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 _____	05/21/2025

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 annual and follow-up survey from May 20, 2025 to May 21, 2025.	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 Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 5 sampled residents (#4 and #5) had completed tuberculosis (TB) testing in compliance with control measures adopted by the Commission for Health Services. The findings are: 1. Review of Resident #5's current FL2 dated 03/12/25 revealed diagnoses included hyperglycemia (too much sugar in the blood), diabetes, and hypertension (high blood pressure). Review of Resident #5's resident register revealed an admission date of 02/26/21.	D 234		

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D 234	Continued From page 1 Review of Resident #5's facility record revealed there was no documentation of a second step TB test completed. Attempted interview with Resident #5 was unsuccessful. Refer to interview with the Administrator on 05/21/25 at 2:25pm. 2. Review of Resident #4's current FL2 dated 01/18/25 revealed diagnoses included diabetes type 2, depression and schizoaffective disorder. Review of Resident #4's Resident Register revealed an admission date of 04/27/23. Review of Resident #4's record revealed there was no documentation a first or second tuberculosis (TB) skin test was completed. Interview with Resident #4 on 05/21/25 at 10:55am revealed he did not know when he last had a TB test. Refer to the interview with the Administrator on 05/21/25 at 2:25pm. _____ Interview with the Administrator on 05/21/25 at 2:25pm revealed: -She did not know the residents did not have TB tests completed. -Her expectations were that the first TB test was done before facility admission and the second TB test was done by the facility's Primary Care Provider (PCP) within a year after admission to the facility. -She did the initial new resident assessment and the Resident Care Coordinator (RCC) completed the new resident documentation. -She was responsible for ensuring TB tests were	D 234		

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D 234	Continued From page 2 completed for all residents.	D 234		
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: Based on interviews, observations and record reviews, the facility failed to ensure there were therapeutic diet menus for food service guidance for 3 of 3 sampled residents with physician's orders for pureed honey thickened liquids and no concentrated sweets (Resident # 3, #4 #5). current FL2 dated 03/12/25 revealed: 1. Review of Resident #3 current FL2 dated 03/12/25 revealed: -Diagnoses included diabetes and hypertension (high blood pressure). -Resident #3 had an order for a controlled carb diet and no added salt. Review of Resident #3 Resident Register revealed an admission date of 06/06/24. Review of the diet book in the kitchen revealed: -Resident #3 was on a controlled carb diet and no added salt.	D 296		

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D 296	Continued From page 3 -There was no therapeutic diet menus. Review of the facility's Weekly Menu for 05/20/25 was a green salad, marinated rosemary chicken, rice pilaf, sauteed yellow squash, baked roll and ice cream. Observation of Resident #3's lunch meal revealed chicken, rice pilaf, sauteed squash, salad, roll, orange sherbet and unsweetened ice tea. 2. Review of Resident #4 current FL2 dated 04/22/25 revealed: -Diagnoses included diabetes and hypertension (high blood pressure). -Resident #4's diet was no concentrated sweets and no added salt. Review of the diet book in the kitchen revealed: -Resident #4 was on a no concentrated sweets diet and no added salt. -There was no therapeutic diet menu. Review of the facility's Weekly Menu for 05/20/25 was a green salad, marinated rosemary chicken, rice pilaf, sauteed yellow squash, baked roll and ice cream. Observation of Resident #4's lunch meal revealed chicken, rice pilaf, sauteed squash, salad, roll, sherbet and unsweetened iced tea. 3. Review of Resident #5's current FL2 dated 03/12/25 revealed: -Diagnoses included anemia (a condition in which the blood does not have enough healthy red blood cells), hypertension (high blood pressure), diabetes, and hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone.	D 296		

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D 296	Continued From page 4 -Resident #5's diet was pureed honey thick liquids and no concentrated sweets. A review of the diet book in the kitchen revealed: - Resident #5 was on a pureed honey thickened liquid diet and no concentrated sweet diet. -There was no therapeutic diet menus. Review of the facility's Weekly Menu for 05/20/25 was a green salad, marinated rosemary chicken, rice pilaf, sauteed yellow squash, baked roll and ice cream. Observation of Resident #5's lunch meal on 05/20/25 revealed resident #5 was served pureed chicken, pureed squash, pureed mashed potatoes, pureed green beans, milk with honey thickened liquid and yogurt with honey thickened liquid. Interview with the Dietary Manager (DM) on 05/20/25 at 11:10am revealed: -She started with the facility two months ago. -She had a list of residents that were on low concentrated sweet diets, and she made sure they did not get food with sugar. -She knew how to puree food and had the different thickeners already made in boxes in the storage room. -She did not know she needed a therapeutic diet menus. Interview with the Administrator on 05/21/25 at 2:10pm revealed: -She was aware the facility did not have therapeutic diet menus. -The facility did not have therapeutic menus because the owner of the company felt there was no need for them if the DM knew how to prepare the diets.	D 296		

