 02/06/20 at 11:15am revealed: -He came from a skilled nursing facility. -He could not remember if he had a TB test before her arrived at the facility. -He has not had once since he came to the facility in October 2020.	{D 234}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049033	A. BUILDING: _____ B. WING _____	R 02/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CREEK MANOR	1902 ORA DRIVE STATESVILLE, NC 28625

(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 234}	Continued From page 2 Refer to interview with the Resident Care Director (RCD) on 02/06/20 at 3:38pm. Refer to interview with the Administrator on 02/06/20 at 5:33pm. _____ Interview with the RCD on 02/06/20 at 3:38pm revealed: -Resident #5 and #2 came from another facility but she could not locate a first step TB results. -She was responsible for giving the residents their TB test when they were due. -On admission all residents were to have a TB test prior to admission or upon admission. -If a resident had a prior TB test the request for a seccond TB test was placed in a TB test folder for her to perform in two weeks. -Every resident was required to have at least one prior to admission to the facility. -Every resident was to have documentation of the first and second TB tests in their record. -Resident #5 and #2 were not on her schedule for TB test administration. Interview with the Administrator on 02/06/20 at 5:33pm revealed: -The current RCD was responsible for assuring residents had required TB skin testing. -Prior to the RCD's employment, approximately 1 month ago, the RCC (Resident Care Coordinator) was responsible for assuring residents had required TB skin testing. -Her expectation was for no resident to be admitted to the facility without having one TB skin test performed. -Her expectation was for responsible staff to then add the resident to their calendar to assure a second TB skin test was performed. -She thought both residents had the required TB testing.	{D 234}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049033	A. BUILDING: _____ B. WING _____	R 02/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CREEK MANOR	1902 ORA DRIVE STATESVILLE, NC 28625

(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 234}	Continued From page 3 -She tried to locate the first step TB tests for Resident #5 and #2 but was unable to locate them. -She tried calling the facilities where Resident #5 and #3 came from but there was no more information provided by 02/10/20.	{D 234}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .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: FOLLOW-UP TO B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to assure physician notification for 1 of 5 sampled residents (Residents #5) related to a failure to coordinate care for a Prothrombin Time/International Normalized Ratio (PT/INR, a lab used to determine the blood ability to clot), and refusals of Coumadin. The findings are:	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049033	A. BUILDING: _____ B. WING _____	R 02/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CREEK MANOR	1902 ORA DRIVE STATESVILLE, NC 28625

(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 273}	Continued From page 4 1.Review of Resident #5's current FL2 dated 10/14/19 revealed: -Diagnoses included paroxysmal atrial fibrillation, localized edema, chronic pain, and viral hepatitis. -An order for Coumadin 5mg every day. -An order to check a PT/INR every two weeks. a. Review of Resident #5's physician orders dated 01/09/20 revealed an order for Coumadin 5mg every day. Review of Resident #5's January 2020 electronic Medication Administration Record (eMAR) revealed: -An entry for Coumadin 5mg every day. -The Coumadin 5mg every day was documented as refused on 01/11/20-01/13/20. -The Coumadin was documented as held from 01/19/20-01/23/20. Review of Resident #5's Nurses/Clinical notes revealed there were no entries related to the notification to Resident #5's physician for the refused or held doses of the Coumadin. Review of the facility's Medication Policy revealed the MA was to notify the Resident Care Coordinator (RCC) and the physician after three refusals. Interview with Resident #5 on 02/06/20 at 11:15am revealed: -His physician ordered Coumadin 5mg every day to treat his atrial fibrillation. -He refused his Coumadin on 01/11/20 - 01/13/20 because the MAs were giving it to him at 9:00am and he told the MA he wanted it at 5:00pm as it was always administered. -He was not offered the Coumadin later in the day until 01/14/20.	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049033	A. BUILDING: _____ B. WING _____	R 02/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CREEK MANOR	1902 ORA DRIVE STATESVILLE, NC 28625

