NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

January 13, 2021

John Miller, Owner
Mill Creek Manor, LLC, Licensee
Mill Creek Manor
138 Bay Hill Drive
Advance, NC 27006

millerj@aol.com
h.odom@millcreekmanorllc.com

Re: Follow-up and Covid Focused Survey completed December 22, 2020 (ASPEN Event ID# Y8DQ11)
Facility: Mill Creek Manor
Licensure Number: HAL-049-033
County: Iredell

Dear Mr. Miller:

Thank you for the cooperation and courtesy extended during the survey completed December 22, 2020 by staff with the Adult Care Licensure Section.

As a result of the follow up survey, it was determined that some of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

Enclosed you will find all violations/deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with the state regulations. You must provide an acceptable Plan of Correction for each violation/deficiency cited in the left column. In the spaces to the right of the form, state your plan for correcting the problem and the completion date by which you will correct each violation/deficiency identified and return it to our office within 15 working days of receipt of this letter. Below you will find what to include in the Plan of Correction for all deficiencies; and, if violations were identified, details of the type of violation(s) and the time frame(s) for compliance are also provided below.

What to include in the Plan of Correction

- Indicate what measures will be put in place to correct the deficient area of practice (i.e. changes in policy and procedures, staff training, changes in staffing patterns, etc.)
- Indicate what measures will be put in place to prevent the problem from occurring again
- Indicate who will monitor the situation to ensure it will not occur again
- Indicate how often the monitoring will take place
- Completion dates by which the plan of correction will be completed. The completion dates must be acceptable to the State.
- Sign and date the bottom of the first page of the State Form.

Return the signed and dated Statement of Deficiencies form within 15 working days from the date of receipt of this letter. We are unable to accept faxed reports at this time; therefore, a copy must be mailed to our office or e-mailed to the survey team leader. Please make sure the copy you mail or e-mail to us is SIGNED AND DATED or it will not be accepted. A response to the plan of correction will be sent ONLY if the plan of correction is not accepted. Please retain a copy for your files.

Informal Dispute Resolution

In accordance with G.S. § 131D-2.11(a2), you have one opportunity to question cited deficiencies through an informal dispute resolution (IDR) process. You may also contest the severity of noncompliance that resulted in a violation determination. To be given such an opportunity, you are required to send your written request identifying the specific deficiencies being disputed postmarked by **February 4, 2021**. An explanation of why you are disputing those deficiencies (or why you are disputing the severity of noncompliance that resulted in a violation determination) along with any supporting documentation must be sent and postmarked by **February 4, 2021**. You must submit 2 copies of material and highlight or use some other means to identify written information pertinent to the disputed deficiency(ies). Additional written material that does not meet these requirements will not be reviewed. This information should be sent to: IDR Coordinator, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action. IDR Procedures can be accessed at: http://www.ncdhhs.gov/dhsr/acls/idr.html.

If you have questions about the enclosed Statement of Deficiencies or the violations, please contact me at (828) 707-3520. A follow up survey will be conducted to determine compliance in all areas cited. If this agency can be of any assistance in providing consultation relative to licensure rules, please let us know.

Sincerely,

Joseph Cline, Licensure Consultant
Adult Care Licensure Section
Division of Health Service Regulation

Enclosures: Statement of Deficiencies
Revisit Report

cc: Jimmi Anne Johnson, Supervisor/Designee, Iredell County
Heather Bingham, Team Supervisor, West 2 Region, Adult Care Licensure Section
Facility File

Please note information regarding Customer Service Survey below.

In an ongoing effort to improve the inspection process with the providers we serve, we would like you to complete a Customer Service Survey. The Survey can be accessed at the web site below. Your opinion is important to us, and will assist us in developing new and better ways to do our job.

Please note: Because the survey is confidential, your identity will not be known to the Division of Health Service Regulation or the North Carolina Department of Health and Human Services.

Thank you for participating in this confidential survey as we strive to improve the services we provide to licensed health care providers across the state of North Carolina. Should you wish to have a confidential discussion regarding this survey or your interaction with the Division of Health Service Regulation, please feel free to contact Mark Payne, Director, Division of Health Service Regulation, at 919-855-3750.

Customer Service Survey web site: **http://info.ncdhhs.gov/dhsr/customerservice.html**
(Survey Max does not work well with all browsers, please access survey with Internet Explorer)

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
HAL049033 Y1	A. Building B. Wing Y2	12/22/2020 Y3

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

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix D0234 Reg. # 10A NCAC 13F .0703(a) LSC	Correction Completed 12/22/2020	ID Prefix D912 Reg. # G.S. 131D-21(2) LSC	Correction Completed 12/22/2020	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR [signature]	DATE 1/13/2021
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 10/17/2019	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 000	Initial Comments The Adult Care Licensure Section conducted follow-up survey and Covid-19 Focused Infection Control Survey on December 15, 2020 through December 22, 2020.	D 000		
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: Based on interviews, observations, and record review the facility failed to ensure referral and follow-up with the physician for 1 of 5 sampled residents (Resident #3) related to not notifying the physician regarding medications to control serum phosphate levels, chronic pain, and constipation. The findings are: Review of Resident #3's current FL2 dated 11/03/20 revealed diagnoses included end stage renal disease, diabetes, cognitive deficit, and chronic pain. a. Review of Resident #3's physician orders dated 10/02/20 revealed there was an order for sevelamer carbonate (a medication used to maintain serum phosphate levels) 800mg three times daily. Review of Resident #3's October 2020 electronic medication administration record (eMAR) revealed sevelamer carbonate was documented as not administered 10/09/20-10/21/20 (39	D 273	D273 10A NCAC 13F .0902(b) Health Care All staff will be trained/inserviced regarding referral and follow up procedures with emphasis in notification of the resident's physician regarding medications. All medication aids will be trained/ inserviced regarding procedures for contacting the resident's physician when the resident misses any dose of medication for any reason. If any question arises regarding missed doses of medications, the medication aid will contact the RCC at the time the missed dose is noted. All medication aids will be trained/ inserviced regarding procedures for ordering medications as needed as well as the responsibilities of ordering medications when needed. All medication aids will be trained/ inserviced regarding procedures for residents refusing medications. The medication aid will notify the RCC when a resident refuses any medication. The RCC is responsible to notify the physician/health care provider when a resident refuses a medication for 3 doses.	2/3/21

