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MILL CREEK MANOR	1902 ORA DRIVE STATESVILLE, NC 28625

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D 000	Initial Comments The Adult Care Licensure Section and Iredell County Department of Social Services conducted an annual survey and complaint investigation from 11/28/23 to 12/01/23. The complaint investigation was initiated by Iredell County Department of Social Services on 11/15/23.	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: Interview with the lead cook on 11/28/23 at 10:00am revealed: -The facility did not have a Dietary Manager (DM). -She had not contacted the menu company to request therapeutic diet menus. -In the absence of a DM, the Administrator oversaw the kitchen.	D 130		

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D 130	Continued From page 1 Telephone interview with the Administrator on 12/01/23 at 2:55pm revealed: -The previous DM quit in June or July of 2023 and the facility did not currently have a DM. -The lead cook oversaw the kitchen but failed the ServeSafe certification test multiple times in the last three months. -One of the other cooks had not been able to pass the ServeSafe certification test after multiple attempts. -She was not ServeSafe certified. -The facility was looking to hire a DM or have a current cook become ServeSafe certified. -She expected the lead cook to come to her with any questions in the absence of a DM. -She was not aware the facility did not have any therapeutic diet menus.	D 130		
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: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to follow-up for 1 of 6 residents (#6) who had a history of seizures with an implanted vagal nerve stimulator (device used to treat difficult-to-control seizure disorders) without physician's orders for using the device, a missed an appointment with the neurologist and not notifying the neurologist of recent head trauma. Review of Resident #6's FL2 dated 11/16/23 revealed:	D 273		

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-Diagnoses included epilepsy (seizure disorder) and intractable encephalopathy (brain dysfunction).
-The recommended level of care was the Special Care Unit (SCU).
-He was constantly disoriented and had convulsions/seizures.

Review of Resident #6's Emergency Department (ED) documentation dated 11/05/23 revealed:
-Resident #6 was transported to the ED after throwing himself on the ground in the facility's dining room and possibly hitting his head.
-He reported pain at the top of his head and remembered having a seizure in the dining room.
-Resident #6 was evaluated for head trauma and seizures at the hospital but was determined to be back to his baseline and discharged to the facility.

Review of Resident #6's ED documentation dated 11/26/23 revealed:
-The resident was transported to the ED after a fall at the facility.
-Resident #6 had a head laceration (cut) from the fall and appeared postictal (the period of time immediately following a seizure).
-Resident #6 stated he had a seizure and the seizure caused the fall.

Review of Resident #6's hospital discharge documentation dated 11/29/23 revealed:
-The resident was admitted on 11/26/23 for evaluation of suspected seizure after a fall.
-The resident had a head laceration from the fall.
-He had a history of refractory (hard to manage) epilepsy with a mild seizure approximately every two weeks despite being on seizure medications.
-He had intermittent episodes of right-sided twitching of the upper eyelid, rolling up of his eyes followed by prolonged postictal lethargy

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(abnormal drowsiness).
-Resident #6 continued to have episodes of eye rolling and twitching movement of his eyelids even though his electroencephalogram (EEG)(a test to measure electrical activity in the brain) revealed no epileptic activity.
-Resident #6 would benefit from continuous EEG monitoring and was transferred to a second hospital for neurological consultation on 11/29/23.

Review of Resident #6's consulting hospital documentation revealed:
-Resident #6 was admitted on 11/29/23.
-Resident #6 had a seizure lasting 30 minutes on 11/30/23 and was transferred to the intensive care unit (ICU).
-A feeding tube was placed on 11/30/23 due to inadequate oral intake related to mental status and somnolence (excess sleepiness).

a. Review of Resident #6's hospital discharge paperwork dated 03/22/23 revealed Resident #6 had a past medical history of epilepsy with a vagus nerve stimulator (VNS).

Review of Resident #6's record on 11/28/23 revealed:
-There was a booklet titled "The VNS Therapy Magnet" that contained information on the care and use of the VNS magnet.
-There was not a physician's order for when or how to use the VNS magnet.

Interview with a medication aide (MA) on 11/29/23 at 2:54pm revealed:
-Resident #6 had a magnet that was supposed to be rubbed on his chest when he was having a seizure.
-She knew how to use Resident #6's VNS magnet since she went to a surgery with him

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several years ago.
-The facility had not provided training on how to use the VNS magnet for Resident #6.
-In September or October 2023, the Resident Care Director (RCD) or Administrator asked her to call Resident #6's neurologist to order more VNS magnets and obtain a physician's order for using the VNS magnet.
-The facility received Resident #6's VNS magnets but she was unsure if the physician's order was received since she had not seen it.
-The box that the VNS magnet was kept in did not have any instructions on how to use the magnet.

Telephone interview with Resident #6's Guardian on 11/29/23 at 9:39am revealed:
-Resident #6 had the VNS implanted prior to 2018, when she became his guardian.
-She thought the facility was aware of his VNS when Resident #6 was admitted in 2020.
-She visited the facility on 11/08/23, Resident #6 started seizing and only one staff member knew how to use the VNS magnet.
-After the seizure was over, she confirmed the staff member used the VNS magnet correctly and told the Administrator that all staff needed to be trained on how to use Resident #6's VNS magnet.
-She was not sure if the facility had a physician's order for using the VNS magnet to treat Resident #6's seizures.

Interview with the Special Care Unit Coordinator (SCC) on 12/01/23 at 2:26pm revealed:
-She started working at the facility in May 2022 and was promoted to SCC at the beginning of October 2023.
-On 11/08/23, Resident #6's Guardian told her Resident #6 had a VNS that used a magnet to decrease the length of seizures.
-There was an instruction manual for Resident

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#6's VNS magnet but she never received training on how use the VNS magnet.
-She was not aware the facility did not have a physician's order for how to use Resident # 6's VNS magnet since the RCD audited the residents' charts and electronic medication administration records (eMAR).