(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 273}	Continued From page 5 -He had a procedure in January 2020 and his Coumadin was on hold 01/19/20 - 01/23/20. -He expected the MAs to administer the Coumadin at 5:00pm and set up the lab visits for the PT/INR as the physician ordered. Interview with the RCD on 02/06/ at 9:35am revealed: -Orders received were to be faxed to the pharmacy the MA, RCC or the RCD, whom every received them. -The pharmacy was responsible for putting the medication order on the eMAR for the MA to administer. -The MAs were responsible for notifying the physician, RCC and the RCD after a medication was refused 3 doses in a row. -The MAs were responsible for documenting in the eMAR the medication refusals. -The MAs were responsible for weekly medication cart and eMAR audits which included: missed medications on the eMAR, and refusals. -The RCC was responsible for monthly medication cart and eMAR audits which included: orders, medications documented as not administered missed on the eMAR, and refusals. -She was responsible for making sure all the audits were performed. -She had not been at the facility long enough to do monthly audits yet. -Resident #5's Coumadin refusals would have been caught on the weekly and monthly audits if they were done. Interview with the RCC on 02/06/20 at 3:38pm revealed: -The MAs were responsible for faxing orders to the pharmacy unless she or the RCD received the orders first. -The pharmacy was responsible for entering the	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049033	A. BUILDING: _____ B. WING _____	R 02/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CREEK MANOR	1902 ORA DRIVE STATESVILLE, NC 28625

(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 273}	Continued From page 6	{D 273}		

orders into the eMAR system and the she was responsible for checking the orders against the eMAR.
-Once the eMAR and orders were compared, then she "released" them in the eMAR system for the MAs to administer the medications or to send out for the labs.
-The MAs were responsible for weekly medication cart and eMAR audits.
-She and the MAs were responsible for administering all medications as ordered by the physician and if a resident refused, then the MAs were to try 3 different time for that same dose.
-If the resident refused three doses of the medication then the physician and her were to be notified.
-She did not know Resident #5 refused his Coumadin 5mg every day for three days or another physician held the Coumadin 4 days later for 5 more days of missed Coumadin.
-She was not notified of the missed doses of Coumadin for Resident #5.
-It was her expectation the MAs administered the Coumadin and when Resident #5 refused his Coumadin 3 doses in a row, she should have been notified as well as the physician.

Interview with a MA on 02/06/20 at 4:15pm revealed:
-During her medication pass on 01/11/20-01/13/20 at 9:00am, she tried to administer Coumadin 5 mg every day as entered on Resident #5's eMAR.
-Resident #5 refused the Coumadin each time and requested it to be administered at 5:00pm as it used to be administered.
-She did not try to offer the Coumadin later those days.
-She knew it was given at 5:00pm but the order was on the eMAR for 9:00am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049033	A. BUILDING: _____ B. WING _____	R 02/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CREEK MANOR	1902 ORA DRIVE STATESVILLE, NC 28625

(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 273}	Continued From page 7 -After a resident refuses 3 doses of a medication in a row then the physician was to be call and the RCC was to be notified. -She did not notify the physician about the 3 doses missed or to inquire about the time it was scheduled. -She did not notify the RCC about the missed doses or Resident #5's concerns about the administration times. Interview with the Administrator on 02/06/20 at 5:35pm revealed: -She did not know Resident #5 refused his Coumadin 3 times in and row and the physician was not notified. -The MAs were responsible for completing audit 3 times a week to check the physician's orders with the eMAR and medications on hand as well as medications documented as not administered. -The RCC and the RCD were responsible for monthly audits to check behind the MAs audits. -The MAs should have originally caught Resident #5's refusals during their 3 times a week audit. -The RCC and the RCD should have caught Resident #5's Coumadin refusals on their monthly audits. -The MAs were responsible for notifying the physician when a medication was refused three times in and row and then notifying the RCC and RCD. -The RCC and the RCD were responsible for following up with the MAs about the residents that refused a medication, 3 doses in a row to make sure the physician was notified. -It was her expectation the MAs, RCC and the RCD preformed their audits in order to catch the refusals and the missed labs and the physician notified to report the refused medications. Telephone interview with Resident #5's physician	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049033	A. BUILDING: _____ B. WING _____	R 02/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CREEK MANOR	1902 ORA DRIVE STATESVILLE, NC 28625