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D 273	Continued From page 1 doses) due to "awaiting order for clarification" or "dialysis". Telephone interview with a first shift medication aide (MA) on 12/16//20 at 1:04pm revealed: -She did not know Resident #3 missed her sevelamer carbonate for ten days in October 2020. -If Resident #3 missed more than three doses of her sevelamer carbonate she was responsible for notifying Resident #3's physician. -She documented Resident #3's missed her sevelamer carbonate when it was not available on the medication cart. -When Resident #3 was out of sevelamer carbonate she contacted the pharmacy to request a refill. -She wrote a note in the unit communication book and told the second shift MA when Resident #3 was out of sevelamer carbonate. -She did not contact Resident #3's physician because it was the pharmacy's responsibility to get the medication refilled. -Medications were delivered to the facility in the evening and the third shift MAs put medications on the medication cart. -The Resident Care Coordinator was responsible for printing Resident #3's eMAR monthly or the missed medication report. -She completed weekly medication cart audits, but she did not print Resident #3's eMARs to look at Resident #3's missed medications. Telephone interview with the Resident Care Coordinator (RCC) on 12/18/20 at 9:35am revealed: -She did not know Resident #3 missed her sevelamer carbonate for ten days in October 2020. -MAs were responsible for contacting the	D 273		

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D 273	Continued From page 2 pharmacy and Resident #3's Nurse Practitioner (NP) when Resident #3 missed medications. -She did not print Resident #3's eMAR weekly to review missed medications. Refer to telephone interview with the Regional RCC on 12/18/20 at 12:00pm. Refer to telephone with Resident #3's nurse practitioner (NP) on 12/17/20 at 3:00pm. Refer to telephone interview with the Administrator on 12/22/20 at 9:30am. b. Review of Resident #3's physician orders dated 10/02/20 revealed there was an order for polyethylene glycol (a medication used to treat constipation)17gm twice daily. Review of Resident #3's October 2020 electronic medication administration record (eMAR) revealed polyethylene glycol was documented as not administered 57 of 62 opportunities due to "resident refused". Review of Resident #3's November 2020 electronic medication administration record (eMAR) revealed polyethylene glycol was documented as not administered 54 of 60 opportunities due to "resident refused". Review of Resident #3's December 2020 electronic medication administration record (eMAR) revealed polyethylene glycol was documented as not administered 25 of 30 opportunities due to "resident refused". Telephone interview with a first shift MA on 12/16//20 at 1:04pm revealed: -She knew Resident #3 refused her polyethylene	D 273		

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D 273	Continued From page 3 glycol. -She told the RCC and the Memory Care Manager (MCM) Resident #3 refused her polyethylene glycol. -She did not know why nothing was done to get the order changed. -She could not remember if she called Resident #3's Nurse Practitioner (NP) to inform her Resident #3 refused the polyethylene glycol. Telephone interview with another first shift MA on 12/17/20 10:37am revealed: -She knew Resident #3 refused her polyethylene glycol. -Resident #3 refused her polyethylene glycol because when she went to dialysis, she did not want to take it. -The RCC and MCM both knew Resident #3 did not want to take her polyethylene glycol, so she did not contact the NP to notify her Resident #3 refused it. Telephone interview with the RCC on 12/18/20 at 9:35am revealed: -The MAs were responsible for contacting Resident #3's NP after Resident #3 refused her polyethylene glycol. -She did not know Resident #3 refused her polyethylene glycol. -She did not print Resident #3's missed medication report because she was still learning how to do it. -The Regional RCC ran the missed medication reports to review Resident #3's missed medications and she did not know when she reviewed Resident #3's missed medication report. Refer to telephone interview with the Regional RCC on 12/18/20 at 12:00pm.	D 273		

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D 273	Continued From page 4 Refer to telephone with Resident #3's NP on 12/17/20 at 3:00pm. Refer to telephone interview with the Administrator on 12/22/20 at 9:30am. c. Review of Resident #3's physician orders dated 10/02/20 revealed there was an order for fluticasone (a medication used to treat allergies) 50mcg twice daily. Review of Resident #3's October 2020 electronic medication administration record (eMAR) revealed fluticasone was documented as not administered 49 of 62 opportunities due to "resident refused". Review of Resident #3's November 2020 electronic medication administration record (eMAR) revealed fluticasone was documented as not administered of 53 of 60 opportunities due to "resident refused". Review of Resident #3's December 2020 electronic medication administration record (eMAR) revealed fluticasone was documented as not administered 26 of 30 opportunities due to "resident refused". Telephone interview with a first shift medication aide (MA) on 12/16//20 at 1:04pm revealed: -She knew Resident #3 refused her fluticasone. -She told the RCC and the Memory Care Manager (MCM) Resident #3 refused her fluticasone. -She did not know why nothing was done to get the order changed. -She could not remember if she called Resident #3's Nurse Practitioner (NP) to inform her Resident #3 refused the fluticasone.	D 273		

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D 273	Continued From page 5 Telephone interview with another first shift MA on 12/17/20 10:37am revealed: -She knew Resident #3 refused her fluticasone. -The RCC and MCM both knew Resident #3 did not want to take her fluticasone, so she did not contact the NP to notify her Resident #3 refused it. Telephone interview with the Resident Care Coordinator (RCC) on 12/18/20 at 9:35am revealed: -The MAs were responsible for contacting Resident #3's NP after Resident #3 refused her fluticasone. -She did not know Resident #3 refused her fluticasone. -She did not print Resident #3's missed medication report because she was still learning how to do it. -The Regional RCC ran the missed medication reports to review Resident #3's missed medications and she did not know when she reviewed Resident #3's missed medication report. Refer to telephone interview with the Regional RCC on 12/18/20 at 12:00pm. Refer to telephone with Resident #3's NP on 12/17/20 at 3:00pm. Refer to telephone interview with the Administrator on 12/22/20 at 9:30am. Telephone interview with the Regional RCC on 12/18/20 at 12:00pm revealed: -She did not know Resident #3 missed and refused her medications in October 2020, November 2020, or December 2020. -The last time she ran the facility's missed	D 273		