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D 296	Continued From page 5 -She knew it was a requirement in North Carolina to have therapeutic menus because they were cited for it last year. -She would discuss this with the owner again. Attempted telephone interview with the owner on 05/21/25 at 10:20am was unsuccessful.	D 296		
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 interviews and record reviews, the facility failed to ensure medications were administered as ordered for 5 of 5 sampled residents (#1, #2, #3, #4, #5) related to medications for elevated blood sugar levels, hypertension, cholesterol, (#3), anxiety, blood clots, memory loss (#5), stroke prevention, hypertension, memory loss, blood clot prevention, mood disorders (#1), lowering blood sugars, stomach acid, constipation, depression, nerve pain, cholesterol (#4), and memory loss (#2). The findings are: 1. Review of Resident #3's current FL2 dated 01/18/25 revealed diagnoses included insulin dependent diabetes, hypertension (high blood	D 358		

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pressure), and increased lipids (high levels of fat particles in the blood).

a. Review of Resident 3's hospital discharge summary dated 03/03/25 revealed an order for lispro (a rapid acting insulin used to lower elevated blood sugar levels) inject per sliding scale before meals and at bedtime: FSBS: 70-150 = 0 units, 151-249 = 2 units, 250-299 = 4 units, 300-349 = 6 units, 350-400 = 8 units.

Review of Resident #3's Primary Care Provider's (PCP) order dated 03/25/25 revealed:
-There was an order to discontinue Resident #3's fingerstick blood sugars (FSBS) and sliding scale insulin four times daily.
-There was an order to check Resident #3's FSBS three times daily with meals.
-There was an order to continue Resident #3's current sliding scale lispro, inject per sliding scale before meals: FSBS: 70-150 = 0 units, 151-249 = 2 units, 250-299 = 4 units, 300-349 = 6 units, 350-400 = 8 units.

Review of Resident #3's PCP orders dated 04/22/25 revealed:
-There was an order to check Resident #3's FSBS three times daily before meals.
-There was an order for lispro, inject per sliding scale three times daily before meals: FSBS: 70-150 = 0 units, 151-249 = 2 units, 250-299 = 4 units, 300-349 = 6 units, 350-400 = 8 units.

Review of Resident #3's March 2025 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for lispro, inject per sliding scale before meals and at bedtime: FSBS: 70-150 = 0 units, 151-249 = 2 units, 250-299 = 4 units, 300-349 = 6 units, 350-400 = 8 units that

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D 358	Continued From page 7 was discontinued on 03/26/25. -There was an entry for lispro, dated 03/25/25, inject per sliding scale before meals: FSBS: 70-150 = 0 units, 151-249 = 2 units, 250-299 = 4 units, 300-349 = 6 units, 350-400 = 8 units. -On 03/06/25 at 7:00pm, the resident's FSBS was 198 and there was no documentation lispro was administered when she should have received 2 units. -On 03/07/25 at 7:00pm, the resident's FSBS was 322 and there was no documentation lispro was administered when she should have received 6 units. -On 03/08/25 at 7:30am, the resident's FSBS was 158 and there was no documentation lispro was administered when she should have received 2 units. -On 03/08/25 at 12:00pm, the resident's FSBS was 235 and there was no documentation lispro was administered when she should have received 2 units. -On 03/08/25 at 4:00pm, the resident's FSBS was 311 and there was no documentation lispro was administered when she should have received 6 units. -On 03/09/25 at 7:30am, the resident's FSBS was 162 and there was no documentation lispro was administered when she should have received 2 units. -On 03/09/25 at 12:00pm, the resident's FSBS was 228 and there was no documentation lispro was administered when she should have received 2 units. -On 03/09/25 at 4:00pm, the resident's FSBS was 289 and there was no documentation lispro was administered when she should have received 4 units. -On 03/09/25 at 7:00pm, the resident's FSBS was 249 and there was no documentation lispro was administered when she should have received 2	D 358		

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D 358	Continued From page 8 units. -On 03/10/25 at 7:30am, the resident's FSBS was 296 and there was no documentation lispro was administered when she should have received 4 units. -On 03/11/25 at 7:30am, the resident's FSBS was 349 and there was no documentation lispro was administered when she should have received 6 units. -On 03/12/25 at 12:00pm, the resident's FSBS was 350 and there was no documentation lispro was administered when she should have received 8 units. -On 03/12/25 at 4:00pm, the resident's FSBS was 382 and there was no documentation lispro was administered when she should have received 8 units. -On 03/12/25 at 7:00pm, the resident's FSBS was 400 and there was no documentation lispro was administered when she should have received 8 units. -On 03/13/25 at 7:30am, the resident's FSBS was 158 and there was no documentation lispro was administered when she should have received 2 units. -On 03/13/25 at 7:00pm, the resident's FSBS was 331 and there was no documentation lispro was administered when she should have received 6 units. -On 03/14/25 at 6:00am, the resident's FSBS was 293 and there was no documentation lispro was administered when she should have received 4 units. -On 03/18/25 at 7:00pm, the resident's FSBS was 351 and there was no documentation lispro was administered when she should have received 8 units. -On 03/19/25 at 7:00pm, the resident's FSBS was 328 and there was no documentation lispro was administered when she should have received 6	D 358		