(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 273}	Continued From page 8 on 02/06/20 at 5:30pm revealed: -Resident #5 was prescribed Coumadin 5 mg every day due to atrial fibrillation, "an irregular heart beat". -Resident#5's heart can beat irregular or to fast which could cause a clot. -Taking the Coumadin prevents clots to help prevent a stroke or heart failure. -He did not know Resident #5 refused the Coumadin 3 times in a row in January 11-13, 2020. -He did not know Resident #5's Coumadin was on hold January 19-23, 2020. -He did not put a hold on Resident #5's Coumadin. -If he had been notified about the refusals and the Coumadin on hold, he would have ordered a PT/INR because the "risk of a stroke and or death". -He expected the facility to call after 3 missed doses of Coumadin, or if another physician had Resident #5 hold the Coumadin. b. Review of Resident #5's physician orders dated 01/09/20 revealed an order to check a PT/INR every week and to fax the physician the results. Review of Resident #5's Nurses/Clinical notes revealed: -There were no entries related to the notification to Resident #5's physician a PT/INR was completed. -There were no entries related to a PT/INR scheduled for Resident #5. Review of the monthly calendar revealed there were no entries for Resident #5 scheduled with a lab or a third-party agency for the PT/INR to be drawn.	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049033	A. BUILDING: _____ B. WING _____	R 02/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CREEK MANOR	1902 ORA DRIVE STATESVILLE, NC 28625

(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 273}	Continued From page 9 Interview with Resident #5 on 02/06/20 at 11:15am revealed: -He was to have his PT/INR every week and had not had it completed since 01/09/20. -He informed a MA and the Administrator several times since 01/09/20 that he did not receive his PT/INRs completed. Interview with the RCD on 02/06/ at 9:35am revealed: -The lab was to be entered on the eMAR, so the MAs were notified of the lab work was to be performed. -The RCC entered the ordered lab work onto the schedule. -The MAs were responsible for weekly eMAR audits which included labs completed or not completed. -The RCC was responsible for monthly eMAR audits which included labs completed or not completed. -Resident #5's PT/INRs that were not completed would have been caught on the weekly and monthly audits if they were done. Interview with the RCC on 02/06/20 at 3:38pm revealed: -Once the eMAR and orders were compared, then she "released" them in the eMAR system for the MAs to send out for the labs. -The MAs and whom ever faxed the pharmacy was to let her know about lab work to be completed on the residents. -She was not notified of the weekly PT/INR were missed for Resident #5. Review of Resident #5's most current laboratory work dated 01/09/20 revealed a PT/INR completed on 01/09/20 documented as 1.9	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049033	A. BUILDING: _____ B. WING _____	R 02/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CREEK MANOR	1902 ORA DRIVE STATESVILLE, NC 28625