Reviewed and Acknowledged by Joseph Cline 04/30/21

Joseph Cline

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D 273	Continued From page 6 medication report was October 2020. -She did not recall seeing any issues with Resident #3's medications. -She was visiting the facility twice a week until the beginning of November 2020 when the facility's COVID-19 prevented her from entering the building. -She provided training to the RCC beginning in October 2020 on learning how to print missed medication reports and oversite of the MAs in their roles. -The MAs were responsible for contacting Resident #3's NP to inform her of missed medication and medication refusals. -The RCC and the MCM were responsible for printing weekly eMARs and facility missed medication reports. Telephone with Resident #3's nurse practitioner (NP) on 12/17/20 at 3:00pm revealed: -She had virtual visits with Resident #3 at least monthly and more frequently as needed. -At the last virtual visit, she was not made aware Resident #3 was missed her medications. -Resident #3 was a dialysis patient and required all her medications administered as ordered. -The staff could reach her by the smart page system or telehealth line. -She expected to be made aware if Resident #3 missed her medications. Telephone interview with the Administrator on 12/22/20 at 9:30am revealed: -He did not know Resident #3's NP was not notified when Resident #3 missed or refused her medications. -He expected the MAs and the RCC to contact Resident #3's NP. -The RCC was expected to review Resident #3's eMAR and missed medication reports.	D 273		

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D 273	Continued From page 7 -He depended on the RCC to complete a review of Resident #3's medications weekly to make sure Resident #3 received all of her medications. -He depended on the pharmacist that visited quarterly to report any medication discrepancies on all the residents. Review of Resident #3's nurses' progress note on 12/17/20 revealed there was no documentation for medications that Resident #3 NP was contacted about Resident #3's missed or refused during the months of October 2020, November 2020, and December 2020. Attempted telephone interview with the MCM on 12/18/20 at 1:00pm was unsuccessful. Attempted telephone interview with Resident #3 on 12/17/20 at 10:00am was unsuccessful.	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, record reviews, and interviews, the facility failed to administer medications as ordered to 2 of 5 sampled residents (#3 and #1) including medications to control blood sugars, serum phosphate levels,	D 358		

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D 358	Continued From page 8 blood potassium levels, and chronic nerve pain (#3), and medications to control blood sugars, bipolar disorder, vitamin D deficiency, anemia, and obtaining fingerstick blood sugars (FSBS) prior to administration of a medication used to control high blood sugars (Resident #1). The findings are: 1. Review of Resident #3's current FL2 dated 11/03/20 revealed diagnoses included end stage kidney disease, diabetes, cognitive deficit, and chronic pain. a. Review of Resident #3's physician orders dated 10/02/20 revealed there was an order for levemir flex pen (control blood sugars) 10 units twice daily. Review of Resident #3's October 2020 electronic medication administration record (eMAR) revealed: -There was an entry for levemir flex pen 10 units to be administered twice daily at 9:00am and 9:00pm. -Resident #3's levemir was not administered 11 of 31 opportunities at 9:00am. -The documented reason the levemir had not been administered was "dialysis". -Resident #3's FSBS at 4:00pm was documented in the range of 200-413. Review of Resident #3's November 2020 electronic medication administration record (eMAR) revealed: -There was an entry for levemir flex pen 10 units to be administered twice daily at 9:00am and 9:00pm. -Resident #3's levemir was not administered 10 of 30 opportunities at 9:00am.	D 358	D358 10A NCAC 13F .1004(a) Medication Administration All medication aids will be trained/ inserviced to ensure compliance with preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with orders by a licensed prescribing practitioner which are maintained in the resident's medical file and rules according to 10A NCAC 13F .1004 (a). The RCC is responsible to ensure all training is completed by all medication aids. The proof of training completion will be maintained in the personnel file. The RCC is responsible to ensure all medication aids have been approved to work as a medication aid. Documentation of this approval will be maintained in the personnel files. The RCC is responsible to review the electronic monitoring system to ensure the residents are receiving their medications and treatments per physician's orders. A back up glucometer will be kept on one of the medication carts. Mill Creek Manor has contracted with a new pharmacy to ensure proper communication and back up.	2/3/21

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D 358	Continued From page 9 -The documented reason the levemir had not been administered was "dialysis". -Resident #3's FSBS at 4:00pm was documented in the range of 180-439. Review of Resident #3's December 2020 electronic medication administration record (eMAR) revealed: -There was an entry for levemir flex pen 10 units to be administered twice daily at 9:00am and 9:00pm. -Resident #3's levemir was not administered 5 of 15 opportunities at 9:00am. -The documented reason the levemir had not been administered was "dialysis". -Resident #3's FSBS at 4:00pm was documented in the range of 277-393. Observation of Resident #5's medications available for administration on 12/21/20 at 10:30am revealed there was one levemir flex pen with a computer-generated pharmacy label attach to a plastic bag for storage, and the directions to administer 4 units three times daily before meals with a dispense date of 12/20/20. Telephone interview with a representative at the facility's contracted pharmacy on 12/21/20 at 2:30pm revealed: -The pharmacy staff filled a 30-day supply of Resident #3's levemir insulin on 9/23/20, 11/11/20, and 12/20/20. -On 09/23/20, 11/11/20, and 12/20/20 two levemir flex pens were delivered to the facility. -Resident #3's levemir was not on an automatic refill system. -The facility's eMAR system scheduled times for the administration of the levemir was set when the order was entered on the eMAR on 02/26/20.	D 358		

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	HAL049033	A. BUILDING: _____ B. WING _____	R 12/22/2020