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units.
-On 03/20/25 at 12:00pm, the resident's FSBS was 237 and there was no documentation lispro was administered when she should have received 2 units.
-On 03/20/25 at 4:00pm, the resident's FSBS was 363 and there was no documentation lispro was administered when she should have received 8 units.
-On 03/20/25 at 7:00pm, the resident's FSBS was 396 and there was no documentation lispro was administered when she should have received 8 units.
-On 03/22/25 at 12:00pm, the resident's FSBS was 357 and there was no documentation lispro was administered when she should have received 8 units.
-On 03/22/25 at 7:00pm, the resident's FSBS was 300 and there was no documentation lispro was administered when she should have received 6 units.
-On 03/23/25 at 6:00am, the resident's FSBS was 234 and there was no documentation lispro was administered when she should have received 2 units.
-On 03/23/25 at 7:00pm, the resident's FSBS was 297 and there was no documentation lispro was administered when she should have received 4 units.
-On 03/24/25 at 7:00pm, the resident's FSBS was 355 and there was no documentation lispro was administered when she should have received 8 units.
-On 03/25/25 at 7:00pm, the resident's FSBS was 338 and there was no documentation lispro was administered when she should have received 6 units.
-On 03/27/25 at 7:00am, the resident's FSBS was 234 and there was no documentation lispro was administered when she should have received 2

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D 358	Continued From page 10 units. -On 03/27/25 at 5:00pm, the resident's FSBS was 372 and there was no documentation lispro was administered when she should have received 8 units. -On 03/28/25 at 5:00pm, the resident's FSBS was 375 and there was no documentation lispro was administered when she should have received 8 units. -On 03/29/25 at 7:00am, the resident's FSBS was 227 and there was no documentation lispro was administered when she should have received 2 units. -On 03/30/25 at 7:00am, the resident's FSBS was 208 and there was no documentation lispro was administered when she should have received 2 units. -On 03/31/25 at 7:00am, the resident's FSBS was 201 and there was no documentation lispro was administered when she should have received 2 units. Review of Resident #3's April 2025 eMAR revealed: -There was an entry for lispro, dated 03/25/25, inject per sliding scale before meals: FSBS: 70-150 = 0 units, 151-249 = 2 units, 250-299 = 4 units, 300-349 = 6 units, 350-400 = 8 units. -On 04/01/25 at 7:00am, the resident's FSBS was 214 and there was no documentation lispro was administered when she should have received 2 units. -On 04/03/25 at 7:00am, the resident's FSBS was 296 and there was no documentation lispro was administered when she should have received 4 units. -On 04/04/25 at 7:00am, the resident's FSBS was 167 and there was no documentation lispro was administered when she should have received 2 units.	D 358		

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D 358	Continued From page 11 -On 04/04/25 at 11:30am, the resident's FSBS was 161 and there was no documentation lispro was administered when she should have received 2 units. -On 04/04/25 at 5:00pm, the resident's FSBS was 222 and there was no documentation lispro was administered when she should have received 2 units. -On 04/05/25 at 7:00am, the resident's FSBS was 235 and there was no documentation lispro was administered when she should have received 2 units. -On 04/05/25 at 5:00pm, the resident's FSBS was 232 and there was no documentation lispro was administered when she should have received 2 units. -On 04/06/25 at 11:30am, the resident's FSBS was 270 and there was no documentation lispro was administered when she should have received 4 units. -On 04/07/25 at 6:00am, the resident's FSBS was 179 and there was no documentation lispro was administered when she should have received 2 units. -On 04/07/25 at 4:00pm, the resident's FSBS was 256 and there was no documentation lispro was administered when she should have received 4 units. -On 04/09/25 at 4:00pm, the resident's FSBS was 244 and there was no documentation lispro was administered when she should have received 2 units. -On 04/15/25 at 11:30am, the resident's FSBS was 241 and there was no documentation lispro was administered when she should have received 2 units. -On 04/15/25 at 4:00pm, the resident's FSBS was 362 and there was no documentation lispro was administered when she should have received 8 units.	D 358		

