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 02/21/2024

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 and the Iredell County Department of Social Services conducted a follow-up survey from 02/20/24 to 02/21/24.	{D 000}		
{D 130}	10A NCAC 13F .0405 Qualifications Of Food Service Supervisor 10A NCAC 13F .0405 Qualifications Of Food Service Supervisor Each facility shall have a food service supervisor that is experienced in food service in commercial, healthcare, or congregate care settings who shall consult with a licensed dietitian/nutritionist as necessary to meet the dietary needs of the residents in accordance with Rule .0904 of this Subchapter. Readopted Eff. February 1, 2022. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure there was a qualified food service supervisor that consulted with a licensed dietitian/nutritionist to meet the dietary needs of the residents. The Findings are: Observation on 02/20/24 at 3:08pm revealed the Administrator was in the kitchen preparing food. Interview with a cook on 02/21/24 at 11:20am revealed: -The facility did not have a Dietary Manager (DM). -If she had any questions related to the kitchen or menus, she would ask the Administrator. Interview with the Administrator on 02/20/24 at 3:09pm revealed:	{D 130}		

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 02/21/2024

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 130}	Continued From page 1 -She was preparing food as both cooks were out. -The facility did not have a DM. -She did not have a dietician to create therapeutic menus. -She planned to get ServeSafe Certified this year. Interview with the Administrator on 02/21/24 at 11:26am revealed: -She was overseeing the kitchen. -The facility had been looking to hire a DM who had experience in health care and could become ServeSafe certified. -The cooks had been unable to pass the ServeSafe certification test since November 2023. -Since the last annual survey (12/01/23) no one had taken the test.	{D 130}		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure physician's orders were implemented for 1 of 5 sampled residents (#4) related to a medication to treat infections. The findings are: Review of Resident #4's current FL2 dated	D 276		

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 02/21/2024

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 276	Continued From page 2 11/22/23 revealed diagnoses that included dementia, hypertension, hyperlipidemia, and chronic obstructive pulmonary disease (COPD). Review of Resident #4's physician order dated 12/22/23 revealed an order to start antibiotics for a urinary tract infection. Review of Resident #4's December 2023 electronic Medication Administration Record (eMAR) revealed: -There was an order for cefpodoxime 200mg, 1 tablet by mouth every 12 hours for 7 days. -Cefpodoxime 200mg 1 tablet by mouth every 12 hours for 7 days had a stop date of 12/28/23. -There was an order for cefdinir 300mg 1 capsule by mouth, twice a day for 7 days. -Cefdinir 300mg 1 capsule by mouth, twice a day for 7 days had a stop date of 01/04/24. Observation of medications on hand for Resident #4 on 02/21/24 revealed there was no Cefpodoxime 200mg or Cefdinir 300mg located on the medication cart. Telephone interview with the facility's contracted pharmacy on 02/21/24 at 11:26am revealed: -Cefpodoxime 200mg 1 tablet every 12 hours for 7 days was sent to the pharmacy on 12/27/23. -Cefpodoxime 200mg was changed to Cefdinir 300mg, 1 tablet twice a day for 7 days due to a high copay the family did not want to pay. -The order for Cefdinir 300mg was sent to the back-up pharmacy on 12/27/23. Telephone interview with the facility's contracted back-up pharmacy on 02/21/24 at 11:40am revealed: -They received the order for Cefdinir 300mg 1 tablet twice a day for 7 days on 12/28/23.	D 276		

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 02/21/2024

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 276	Continued From page 3	D 276		

-They dispensed 14 tablets on 12/28/23.
-The medication was not picked up and was held at the pharmacy for 14 days and was put back in stock.
-There was one call placed to the facility on 12/28/23 to make them aware a medication was ready for pick-up but did not know who they talked to.
-If Cefdinir 300mg was not given, it could cause burning or itching after urination.

Interview with a medication aide (MA) on 02/20/24 at 9:32am revealed:
-She was not aware of Cefdinir 300mg being ordered for Resident #4.
-She was aware of the order on the eMAR for Resident #4, but it had a stop date, so she thought it had been discontinued.

Interview with the Special Care Unit Coordinator (SCC) on 02/21/24 at 12noon revealed:
-She was not aware of an order for Cefdinir 300mg for Resident #4.
-She did not know how the pharmacy received the order on 12/27/23 unless it was sent by the PCP to the pharmacy.
-She did not receive a call from the back-up pharmacy making the facility aware a medication was ready for pick-up.
-Medication cart audits for the Special Care Unit were done by the SCC on Monday, Wednesday, and Friday.
-Medication cart audits consisted of checking physician orders to the eMAR, eMAR to medications on the cart and expired medications.

Interview with the Administrator on 02/21/24 at 12:42pm revealed:
-She was not aware Resident #4 had not received his medication for a urinary tract infection.

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 02/21/2024

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 276	Continued From page 4 -The SCC would make rounds with the PCP on Thursdays and the orders were faxed to the pharmacy. -It was the SCC's responsibility to make sure all medications on the Special Care Unit were received from the pharmacy. -The Administrator was to receive a copy of all orders so she could follow-up, but she never received Resident #4's order for his medication. -The SCC does an eMAR to PCP orders audit every week and medication cart audits three times a week and results were given to the Administrator. -She was not sure why Resident #4's medication was not received and why it was not discovered when the audits were completed. -The Administrator expected all residents to receive their medication as ordered. Attempted telephone interview with Resident #4's Primary Care Physician (PCP) on 02/21/24 at 12:15pm was unsuccessful.	D 276		
{D 296}	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by:	{D 296}		

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 02/21/2024

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 296}	Continued From page 5 Based on interviews, observations and record reviews, the facility failed to ensure there were therapeutic diet menus for food service guidance for 1 of 1 sampled resident with physician's orders for a low concentrated sweet diet (Resident #2). The findings are: Review of Resident #2's current FL2 dated 11/01/23 revealed: -Diagnoses included insulin dependent diabetes mellitus. -Resident #2 had an order for a low concentrated sweets diet. A review of the diet book in the kitchen revealed Resident #2 was on a low concentrated sweet diet. Review of the facility's week-at-glance menu revealed the regular diet lunch meal for 02/21/24 was a fish filet, pasta salad, cole slaw and fruit compote. Observation of Resident #2's lunch meal service on 02/21/24 at 11:55am revealed: -Resident #2 was served a sandwich, pasta salad, cole slaw, water and unsweetened iced tea. -Resident #2 ate 3/4 of her cold meat sandwich, 1/4 of the pasta salad and did not consume any of the cole slaw. Interview with the cook on 02/21/24 at 11:20am revealed: -The facility did not have a Dietary Manager (DM) -If she had questions related to therapeutic menus, she would ask the Administrator. -She had a list of residents that were on a low	{D 296}		

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 02/21/2024

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 296}	Continued From page 6 concentrated sweet diet and made sure they did not receive any sugar. -She would not serve Resident #2 the fruit compote as it was packed in light syrup but would substitute yogurt. -Resident #2 would receive a sandwich in place of fish due to her preference. Interview with Resident #2 on 02/21/24 at 11:56am revealed she was offered yogurt but did not want any because she did not feel well. Interview with the Administrator on 02/21/24 at 11:26am revealed: -The facility did not have a DM and had been unsuccessful at hiring one. -The facility did not have therapeutic menus because the owner of the company did not understand the need for therapeutic menus and had not provided therapeutic menus to the facility. -She knew it was a requirement in North Carolina to have therapeutic menus. Attempted telephone interview with the owner on 02/21/24 at 11:26am was unsuccessful.	{D 296}		