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 10 Refer to telephone interview with the pharmacist at the facility's contracted pharmacy on 12/22/20 at 9:30am. Refer to telephone interview with a first shift medication aide (MA) on 12/16//20 at 1:04pm. Refer to telephone interview with third shift MA on 12/17/20 at 8:30am. Refer to telephone interview with another first shift MA on 12/17/20 10:37am. Refer to telephone interview with the Resident Care Coordinator (RCC) on 12/18/20 at 9:35am. Refer to telephone interview with the Regional RCC on 12/18/20 at 12:00pm. Refer to telephone interview with Resident #3's nurse practitioner (NP) on 12/17/20 at 3:00pm. Refer to telephone interview with the Administrator on 12/22/20 at 9:30am. b. Review of Resident #3's physician orders dated 10/02/20 revealed there was an order for novolog 100 unit/ml flex pen (control blood sugars) 4 units three times daily before meals. Review of Resident #3's October 2020 electronic medication administration record (eMAR) revealed: -There was an entry for novolog 100 unit/ml Flex Pen 4 units three times daily before meals at 7:00am, 11:00am, and 4:00pm. -Resident #3's novolog was not administered 11 of 31 opportunities at 11:00am. -The documented reason the novolog had not been administered was "dialysis". -Resident #3's FSBS at 4:00pm was documented	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 11 in the range of 200-413. Review of Resident #3's November 2020 electronic medication administration record (eMAR) revealed: -There was an entry for novolog 100 unit/ml Flex Pen 4 units three times daily before meals at 7:00am, 11:00am, and 4:00pm. -Resident #3's novolog was not administered 10 of 30 opportunities at 11:00am. -The documented reason the novolog had not been administered was "dialysis". -Resident #3's FSBS at 4:00pm was documented in the range of 180-439. Review of Resident #3's December 2020 electronic medication administration record (eMAR) revealed: -There was an entry for novolog 100 unit/ml Flex Pen 4 units three times daily before meals at 7:00am, 11:00am, and 4:00pm. -Resident #3's novolog was not administered 5 of 15 opportunities at 11:00am. -The documented reason the novolog had not been administered was "dialysis". -Resident #3's FSBS at 4:00pm was documented in the range of 277-393. Observation of Resident #5's medications available for administration on 12/21/20 at 10:30am revealed there was one novolog flex pen with a computer-generated pharmacy label attached to a plastic bag for storage, and the directions to administer 4 units three times daily before meals with a dispense date of 12/08/20. Telephone interview with a representative at the facility's contracted pharmacy on 12/21/20 at 2:30pm revealed: -The pharmacy staff filled a 30-day supply of	D 358		

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D 358	Continued From page 12 Resident #3's novolog insulin on 10/21/20, 11/11/20, and 12/08/20. -On 10/21/20, 11/11/20, and 12/08/20 two novolog flex pens were delivered to the facility. -Resident #3's novolog was not on an automatic refill system. -The facility's eMAR system scheduled times for the administration of the novolog was set when the order was entered in the eMAR on 08/24/20. Refer to telephone interview with the pharmacist at the facility's contracted pharmacy on 12/22/20 at 9:30am. Refer to telephone interview with a first shift MA on 12/16//20 at 1:04pm. Refer to telephone interview with third shift MA on 12/17/20 at 8:30am. Refer to telephone interview with another first shift MA on 12/17/20 10:37am. Refer to telephone interview with the RCC on 12/18/20 at 9:35am. Refer to telephone interview with the Regional RCC on 12/18/20 at 12:00pm. Refer to telephone interview with Resident #3's NP on 12/17/20 at 3:00pm. Refer to telephone interview with the Administrator on 12/22/20 at 9:30am. c. Review of Resident #3's physician orders dated 10/02/20 revealed there was an order for sevelamer carbonate (a medication used to control serum phosphate levels) 800mg three times daily.	D 358		

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D 358	Continued From page 13 Review of Resident #3's October 2020 electronic medication administration record (eMAR) revealed: -There was an entry for sevelamer carbonate 800mg three times daily with administration times of 6:00am, 12:00pm, and 6:00pm. -There was documentation the sevelamer carbonate 800mg had not been administered 12 of 31 opportunities at 12:00pm. -The documented reason the sevelamer carbonate had not been administered was "dialysis". Review of Resident #3's November 2020 electronic medication administration record (eMAR) revealed: -There was an entry for sevelamer carbonate 800mg three times daily with administration times of 6:00am, 12:00pm, and 6:00pm. -There was documentation the sevelamer carbonate 800mg had not been administered 12 of 30 opportunities at 12:00pm. -The documented reason the sevelamer carbonate had not been administered was "dialysis". Review of Resident #3's December 2020 electronic medication administration record (eMAR) revealed: -There was an entry for sevelamer carbonate 800mg three times daily with administration times of 6:00am, 12:00pm, and 6:00pm. -There was documentation the sevelamer carbonate 800mg had not been administered 6 of 14 opportunities at 12:00pm. -The documented reason the sevelamer carbonate had not been administered was "dialysis".	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 14 Observation of Resident #5's medications available for administration on 12/21/20 at 10:30am revealed: -There was a blister pack of sevelamer with a computer-generated pharmacy label attached and the directions to administer one tablet three times daily with a dispense date of 09/26/20. -There were 27 tablets remaining in the blister pack with a dispense date of 09/26/20. -There was a blister pack of sevelamer with a computer-generated pharmacy label attached and the directions to administer one tablet three times daily with a dispense date of 10/21/20. -There were 5 tablets remaining in the blister pack with a dispense date of 10/21/20. -There were 3 blister packs of sevelamer with a computer-generated pharmacy label attached and the directions to administer one tablet three times daily with a dispense date of 11/14/20. -There were 90 tablets remaining in the blister packs with a dispense date of 11/14/20. Telephone interview with a representative at the facility's contracted pharmacy on 12/21/20 at 2:30pm revealed: -The pharmacy staff filled a 30-day supply of Resident #3's sevelamer on 09/26/20, 10/21/20, 11/14/20 and 12/08/20. -Resident #3's sevelamer was not on an automatic refill system. Refer to telephone interview with the pharmacist at the facility's contracted pharmacy on 12/22/20 at 9:30am. Refer to telephone interview with a first shift medication aide (MA) on 12/16//20 at 1:04pm. Refer to telephone interview with third shift MA on 12/17/20 at 8:30am.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 15 Refer to telephone interview with another first shift MA on 12/17/20 10:37am. Refer to telephone interview with the RCC on 12/18/20 at 9:35am. Refer to telephone interview with the Regional RCC on 12/18/20 at 12:00pm. Refer to telephone interview with Resident #3's NP on 12/17/20 at 3:00pm. Refer to telephone interview with the Administrator on 12/22/20 at 9:30am. d. Review of Resident #3's physician orders dated 10/02/20 revealed there was an order to administer kayexalate (a medication used to control potassium blood level) 15gm/60ml fifteen milliliters every day. Review of Resident #3's October 2020 electronic medication administration record (eMAR) revealed: -There was an entry for kayexalate 15gm/60ml 15ml every day at 9:00am. -Resident #3's kayexalate 15gm/60ml was not administered 10 of 31 opportunities. -The documented reason the kayexalate 15gm/60ml had not been administered was "dialysis". Review of Resident #3's November 2020 electronic medication administration record (eMAR) revealed: -There was an entry for kayexalate 15gm/60ml 15ml every day at 9:00am. -Resident #3's kayexalate 15gm/60ml was not administered 10 of 31 opportunities.	D 358		