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D 358	Continued From page 12 -On 04/16/25 at 11:30am, the resident's FSBS was 249 and there was no documentation lispro was administered when she should have received 2 units. -On 04/18/25 at 11:30am, the resident's FSBS was 298 and there was no documentation lispro was administered when she should have received 4 units. -On 04/18/25 at 4:00pm, the resident's FSBS was 396 and there was no documentation lispro was administered when she should have received 8 units. -On 04/19/25 at 6:00am, the resident's FSBS was 306 and there was no documentation lispro was administered when she should have received 6 units. -On 04/19/25 at 4:00pm, the resident's FSBS was 181 and there was no documentation lispro was administered when she should have received 2 units. -On 04/20/25 at 11:30am, the resident's FSBS was 258 and there was no documentation lispro was administered when she should have received 4 units. -On 04/20/25 at 4:00pm, the resident's FSBS was 240 and there was no documentation lispro was administered when she should have received 2 units. -On 04/22/25 at 6:00am, the resident's FSBS was 184 and there was no documentation lispro was administered when she should have received 2 units. -On 04/22/25 at 4:00pm, the resident's FSBS was 157 and there was no documentation lispro was administered when she should have received 2 units. -On 04/28/25 at 11:30am, the resident's FSBS was 256 and there was no documentation lispro was administered when she should have received 4 units.	D 358		

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D 358	Continued From page 13 -On 04/29/25 at 11:30am, the resident's FSBS was 178 and there was no documentation lispro was administered when she should have received 2 units. Review of Resident #3's May 2025 eMAR revealed: -There was an entry for lispro, dated 03/25/25, inject per sliding scale before meals: FSBS: 70-150 = 0 units, 151-249 = 2 units, 250-299 = 4 units, 300-349 = 6 units, 350-400 = 8 units. -On 05/02/25 at 11:30am, the resident's FSBS was 185 and there was no documentation lispro was administered when she should have received 2 units. -On 05/07/25 at 4:00pm, the resident's FSBS was 157 and there was no documentation lispro was administered when she should have received 2 units. -On 05/08/25 at 11:30am, the resident's FSBS was 232 and there was no documentation lispro was administered when she should have received 2 units. -On 05/10/25 at 11:30am, the resident's FSBS was 237 and there was no documentation lispro was administered when she should have received 2 units. -On 05/10/25 at 4:00pm, the resident's FSBS was 206 and there was no documentation lispro was administered when she should have received 2 units. -On 05/11/25 at 6:00am, the resident's FSBS was 220 and there was no documentation lispro was administered when she should have received 2 units. -On 05/11/25 at 11:30am, the resident's FSBS was 268 and there was no documentation lispro was administered when she should have received 4 units. -On 05/12/25 at 4:00pm, the resident's FSBS was	D 358		

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163 and there was no documentation lispro was administered when she should have received 2 units.
-On 05/17/25 at 11:30am, the resident's FSBS was 164 and there was no documentation lispro was administered when she should have received 2 units.
-On 05/17/25 at 4:00pm, the resident's FSBS was 248 and there was no documentation lispro was administered when she should have received 2 units.

Interview with a medication aide (MA) on 05/21/25 at 1:09pm revealed:
-She was unsure why sometimes no units of Resident #3's lispro was not documented on the eMAR because the MA had to enter the units before the software would allow the MA to finalize the entry.
-The previous Resident Care Director (RCD) had informed the MAs that there were times Resident #3's lispro dosage was not documented but she was not sure how that was possible.

Interview with a representative from the facility's contracted pharmacy on 05/21/25 at 12:27pm revealed if Resident #3 did not receive her lispro insulin she could have increased blood sugar levels.

Refer to the interview with the Administrator on 05/21/25 at 10:15am.

Refer to the interview with the Administrator on 05/21/25 at 2:40pm.

b. Review of Resident #3's Primary Care Provider's (PCP) orders dated 01/18/25 revealed an order for lantus 100units/ml (a medication to treat high blood sugar levels) 50 units at bedtime.

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D 358	Continued From page 15 Review of Resident #3's PCP order dated 03/25/25 revealed an order for lantus 30 units at bedtime. Review of Resident #3's April 2025 eMAR revealed: -There was an entry for lantus 30units at bedtime. -There was no documenting lantus 30units was administered 04/23/25. -There was no documentation why lantus 30units was not administered to Resident #3 on 04/23/25. Review of Resident #3's May 2025 eMAR revealed: -There was an entry for lantus 30 units at bedtime. -There was no documentation lantus 30units was administered on 04/02/25, 04/07/25, 04/13/25 and 04/18/25. -There was no documentation why lantus 30units was not administered on 04/02/25, 04/07/25, 04/13/25 and 04/18/25. Interview with a representative from the facility's contracted pharmacy on 05/21/25 at 12:27pm revealed if Resident #3 did not receive her lantus insulin she could have increased blood sugar levels. Refer to the interview with the Administrator on 05/21/25 at 10:15am. Refer to the interview with the Administrator on 05/21/25 at 2:40pm. c. Review of Resident #3's Primary Care Provider's (PCP) orders dated 01/18/25 revealed an order for metformin ER (a medication to lower blood sugar) 500mg, two tablets daily.	D 358		