(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 273}	Continued From page 10 (therapeutic range is between 2-3). Telephone interview with the Administrator on 02/07/20 at 1:00pm revealed: -She had a PT/INR drawn last night (02/06/20) on Resident #5. -The PT/INR was sub-therapeutic at 1.2. -She reported the PT/INR to Resident #5's physician on 02/06/20. Telephone interview with Resident #5's physician on 02/06/20 at 5:30pm revealed: -The PT/INR is a lab he used to regulate the amount of Coumadin to be administered. -He did not know Resident #5 did not have the weekly PT/INR he ordered since 01/09/20. -He expected the facility to call if the PT/INR was not done as ordered. Telephone interview with Resident #5's physician's office assistant on 02/07/20 at 9:00am revealed Resident #5's PT/INR was reported to the physician last night and another lab draw was ordered for one week. Interview with the Administrator on 02/06/20 at 5:35pm revealed: -She did not know the PT/INR was not obtained as ordered and reported to the physician. -The MAs were responsible for receiving the orders, fax to the pharmacy, make a copy of the order, initials the copy, document it in the 24-hour report and give the copy to the RCC. -The RCC was responsible for documenting the lab orders in the monthly schedule and lab book. -A lab order would show up on the eMAR to notify the MAs a lab was due. -The MAs should have originally caught Resident #5's lab orders during their 3 times a week audit. -The RCC and the RCD should have caught	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049033	A. BUILDING: _____ B. WING _____	R 02/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CREEK MANOR	1902 ORA DRIVE STATESVILLE, NC 28625

(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 273}	Continued From page 11 Resident #5's lab orders on their monthly audits. -It was her expectation the MAs, RCC and the RCD preformed their audits in order to catch the missed labs and the physician notified to report the missed labs. _____ The facility failed to notify the physician after a resident refused his Coumadin for 3 days, had it held for a procedure for 5 days and missed 4 weekly lab draws to test the viscosity of his blood as it relates to Coumadin (Resident #5). This failure increased the risk for clots which could cause stroke and death. This failure was detrimental to the health and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a Plan of Protection on 02/06/20 in accordance with G. S. 131D-24. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 9, 2020.	{D 273}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 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: Based on observations, interview and record reviews, the facility failed to administer	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049033	A. BUILDING: _____ B. WING _____	R 02/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CREEK MANOR	1902 ORA DRIVE STATESVILLE, NC 28625

(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 358}	Continued From page 12	{D 358}		

medications as ordered by a family nurse practitioner for 2 of 5 sampled residents (Resident #1 and #3) related to an anti-anxiety medication being unavailable for administration during the medication pass (Resident #1) and insulin not being administered according to the ordered parameters (Resident #3).

The findings are:

Review of Resident #1's current FL-2 dated 11/27/19 revealed diagnoses including dementia.

Review of Resident #1's medication order dated 12/23/19 revealed that lorazepam 0.5 milligram (mg) tablet was ordered to be administered three times a day (a medication used to decrease anxiety).

Observation of the medication pass at 2:30pm on 02/05/20 for Resident #1 revealed lorazepam 0.5mg tablet for Resident #1 was not available to be administered.

Review of the Medication Administration Record (MAR) for February 2019 revealed the most recent administration of lorazepam for Resident #1 was at 9:12am on 02/05/20.

Interview with the Medication Aide (MA) at 2:34pm on 02/05/20 revealed:
-She gave the first of three scheduled doses of lorazepam to Resident #1 at 9:12am on 02/05/20.
-She had never ordered medications from the pharmacy before.
-The lorazepam was not available to be administered to Resident #1.

Interview with the Resident Care Coordinator (RCC) for the Special Care Unit (SCU) at 2:37pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049033	A. BUILDING: _____ B. WING _____	R 02/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CREEK MANOR	1902 ORA DRIVE STATESVILLE, NC 28625

(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 358}	Continued From page 13 on 02/05/20 revealed: -She remembered ordering the lorazepam for Resident #1. -When she checked the computer, she realized that the lorazepam for Resident #1 had not been reordered. -The 3:00pm dose of lorazepam for Resident #1 would not be received from the contracted pharmacy by 4:00pm. -The medication should have been reordered, but it was missed. Interview with the Resident Care Director (RCD) at 3:40pm on 02/05/20 revealed: -There was a reorder icon on the computer that the MAs were supposed to use when a medication was low. -When the reorder icon was utilized, this would indicate to the MA when the last time the medication was ordered. -The MA was responsible for reordering medications. -If the MA found a medication was not available for administration, the MA should call the pharmacy immediately. -She was not aware the lorazepam for Resident #1 was not available. Interview with the Administrator at 6:05pm on 02/07/20 revealed: -If medication was not available for a resident the medication aide should contact the pharmacy. -The pharmacy will send out medications immediately to the facility. -She expected medications for all residents to be available "24/7." -MAs should understand the importance of following physician's orders. -She was not aware Resident #1 was out of her lorazepam.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049033	A. BUILDING: _____ B. WING _____	R 02/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CREEK MANOR	1902 ORA DRIVE STATESVILLE, NC 28625