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D 358	Continued From page 16 -The documented reason the kayexalate 15gm/60ml had not been administered was "dialysis". Review of Resident #3's December 2020 electronic medication administration record (eMAR) revealed: -There was an entry for kayexalate 15gm/60ml 15ml every day at 9:00am. -Resident #3's kayexalate 15gm/60ml was not administered 10 of 31 opportunities. -The documented reason the kayexalate 15gm/60ml had not been administered was "dialysis". Observation of Resident #5's medications available for administration on 12/21/20 at 10:30am revealed: -There was one half full bottle of kayexalate with a computer-generated pharmacy label attached and the directions to administer 15ml every day with a dispense date of 11/16/20. -There was one full bottle of kayexalate with a computer-generated pharmacy label attached and the directions to administer 15ml every day with a dispense date of 12/17/20. Telephone interview with a representative at the facility's contracted pharmacy on 12/21/20 at 2:30pm revealed: -The pharmacy staff filled a 30-day supply of Resident #3's kayexalate on 10/26/20, 11/16/20, and 12/17/20. -On 10/26/20, 11/16/20, and 12/17/20 one bottle of 473ml kayexalate suspension was delivered to the facility. -Resident #3's kayexalate was not on an automatic refill system. Refer to telephone interview with the pharmacist	D 358		

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D 358	Continued From page 17 at the facility's contracted pharmacy on 12/22/20 at 9:30am. Refer to telephone interview with a first shift MA on 12/16//20 at 1:04pm. Refer to telephone interview with third shift MA on 12/17/20 at 8:30am. Refer to telephone interview with another first shift MA on 12/17/20 10:37am. Refer to telephone interview with the RCC on 12/18/20 at 9:35am. Refer to telephone interview with the Regional RCC on 12/18/20 at 12:00pm. Refer to telephone interview with Resident #3's NP on 12/17/20 at 3:00pm. Refer to telephone interview with the Administrator on 12/22/20 at 9:30am. e. Review of Resident #3's physician orders dated 10/02/20 revealed there was an order to administer gabapentin (a medication used to control chronic nerve pain) 300mg three times daily. Review of Resident #3's October 2020 electronic medication administration record (eMAR) revealed: -There was an entry for gabapentin 300mg three times daily at 9:00am, 2:00pm, and 9:00pm. -Resident #3's gabapentin 300mg was not administered 10 of 31 opportunities at 9:00am. -Resident #3's gabapentin 300mg was not administered 5 of 31 opportunities at 2:00pm. -The documented reason the gabapentin was not	D 358		

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D 358	Continued From page 18 administered was "dialysis". Review of Resident #3's November 2020 electronic medication administration record (eMAR) revealed: -There was an entry for gabapentin 300mg three times daily at 9:00am, 2:00pm, and 9:00pm. -Resident #3's gabapentin 300mg was not administered 10 of 30 opportunities at 9:00am. -Resident #3's gabapentin 300mg was not administered 5 of 30 opportunities at 2:00pm. -The documented reason the gabapentin was not administered was "dialysis". Review of Resident #3's December 2020 electronic medication administration record (eMAR) revealed: -There was an entry for gabapentin 300mg three times daily at 9:00am, 2:00pm, and 9:00pm. -Resident #3's gabapentin 300mg was not administered 4 of 15 opportunities at 9:00am. -Resident #3's gabapentin 300mg was not administered 2 of 15 opportunities at 2:00pm. -The documented reason the gabapentin was not administered was "dialysis". Observation of Resident #5's medications available for administration on 12/21/20 at 10:30am revealed: -There was a blister pack of gabapentin with a computer-generated pharmacy label attached and the directions to administer one tablet three times daily with a dispense date of 11/28/20. -There were 29 tablets remaining in the blister pack with a dispense date of 11/28/20. Refer to telephone interview with the pharmacist at the facility's contracted pharmacy on 12/22/20 at 9:30am. Telephone interview with a representative at the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 19 facility's contracted pharmacy on 12/21/20 at 2:30pm revealed: -The pharmacy staff filled a 30-day supply of Resident #3's gabapentin on 09/27/20, 10/24/20, 11/28/20. -Resident #3's gabapentin was not on an automatic refill system. Refer to telephone interview with a first shift MA on 12/16//20 at 1:04pm. Refer to telephone interview with third shift MA on 12/17/20 at 8:30am. Refer to telephone interview with another first shift MA on 12/17/20 10:37am. Refer to telephone interview with the RCC on 12/18/20 at 9:35am. Refer to telephone interview with the Regional RCC on 12/18/20 at 12:00pm. Refer to telephone interview with Resident #3's NP on 12/17/20 at 3:00pm. Refer to telephone interview with the Administrator on 12/22/20 at 9:30am. Review of Resident #3's nurses' progress note on 12/17/20 revealed there was no documentation for medications that were not offered to Resident #3 during the months of October 2020, November 2020, and December 2020. Review of Resident #3's physician orders revealed no written physician orders in October 2020, November 2020, and December 2020 to change Resident #3's medication administration times.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 20 Telephone interview with the pharmacist at the facility's contracted pharmacy on 12/22/20 at 9:30am revealed: -The facility was required to send the pharmacy a request for refill of Resident #3's medications through the eMAR system, by faxing a refill label to the pharmacy, or calling the pharmacy for a refill. -The facility's eMAR system scheduled times for the administration of Resident #3's medication when the pharmacy entered the medication orders in the eMAR system. -If Resident #3 required the time of the administration of her medications to be changed the facility needed to fax a physician order to the pharmacy with the time for administration. -There was no record the facility had attempted to reach out to the pharmacy by telephone, email, or facsimile to request Resident #3's medication administration times be changed. Telephone interview with a first shift MA on 12/16/20 at 1:04pm revealed: -She did not administer medications to Resident #3 when she was out of the facility. -She documented the reason Resident #3 was out of the facility for each medication she missed while she was gone. -Resident #3 returned from dialysis between 12:30pm and 1:30pm on Mondays, Wednesdays, and Fridays. -She did not know Resident #3 missed her medications for the past three months while Resident #3 was gone to dialysis. -She did not know how to document that she administered Resident #3's medications after she returned from dialysis. -She did not know how to get the time changed for Resident #3's medications she missed while	D 358		