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D 358	Continued From page 16 Review of Resident #3's hospital discharge summary dated 03/03/25 revealed an order for metformin ER 500mg, two tablets daily with the evening meal. Review of Resident #3's PCP orders dated 04/22/25 revealed an order for metformin ER, two tablets daily with dinner. Review of Resident #3's March 2025 electronic Medication Administration Record (eMAR) revealed: -There was an entry for metformin ER 500mg, two tablets daily with dinner. -There was no documentation metformin ER 500mg, two tablets were administered on 03/03/25 and 03/10/25. -There was no documentation why metformin ER 500mg, two tablets was not administered. -There was documentation Resident #3 was out of the facility on 03/10/25 at 4:00pm. Review of Resident #3's April 2025 eMAR revealed: -There was an entry for metformin ER 500mg, two tablets daily with dinner. -There was no documentation metformin ER 500mg, two tablets were administered daily on 04/01/25. -There was no documentation why metformin ER 500mg, two tablets was not administered. Review of Resident #3's May 2025 eMAR revealed: -There was an entry for metformin ER 500mg, two tablets daily with dinner. -There was no documentation metformin ER 500mg, two tablets were administered on 05/08/25 and 08/18/25.	D 358		

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D 358	Continued From page 17 -There was no documentation why metformin ER 500mg, two tablets was not administered. Interview with a representative from the facility's contracted pharmacy on 05/21/25 at 12:27pm revealed if Resident #3 did not receive metformin as prescribed she could have increased blood sugar levels. Refer to the interview with the Administrator on 05/21/25 at 10:15am. Refer to the interview with the Administrator on 05/21/25 at 2:40pm. d. Review of Resident #3's Primary Care Provider's (PCP) orders dated 01/18/25 revealed an order for lisinopril-HCTZ (to treat hypertension) 20-12.5mg, one tablet twice daily. Review of Resident #3's PCP orders dated 04/22/25 revealed an order for lisinopril-HCTZ 20-12.5mg, one tablet twice daily. Review of Resident #3's March 2025 eMAR revealed: -There was an entry for lisinopril-HCTZ 20-12.5mg, one tablet twice daily. -There was no documentation lisinopril-HCTZ 20-12.5mg one tablet was administered twice daily at on 03/03/25 and 03/28/25 at 8:00am, and on 03/15/25 at 7:00pm. -There was documentation Resident #3 was "physically unable to take" lisinopril-HCTZ 20-12.5mg, one tablet on 03/28/25 at 8:00am. -There was no documentation why lisinopril-HCTZ 20-12.5mg, one tablets was not administered on 03/03/25 at 8:00am and on 03/15/25 at 7:00pm.	D 358		

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Review of Resident #3's May 2025 eMAR revealed:
-There was an entry for lisinopril-HCTZ 20-12.5mg, one tablet twice daily.
-There was no documentation lisinopril-HCTZ 20-12.5mg one tablet was administered twice daily on 05/02/25 and 05/07/25 at 7:00pm.
-There was no documentation why lisinopril-HCTZ 20-12.5mg, one tablets was not administered.

Interview with a representative from the facility's contracted pharmacy on 05/21/25 at 12:27pm revealed if Resident #3 did not receive lisinopril-HCTZ as prescribed she could have increased blood pressures.

Refer to the interview with the Administrator on 05/21/25 at 10:15am.

Refer to the interview with the Administrator on 05/21/25 at 2:40pm.

e. Review of Resident #3's Primary Care Provider's (PCP) orders dated 01/18/25 revealed an order for rosuvastatin (to lower cholesterol levels) 10mg at bedtime.

Review of Resident #3's PCP orders dated 04/22/25 revealed an order for rosuvastatin 10mg at bedtime.

Review of Resident #3's March 2025 eMAR revealed:
-There was an entry for rosuvastatin 10mg, one tablet at bedtime
-There was no documentation rosuvastatin 10mg, one tablet was on 03/15/25.
-There was no documentation why rosuvastatin 10mg was not administered.