(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 358}	Continued From page 14 Interview with the Family Nurse Practitioner at 11:45am on 02/07/20 revealed it was concerning if staff were administering medications and not following orders. 2. Review of Resident #3's current FL-2 dated 11/27/19 revealed diagnoses included diabetes. Review of the medication order for Levemir (insulin used for treatment of diabetes) dated 12/04/19 revealed: -Levemir (insulin) 55 units was to be administered to Resident #3 every morning. -If Resident #3 had a blood glucose level below 100, the Levemir was not to be administered. Review of Resident #3's medication administration record (MAR) for December 2019 revealed: -Resident #3 had a blood glucose level of 86 on 12/09/19 and was administered Levemir. -Resident #3 did not have a blood glucose level decline after the Levemir admnistration on 12/09/19. -Resident #3 had a blood glucose level of 88 on 12/11/19 and was administered Levemir. -Resident #3 did not have a blood glucose level decline after the Levemir admnistration on 12/11/19. Review of Resident #3's MAR for January 2020 revealed: -Resident #3 had a blood glucose level of 97 on 01/12/20 and was administered Levemir. -Resident #3 did not have a blood glucose level decline after the Levemir admnistration on 01/12/20. -Resident #3 had a blood glucose level of 68 on 01/31/20 and was administered Levemir.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049033	A. BUILDING: _____ B. WING _____	R 02/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CREEK MANOR	1902 ORA DRIVE STATESVILLE, NC 28625

(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 358}	Continued From page 15 -Resident #3 did not have a blood glucose level decline after the Levemir admnistration on 01/31/20. Interview with the Resident Care Director (RCD) at 9:35am on 02/06/20 revealed: -After reviewing the December and January MAR, the Levemir should not have been administered. -The medication aide (MA) must not have been paying attention to the order. -The MA did not administer the insulin properly because it should have been held. Interview with the Resident Care Coordinator (RCC) at 10:40am on 02/06/20 revealed: -She checked the MARs at the beginning of the month against the previous month's MARs. -She had not caught the error of the MA administering Levemir to Resident #3 when she should not have administered it. -The MA that administered the Levemir to Resident #3 must not have been paying attention. Interview with the MA by phone call at 11:21am on 02/06/20 who administered the Levemir to Resident #3 on 12/09/19, 12/11/19, 01/12/20 and 01/31/20 revealed: -She regularly administered Resident #3's insulin. -She could not remember if Resident #3 had parameters for holding her insulin based on her blood glucose level. -She must have overlooked the order to hold the insulin if Resident #3's blood glucose was less than 100. Interview with the Administrator at 6:05pm on 02/07/20 revealed she was not aware the MA was administering insulin to Resident #3 outside the parameters set in the physician's order.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049033	A. BUILDING: _____ B. WING _____	R 02/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CREEK MANOR	1902 ORA DRIVE STATESVILLE, NC 28625

(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 358}	Continued From page 16 Interview with the Family Nurse Practitioner at 11:45am on 02/07/20 revealed it was concerning if staff that were administering medications and not following orders.	{D 358}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to health care. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure physician notification for 1 of 5 sampled residents (Residents #5) related to a failure to coordinate care for a Prothrombin Time/International Normalized Ratio (PT/INR, a lab used to determine the blood ability to clot), and refusals of Coumadin. [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	{D912}		