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D 358	Continued From page 21 at dialysis. Telephone interview with third shift MA on 12/17/20 at 8:30am revealed: -Resident #3 was ready to leave for dialysis on Mondays, Wednesday, and Fridays between 7:00am and 7:30am. -She checked Resident #3's fingerstick blood sugars and administered her 6:00am scheduled medications. -Resident #3 asked for some of her medications scheduled at 9:00am, but she was not able to administer them early and document them on the eMAR. -She told the RCC about the need to change the administration times a couple of months ago. -The RCC printed an eMAR and the times for Resident #3's medications were supposed to be corrected in May 2020 she could not recall the exact day. -The RCC said she was going to get the administration times changed so Resident #3 could get all her medications before or after she returned from dialysis. Telephone interview with another first shift MA on 12/17/20 10:37am revealed: -When Resident #3 was out of the facility at dialysis she documented Resident #3 was at dialysis. -Resident #3 was not able to get her medications that were scheduled between 8am and 2pm on Mondays, Wednesdays, and Fridays because she was at dialysis. -She did not know how to change the times of Resident #3's medications so they could be given after Resident #3 returned from dialysis. -She did not know how long Resident #3 was not getting her medications that were scheduled for dialysis because the RCC printed the eMARs.	D 358		

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D 358	Continued From page 22 -She did not check Resident #3's amount of medications left on the medication cart during weekly cart audits. -During weekly cart audits she checked Resident #3's medications on hand with the physician's order to make sure Resident #3 had all of her medications on the cart. Telephone interview with the RCC on 12/18/20 at 9:35am revealed: -She did know Resident #3 missed her medications that were scheduled when she went to dialysis. -The MAs were responsible for completing medication cart audits weekly. -During weekly medication cart audits the MAs compared Resident #3's medications on the cart to Resident #3's physician orders to make sure all of Resident #3 had all her medications available on the medication cart. -The MAs did not count the amount of a medication left on the medication cart. -She started training with the Regional RCC in October 2020 because the previous RCC left in April 2020. -She did not print Resident #3's eMARs to review them to find Resident #3 did not get her medications when Resident #3 was gone to dialysis. -The Regional RCC was coming two days a week to train and help her until the end of October 2020 when she was no longer able to visit because of a COVID-19 outbreak. Telephone interview with the Regional RCC on 12/18/20 at 12:00pm revealed: -The RCC or the Memory Care Manager were responsible for printing eMARs monthly to review when Resident #3 refused and missed scheduled medications.	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 12/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 23 -She began training the new RCC in October 2020 to review all the residents' eMARs with medications on the medication cart to identify when residents did not get their medications. -She was visiting the facility twice weekly until the COVID-19 outbreak in October 2020. -The last time she visited and assisted the RCC with reviewing medications was in the beginning of October 2020. -She did not know Resident #3 was not getting her medications when she was gone to dialysis. -The last time the pharmacy visited to perform medication reviews for Resident #3 was in October 2020. Telephone with Resident #3's NP on 12/17/20 at 3:00pm revealed: -She had virtual visits with Resident #3 at least monthly and more frequently as needed. -At the last virtual visit, she was not made aware Resident #3 was not getting her medications, insulin and fingerstick blood sugar checks on the days Resident #3 went to dialysis. -Resident #3 was a dialysis patient and required all her medications administered as ordered. -If Resident #3 did not get her medications because she was at dialysis, she expected to be contacted by the staff at the facility, so the times to administer them could be changed in order to ensure Resident #3 received them. -She gave the previous RCC an order to get the pharmacy to change the administration times for Resident #3 to get her medications when she returned or before she left for dialysis in April 2020. Telephone interview with the Administrator on 12/22/20 at 9:30am revealed: -He did not know Resident #3 missed her medications when she was out of the facility to	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 24 dialysis for the past 3 months. -He expected the MAs to inform the RCC that Resident #3 was not getting her scheduled medications when Resident #3 was out to dialysis because the times needed to be changed. -The RCC was expected to review Resident #3's eMAR and medications on hand every week. -He depended on the RCC to complete a review of Resident #3's medications weekly to make sure Resident #3 received all of her medications. -He depended on the pharmacist that visited quarterly to report any medication discrepancies on all the residents. -The facility failed to identify Resident #3 was not getting her medications after she returned from dialysis because Resident #3's medications were not reviewed weekly checking the eMAR for medications that were not given. Attempted telephone interview with Resident #3 on 12/17/20 at 10:00am was unsuccessful. 2. Review of Resident #1's current FL2 dated 04/08/20 revealed diagnoses included bipolar disorder, vitamin D deficiency, anemia, diabetes mellitus, and dementia. a. Review of Resident #1's physician orders dated 06/08/20 revealed there was an order for escitalopram (a medication used to treat anxiety and depression) 10mg daily. Review of Resident #1's October 2020 electronic medication administration record (eMAR) revealed: -There was an entry for escitalopram 10mg daily at 9:00am. -There was documentation the escitalopram 10mg had not been administered 11 of 31 opportunities at 9:00am.	D 358		