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D 358	Continued From page 19 Review of Resident #3's May 2025 eMAR revealed: -There was an entry for rosuvastatin 10mg, one tablet at bedtime -There was no documentation rosuvastatin 10mg was administered on 05/02/25 and 05/07/25. -There was no documentation why rosuvastatin 10mg, one tablet was not administered. Interview with a representative from the facility's contracted pharmacy on 05/21/25 at 12:27pm revealed if Resident #3 did not receive rosuvastatin as prescribed she could have increased cholesterol levels or suffer a stroke. Refer to the interview with the Administrator on 05/21/25 at 10:15am. Refer to the interview with the Administrator on 05/21/25 at 2:40pm. 2. Review of Resident #5's current FL2 dated 03/12/25 revealed diagnoses included dementia with behaviors, schizophrenia and diabetes. Review of Resident #5's Resident Register revealed an admission date of 02/26/21. a. Review of Resident #5's PCP order on 03/12/25 revealed an order for clonazepam 0.25mg (for anxiety) by mouth twice a day. Review of Resident #5's May 2025 eMAR revealed: -There was an entry for clonazepam 0.25mg twice daily. -There was no documentation clonazepam 0.25mg was administered on 05/13/25 and 05/15/25. -There was no reason why clonazepam 0.25mg	D 358		

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was not administered.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 05/21/25 at 1:10pm revealed:
-Resident #5 was on cycle fill monthly for Clonazepam 0.25mg twice daily and received 60 tablets on 02/20/25, 03/15/25, 4/22/25, and 05/21/25.
-If Resident #5 did not receive Clonazepam he could become more anxious or psychotic.
date of 02/26/21.

b. Review of Resident #5's PCP order on 03/12/25 an order for eliquis (to prevent blood clots) 5mg one tablet by mouth twice a day.

Review of Resident #5's May 2025 eMAR revealed:
-There was an entry for eliquis 5mg twice daily.
-There was no documentation why eliquis 5mg was not administered to Resident #5 on 05/13/25 and 05/15/25.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 05/21/25 at 1:10pm revealed Resident #5 was on cycle fill monthly for eliquis 5mg twice day and received 60 tablets on 02/24/25, 03/24/25, 04/22/25 and 05/19/25.

c. Review of Resident #2's current FL2 dated 03/12/25 revealed diagnoses included Alzheimer's Disease, hypertension (high blood pressure) and asthma.

Review of Resident #2's Resident Register revealed an admission date of 06/06/24.

Review of Resident #2's PCP order on 03/12/25

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revealed an order for memantine (for memory loss) HCL 5mg by mouth twice daily.

Review of Resident #2's May 2025 eMAR revealed:
-There was an entry for memantine HCL 5mg by mouth twice daily.
-There was no documentation memantine 5mg was administered to Resident #2 on 05/03/25, 05/13/25 and 05/15/25.
-There was no documentation why memantine 5mg was not administered.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 05/21/25 at 1:10pm revealed:
-Resident #2 was on cycle fill monthly for memantine HCL 5mg twice daily and received 60 tablets on 02/24/25, 03/24/25, 4/22/25, and 05/10/25.
-If Resident #2 did not receive memantine she could become more confused.

Attempted telephone interview with the facility PCP was unsuccessful.

Refer to the interview with the Administrator on 05/21/25 at 10:15am.

Refer to the interview with the Administrator on 05/21/25 at 2:40pm.
3. Review of Resident #1's current FL2 dated 03/12/25 revealed diagnoses included hypertension (high blood pressure), peripheral vascular disease, anxiety, atrial fibrillation (an irregular heartbeat) and hyperlipidemia (high levels of fat particles in the blood).

Review of Resident #1's Resident Register revealed an admission date of 09/06/23.

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D 358	Continued From page 22 a. Review of Resident #1's Primary Care Provider's (PCP) orders dated 04/22/25 revealed an order for aspirin (to prevent a stroke) EC 81 mg one tablet daily. Review of Resident #1's May 2025 electronic Medication Administration Record (eMAR) revealed: -There was an entry for aspirin 81mg one tablet daily. -There was no documentation aspirin EC 81 mg one tablet was administered to Resident #1 on 05/03/25, 05/13/25 and 05/15/25. -There was no documentation why aspirin EC 81mg was not administered. Refer to the interview with the Administrator on 05/21/25 at 10:15am. Refer to the interview with the Administrator on 05/21/25 at 2:40pm. b. Review of Resident #1's PCP orders dated 04/22/25 revealed there was an order for carvedilol (for high blood pressure) 3.125 mg ½ tablet twice daily. Review of Resident #1's May 2025 eMAR revealed: -There was an entry for carvedilol 3.125 mg ½ tablet twice daily. -There was no documentation carvedilol 3.125 mg ½ tablet was administered on 05/3/25, 05/13/25 and 05/15/25. Refer to the interview with the Administrator on 05/21/25 at 10:15am. Refer to the interview with the Administrator on	D 358		

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D 358	Continued From page 23 05/21/25 at 2:40pm. c. Review of Resident #1's PCP orders dated 04/22/25 revealed: -There was an order for donepezil HCL (for memory loss) 10 mg daily at bedtime. Review of Resident #1's May 2025 eMAR revealed: -There was an entry for donepezil HCL 10mg tablet daily at bedtime. -There was no documentation donepezil HCL 10 mg was administered on 05/03/25, 05/13/25 and 05/15/25. Refer to the interview with the Administrator on 05/21/25 at 10:15am. Refer to the interview with the Administrator on 05/21/25 at 2:40pm. d. Review of Resident #1's PCP orders dated 04/22/25 revealed there was an order for eliquis (prevent blood clots and lower the risk of stroke) 5mg tablet twice daily. Review of Resident #1's May 2025 eMAR revealed: -There was an entry for Eliquis 5mg tablet twice daily. -There was no documentation eliquis 5mg tablet twice daily on 05/03/25, 05/13/25 and 05/15/25. -There was no documentation why eliquis 5mg was not administered.. Refer to the interview with the Administrator on 05/21/25 at 10:15am. Refer to the interview with the Administrator on 05/21/25 at 2:40pm.	D 358		

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e. Review of Resident #1's PCP orders dated 04/22/25 revealed there was an order for olanzapine (for mood disorders) 10mg tablet daily at bedtime.

Review of Resident #1's May 2025 eMAR revealed:
-There was an entry for olanzapine 10mg tablet daily at bedtime.
-There was no documentation olanzapine 10mg daily was administered on 05/03/25, 05/13/25 and 05/15/25.
-There was no documentation why olanzapine 10 mg was not administered.

Refer to the interview with the Administrator on 05/21/25 at 10:15am.

Refer to the interview with the Administrator on 05/21/25 at 2:40pm.

5. Review of Resident #4's current FL2 dated 01/18/25 revealed diagnoses included deep vein thrombosis (blood clot), debility, tachycardia (irregular heartbeat), diabetes type 2, depression and schizoaffective disorder (a condition including mood disorder symptoms)
.
Review of Resident #4's Resident Register revealed an admission date of 04/27/23.

a. Review of Resident #4's Primary Care Provider's (PCP) orders dated 01/18/25 revealed there was an order for metformin HCL (lower blood sugar levels) 500mg tablet twice daily.

-Review of Resident #4's March 2025 eMAR revealed:
-There was an entry for metformin HCL 500mg

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tablet twice daily.
-There was no documentation metformin HCL 500mg was administered on 03/03/25.
-There no documentation why metformin HCL was not administered.

Review of Resident #4's April 2025 eMAR revealed:
-There was an entry for metformin HCL 500mg tablet twice daily.
-There was no documentation metformin HCL 500mg was administered on 04/01/25, 04/18/25 and 04/22/25 at 5pm.
-There was no documentation why metformin HCL was not administered.

Review of Resident #4's May 2025 eMAR revealed:
-There was an entry for metformin HCL 500mg tablet twice daily.
-There was no documentation metformin HCL 500mg was administered on 05/09/25 and 05/15/25 at 5:00pm.
-There was no documentation why metformin HCL 500mg was not administered.

b. Review of Resident #4's PCP orders dated 01/18/25 revealed there was an order for omeprazole DR (to reduce stomach acid) 40mg capsule each morning.

Review of Resident #4's March 2025 eMAR revealed:
-There was an entry for omeprazole DR 40mg capsule each morning.
-There was no documentation omeprazole DR was administered on 03/ 08/25 and 03/23/25.
-There was no documentation why omeprazole DR 40mg was not administered.

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D 358	Continued From page 26 c. Review of Resident #4's PCP orders dated 01/18/25 revealed there was an order for atorvastatin (used to lower cholesterol) 40mg tablet daily at bedtime. -Review of Resident #4's May 2025 eMAR revealed: -There was an entry for atorvastatin 40mg tablet daily at bedtime. -There was no documentation atrovastatin 40mg tablet was documented as administered on 05/13/25 and 05/15/25. -There was no documentation why atorvastatin 40mg was not administered. d. Review of Resident #4's PCP orders dated 01/18/25 revealed there was an order for docusate sodium (used for managing and treating constipation) 100mg softgels two capsules at bedtime. -Review of Resident #4's May 2025 eMAR revealed: -There was an entry for docusate sodium100mg two capsules at bedtime. -There was no documentation docusate sodium 100mg was documented as administered on 05/13/25 and 05/15/25. -There was no documentation why docusate sodium 100mg was not administered. e. Review of Resident #4's PCP orders dated 01/18/25 revealed there was an order for nortriptyline HCL (used to treat depression) 50mg capsule at bedtime. -Review of Resident #4's May 2025 eMAR revealed: -There was an entry for nortriptyline HCL 50mg capsule at bedtime.	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 _____	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 27	D 358		

-There was no documentation nortriptyline HCL 50mg capsule was documented as administered on 05/13/25 and 05/15/25.
-There was no documentation why nortriptyline HCL 50mg was not administered.