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D 358	Continued From page 25 -The documented reason the escitalopram had not been administered was "physically unable to take" on 8 occurrences, "med on order" for 2 occurrences and "awaiting pharmacy" for 1 occurrence. Review of Resident #1's November 2020 electronic medication administration record (eMAR) revealed: -There was an entry for escitalopram 10mg daily at 9:00am. -There was documentation the escitalopram 10mg had not been administered 3 of 30 opportunities at 9:00am. -The documented reason the escitalopram had not been administered was "awaiting order clarification" for all 3 occurrences. Observation of Resident #1's medications available for administration on 12/21/20 at 10:30am revealed: -There was a blister pack of escitalopram 10mg with a computer-generated pharmacy label attached and the directions to administer one tablet daily with a dispense date of 12/09/20. -There were 21 tablets remaining in the blister pack with a dispense date of 12/09/20. Telephone interview with a representative at the facility's contracted pharmacy on 12/22/20 at 9:06am revealed: -The pharmacy staff filled Resident #1's escitalopram 10mg on 10/13/20, 11/06/20, and 12/09/20. -On 10/13/20, 11/06/20, and 12/09/20 a thirty-day supply (30 tablets) of escitalopram was delivered to the facility. -Resident #1's escitalopram was not on an automatic refill system.	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 12/22/2020

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D 358	Continued From page 26 Record review of Resident #1's psychiatry progress note dated 10/05/20 revealed: -Diagnoses included Alzheimer's disease, Bipolar II disorder, anxiety disorder, and insomnia. -She was prescribed prn escitalopram for anxiety, and it had not been administered, and should be continued at the current dose. Record review of Resident #1's psychiatry progress note dated 11/02/20 and the October 2020 eMAR revealed: -The prn escitalopram had been administered 9 times from 10/10/20 to 10/28/20. -The prn medication was effective each time and should be continued. Telephone interview with a second shift MA on 12/22/20 at 12:31pm revealed she was responsible for medications being available for administration to residents. Refer to telephone interview with a first shift MA on 12/22/20 at 11:26am. Refer to telephone interview with the Regional RCC on 12/18/20 at 12:00pm. Refer to telephone interview with the Administrator on 12/22/20 at 9:30am and 2:20pm. b. Review of Resident #1's current FL2 dated 04/08/20 revealed an order for vitamin D2 (a medication used to treat vitamin D deficiency) 2000 international units (IU) take 2 capsules once daily. Review of Resident #1's October 2020 electronic medication administration record (eMAR) revealed: -There was an entry for vitamin D2 2000 IU two	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 27	D 358		

capsules daily at 9:00am.
-There was documentation the vitamin D2 2000 IU had not been administered 10 of 31 opportunities at 9:00m.
-The documented reason the vitamin D2 2000 IU had not been administered was "physically unable to take" on 6 occurrences, "med on order" for 2 occurrences, "awaiting pharmacy" for 1 occurrence, and "refused" on 1 occurrence.

Review of Resident #1's November 2020 electronic medication administration record (eMAR) revealed:
-There was an entry for vitamin D2 2000 IU two capsules daily at 9:00am.
-There was documentation the vitamin D2 2000 IU had not been administered 2 of 30 opportunities at 9:00m.
-The documented reason the vitamin D2 2000 IU had not been administered was "awaiting order clarification" on 2 occurrences.

Observation of Resident #1's medications available for administration on 12/21/20 at 10:30am revealed:
-There was a blister pack of vitamin D2 2000 IU with a computer-generated pharmacy label attached and the directions to administer two capsules daily with a dispense date of 12/09/20.
-There were 28 capsules remaining in the blister pack with a dispense date of 12/09/20.

Telephone interview with a representative at the facility's contracted pharmacy on 12/22/20 at 9:06am revealed:
-The pharmacy staff filled Resident #1's vitamin D2 2000 IU on 08/10/20 and 12/09/20.
-On 08/09/20 and 12/09/20 a thirty-day supply (60 tablets) of vitamin D2 was delivered to the facility.
-Resident #1's vitamin D2 was not on an

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MILL CREEK MANOR	1902 ORA DRIVE STATESVILLE, NC 28625

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D 358	Continued From page 28 automatic refill system. -There were no refills requested between 09/10/20 and 12/08/20. Telephone interview with a second shift MA on 12/22/20 at 12:31pm revealed she was responsible for medications being available for administration to residents. Refer to telephone interview with a first shift MA on 12/22/20 at 11:26am. Refer to telephone interview with the Regional RCC on 12/18/20 at 12:00pm. Refer to telephone interview with the Administrator on 12/22/20 at 9:30am and 2:20pm. c. Review of Resident #1's current FL2 dated 04/08/20 revealed an order for folic acid (a medication used to treat anemia) 1mg daily. Review of Resident #1's November 2020 electronic medication administration record (eMAR) revealed: -There was an entry for folic acid 1mg tablet daily at 8:00am. -There was documentation the folic acid 1mg had not been administered 6 of 30 opportunities at 8:00am. -The documented reason the folic acid had not been administered was "awaiting order clarification" on 1 occurrence, "med on order" for 1 occurrence, and "awaiting arrival" for 4 occurrences. Observation of Resident #1's medications available for administration on 12/21/20 at 10:30am revealed: -There was a blister pack of folic acid 1mg with a	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 29 computer-generated pharmacy label attached and the directions to administer one tablet daily with a dispense date of 11/21/20. -There were 5 tablets remaining in the blister pack with a dispense date of 11/21/20. Telephone interview with a representative at the facility's contracted pharmacy on 12/22/20 at 9:06am revealed: -The pharmacy staff filled Resident #1's folic acid 1mg on 10/13/20 and 11/21/20. -On 10/13/20 and 11/21/20 a thirty-day supply (30 tablets) of folic acid was delivered to the facility. -Resident #1's folic acid was not on an automatic refill system. Telephone interview with a second shift MA on 12/22/20 at 12:31pm revealed she was responsible for medications being available for administration to residents. Refer to telephone interview with a first shift MA on 12/22/20 at 11:26am. Refer to telephone interview with the Regional RCC on 12/18/20 at 12:00pm. Refer to telephone interview with the Administrator on 12/22/20 at 9:30am and 2:20pm. d. Review of Resident #1's physician orders dated 07/20/20 revealed there was an order for quetiapine fumarate (used to treat mania and depression) 200mg at bedtime. Review of Resident #1's October 2020 electronic medication administration record (eMAR) revealed: -There was an entry for quetiapine fumarate 200mg at bedtime.	D 358		

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D 358	Continued From page 30 -There was documentation the quetiapine fumarate 200mg had not been administered 2 of 31 opportunities at 9:00pm. -The documented reason the quetiapine fumarate had not been administered was "meds on order". Review of Resident #1's November 2020 eMAR revealed: -There was an entry for quetiapine fumarate 200mg at bedtime. -There was documentation the quetiapine fumarate 200mg had not been administered 1 of 30 opportunities at 9:00pm. -The documented reason the quetiapine fumarate had not been administered was "awaiting order clarification". Observation of Resident #1's medications available for administration on 12/21/20 at 10:30am revealed: -There was a blister pack of quetiapine fumarate 200mg with a computer-generated pharmacy label attached and the directions to administer one tablet at bedtime with a dispense date of 12/02/20. -There were 10 tablets remaining in the blister pack with a dispense date of 12/02/20. Telephone interview with a representative at the facility's contracted pharmacy on 12/22/20 at 9:06am revealed: -The pharmacy staff filled Resident #1's quetiapine fumarate 200mg on 10/13/20 11/06/20 and 12/02/20. -On 10/13/20, 11/06/20 and 12/02/20 a thirty-day supply (30 tablets) was delivered to the facility. -Resident #1's quetiapine fumarate was not on an automatic refill system. Telephone interview with a second shift MA on	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 31 12/22/20 at 12:31pm revealed: -She recalled that Resident #1's quetiapine fumarate was on order in October 2020 and was not available for administration twice. -She was responsible for medications being available for administration to residents. Refer to telephone interview with a first shift MA on 12/22/20 at 11:26am. Refer to telephone interview with the Regional RCC on 12/18/20 at 12:00pm. Refer to telephone interview with the Administrator on 12/22/20 at 9:30am and 2:20pm. e. Review of Resident #1's physician orders dated 11/04/20 revealed there was an order for Levemir flex-pen (a medication used to control blood sugars) 5 units subcutaneous at bedtime and an order to check blood sugars twice daily before meals. Review of Resident #1's November 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Levemir flex-pen 5 units to be administered at 8:00pm. -There was an order to check FSBS twice daily before meals at 6:30am and 4:30pm and to notify the physician if less than 70 or greater than 400. -Resident #1's FSBS was not obtained prior to administration of the Levemir on 11/05/20, 11/06/20, 11/08/20, 11/09/20, and 11/10/20 at 4:30pm. -The documented reason the FSBS had not been performed was blank. Telephone interview with a second shift medication aide (MA) on 12/22/20 at 12:31pm	D 358		

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D 358	Continued From page 32 revealed: -Initially, there was a delay in getting the glucometer from the pharmacy in November 2020. -The facility did not have a back-up glucometer available, so Resident #1 "had to wait". -She only checked FSBS in the morning for Resident #1. Review of Resident #1's lab results dated 10/10/20 revealed a hemoglobin A1C of 7.4% (normal is less than 5.7%). Telephone interview with the Administrator on 12/22/20 at 2:20pm revealed he did not know the FSBS were not obtained 5 times prior to administration of Levemir at bedtime in November 2020. Review of an email from the Regional Resident Care Coordinator on 12/22/20 at 1:42pm revealed she could not find FSBS results that were missed from 11/05/20 to 11/20/20. Observation of Resident #1's medications available for administration on 12/21/20 at 10:30am revealed there was one Levemir flex-pen with a computer-generated pharmacy label attach to a plastic bag for storage, and the directions to administer 5 units at bedtime. Telephone interview with a second shift MA on 12/22/20 at 12:31pm revealed: -There was a delay in getting the glucometer from the pharmacy in November 2020. -The facility did not have a back-up glucometer available. Telephone interview with the Resident Care Coordinator (RCC) on 12/18/20 at 9:35am	D 358		

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D 358	Continued From page 33 revealed: -The MAs were responsible for completing medication cart audits weekly. -The MAs did not count the amount of a medication left on the medication cart. -The Regional RCC came and was printing the residents' eMARs to check when residents did not take their medications. Attempted telephone with Resident #1's nurse practitioner (NP) on 12/22/20 at 9:09am was unsuccessful. Refer to telephone interview with a first shift MA on 12/22/20 at 11:26am. Refer to telephone interview with the Regional RCC on 12/18/20 at 12:00pm. Refer to telephone interview with the Administrator on 12/22/20 at 9:30am and 2:20pm. _____ Telephone interview with a first shift MA on 12/22/20 at 11:26am revealed: -They had "problems" getting medications on hand from the pharmacy provider. -The pharmacy provider would state that medications were sent, that were never received by the facility. -She had to call the pharmacy provider, for Resident #1 and ask for refills and was told the medications had been sent when they had not. -She did not have any documentation of contacting the pharmacy regarding Resident #1's medications in October and November 2020 due to time constraints related to the COVID-19 pandemic. -She could not recall if Resident #1 missed doses of 4 medications in October and November 2020. -The other MA that documented missed doses	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 34 was no longer employed at the facility. Telephone interview with the Regional RCC on 12/18/20 at 12:00pm revealed: -The Memory Care Manager (MCM) or RCC were responsible for printing eMARs monthly to review when a resident missed scheduled medications. -She was visiting the facility twice weekly until the COVID-19 outbreak in October 2020. -The last time she visited and assisted the RCC with reviewing medications was in the beginning of October 2020. Telephone interview with the Administrator on 12/22/20 at 9:30am and 2:20pm revealed: -He did not know Resident #1 missed her medications in October and November 2020. -He expected the MAs to inform the MCM that Resident #1 was not getting her scheduled medications and to make sure medications were available for administration. -The MCM was expected to review Resident #1's eMAR and medications on hand every week. -He depended on the MCM to complete a review of Resident #1's medications weekly to make sure she received all of her medications. -He was not aware Resident #1 was not getting her medications because her medications were not reviewed weekly checking the eMAR for medications that were not given. -He depended on the pharmacist that visited quarterly to report any medication discrepancies on all the residents. -He did not have any pharmacy reports for Resident #1's missed medications.	D 358		