Refer to the interview with the Administrator on 05/21/25 at 10:15am.

Refer to the interview with the Administrator on 05/21/25 at 2:40pm.

f. Review of Resident #4's PCP orders dated 0 1/18/25 revealed there was an order for pregabalin (for chronic nerve pain) 75 mg capsule twice daily.

-Review of Resident #4's May 2025 eMAR revealed:
-There was an entry for pregabalin 75mg capsule twice daily.
-There was no documentation pregabalin 75 mg capsule was administered on 05/13/25 and 05/15/25 at 8pm.
-There was no documentation why pregabalin 75mg capsule was not administered.

Refer to the interview with the Administrator on 05/21/25 at 10:15am.

Refer to the interview with the Administrator on 05/21/25 at 2:40pm.

g. Review of Resident #4's PCP orders dated 01/18/25 revealed there was an order for sulfasalazine (used to treat inflammatory bowel diseases and certain types of arthritis) tablet 500mg tablet twice daily.

-Review of Resident #4's May 2025 eMAR

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D 358	Continued From page 28 revealed: -There was an entry for sulfasalazine 500 mg tablet twice daily. -There was no documentation sulfasalazine 500mg tablet was documented as administered on 05/13/25 and 05/15/25 at 8pm. -There was no documentation why sulfasalazine 500mg tablet was not administered. Refer to the interview with the Administrator on 05/21/25 at 10:15am. Refer to the interview with the Administrator on 05/21/25 at 2:40pm. _____ Interview with the Administrator on 05/21/25 at 10:15am revealed: -Exceptions for medications not documented on the eMAR are not documented anywhere else in the resident record. -She wasn't aware of the number of missing medication documentation and didn't know why there were holes in medication documentation. -She believed the facility had been having trouble getting internet connections for eMARs in April and May 2025. -She believed the system would "automatically" record the missing medication entries when the internet was restored. -She had requested and received paper MARs from the pharmacy in April and May for the facility but they were not used due to restoration of the internet signal. Interview with the Administrator on 05/21/25 at 2:40pm revealed: -The medication aide (MA) was responsible for documenting the medications. -The RCC or the Administrator was responsible to audit the eMARs.	D 358		

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D 358	Continued From page 29 -She required the RCC to audit the eMARs weekly. -The previous RCC left the position April 2025, but a new RCC had been hired.	D 358		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules .0801 and .0802 of this Subchapter, the facility shall: (1) Within 30 days of admission to the special care unit and quarterly thereafter, develop a written resident profile containing assessment data that describes the resident's behavioral patterns, selfhelp abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) Develop or revise the resident's care plan required in Rule .0802 of this Subchapter based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that 2 of 3 sampled resident (#1 and #2) residing in the Special Care Unit (SCU) had a resident profile within 30 days of admission and quarterly thereafter. 1. Review of Resident #1's current FL2 dated	D 464		

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D 464	Continued From page 30 03/12/25 revealed: -Diagnoses included dementia, anxiety and hypertension (high blood pressure). -She was constantly disoriented. -The recommended level of care was SCU. Review of Resident #1's Resident Register revealed an admission date of 09/06/23. Review of Resident #1's record revealed: -There was no SCU resident profile completed within 30 days of admission and quarterly thereafter. -There was a care plan completed on 05/14/24. Refer to interview with the Administrator on 05/21/25 at 2:20pm. 2. Review of Resident #5's current FL2 dated 03/12/25 revealed: -Diagnoses included dementia with behavior disturbance, and schizoaffective disorder (a mental illness that causes persistent and intense changes in a person's mood, energy and behavior). -He was constantly disoriented. -The recommended level of care was SCU. Review of Resident #5's Resident Register revealed an admission date of 02/26/21. Review of Resident #5's record revealed: -There was no SCU resident profile completed within 30 days of admission and quarterly thereafter. -There was a care plan completed 04/22/25. Refer to interview with the Administrator on 05/21/25 at 2:20pm.	D 464		

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D 464	Continued From page 31 Interview with the Administrator on 05/21/25 at 2:20pm revealed: -She was aware the SCU resident profile was to be done prior to admission. -She was not aware the SCU resident care plan was to be done quarterly. -The resident care coordinator (RCC) or Special Care Coordinator (SCC) was responsible to complete them. -The SCC left her position in February 2025. -Her expectation was the SCU resident profile would be completed by the RCC or SCC within 30 days of SCU admission and quarterly thereafter. -In the absence of the SCC, she was responsible for ensuring the SCU profiles and quarterly profiles were completed.	D 464		