Interview with the RCD on 11/29/23 at 3:40pm revealed:
-She was not aware Resident #6 had a VNS until October 2023, when his Guardian told her about it and demonstrated how to use the VNS magnet.
-She assumed there was a physician's order for the VNS magnet and the it was on the eMAR.
-She did not ask any of the staff to order more VNS magnets for Resident #6.
-She was not aware until today (11/29/23) that the facility did not have an order for how to use the VNS magnet.
-She assumed the SCC knew how to use Resident #6's VNS magnet since the SCC had worked at the facility longer than she had.

Telephone interview with the Assistant Nurse Manager of Resident #6's neurology clinic on 11/30/23 at 12:42pm revealed:
-Resident #6's VNS was originally implanted in 2004 under the care of a different neurologist.
-Resident #6's first encounter with this neurology clinic was in May 2020.
-A VNS was used to prevent seizure activity in the brain and should be used according to the orders from Resident #6's neurologist and the education provided in the clinic.
-The success rate of stoping or decreasing the length of a seizure with the VNS magnet varied for each patient.
-Someone at Resident #6's facility contacted the VNS Coordinator on 11/07/23 to request VNS

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magnets.
-Yesterday (11/29/23) the facility requested a physician's order for how to use the VNS magnet but prior to that she could not find any documentation of requests for an order or education for Resident #6's VNS magnet.

Telephone interview with the Administrator on 12/01/23 at 2:55pm revealed:
-Resident #6's Guardian made her aware on 11/08/23, Resident #6 had a VNS and there was a magnet that needed to be used on his chest during a seizure.
-She was not sure if staff were ever trained how to use the VNS magnet when Resident #6 was seizing but one of the MAs knew to slide the magnet over his chest during a seizure.
-Resident #6's neurologist sent the facility an instruction manual for the VNS magnet but she was not aware the facility did not have a physician's order for using the device.
-She expected the RCD to request the physician's order for the VNS magnet when the additional VNS magnets were ordered in September or October 2023.

Attempted telephone interview with Resident #6's PCP on 11/30/23 at 11:18am was unsuccessful.

b. Review of Resident #6's hospital discharge paperwork dated 03/22/23 revealed:
-Resident #6's primary discharge diagnosis was refractory epilepsy with VNS.
-He did not experience any seizures during admission but remained at risk for seizures based on EEG readings and history of seizures.
-Resident #6 was scheduled to follow up at the neurology clinic on 07/31/23.

Review of Resident #6's record on 11/28/23

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revealed there was not a documented visit with his neurologist on 07/31/23.

Review of Resident #6's October 2023 progress notes revealed on 10/12/23 he was scheduled an appointment with his neurologist for 01/22/24 and his Guardian was made aware.

Telephone interview with an Assistant Nurse Manager at Resident # 6's neurologist's office on 11/30/23 at 12:42pm revealed:
-Resident #6 did not show up for his appointment on 07/31/23 and it had to be rescheduled for 01/22/24.
-The neurologist preferred to assess patients every six months and Resident #6 had not been assessed since his hospitalization from 03/20/23 to 03/22/23.
-If Resident #6 had increased seizure like symptoms then he would be at risk for brain injury and would be need to be evaluated sooner than his six month appointment.
-Increased seizure like symptoms may require an admission to the hospital's epilepsy monitoring unit for evaluation.
-Resident #6 was currently admitted in the hospital and was transferred to the neurology ICU today (12/01/23) to monitor for seizure activity.
-Resident #6's fall on 11/26/23 could have damaged his VNS since he hit his head.
-Resident #6's neurologist should have been notified of any falls that resulted in head trauma, specifically if the head trauma was accompanied with seizures.
-In the last eight months, the neurology clinic had not been notified of Resident #6 experiencing any head trauma.

Telephone interview with Resident #6's Guardian on 11/30/23 at 9:39am revealed:

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-She called the facility monthly to check on Resident #6.
-She was aware Resident #6 was scheduled to see his neurologist on 07/31/23.
-She visited the facility on 09/14/23 and could not find any notes from Resident #6's neurologist related to the appointment on 07/31/23.
-One of the personal care aides (PCA) told her Resident #6 missed his appointment due to trouble with transportation.
-She had a telephone call with the Administrator on 10/12/23 and the Administrator was not aware Resident #6 had missed an appointment with his neurologist.

Interview with the Activity Director on 12/01/23 at 9:47am revealed she started driving residents to their appointments in September 2023 and the previous driver no longer worked at the facility.

Interview with the SCC on 12/01/23 at 2:26pm revealed the RCD was responsible for making resident's appointments and contacting the medical providers.

Interview with the RCD on 12/01/23 at 3:47pm revealed:
-She was made aware Resident #6 missed his 07/31/23 appointment with his neurologist by Resident # 6's Guardian on 10/12/23.
-When she became the RCD at the end of July 2023, she could not read the appointment calendar and did not have the contact information for the staff member that made the calendar.
-She did not know how to find out which residents had appointments scheduled and did not contact their PCP to find out.
-On 10/12/23, she called to reschedule Resident #6's appointment with his neurologist and the earliest available appointment was on 01/22/24.

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D 273	Continued From page 9 -The MAs contacted Resident #6's PCP to inform her of falls/injuries but no one contacted Resident #6's neurologist to inform her of head trauma. Telephone interview with the Administrator on 12/01/23 at 2:55pm revealed: -She was not made aware of Resident #6's appointment with his neurologist on 07/31/23 until the appointment had passed. -The current RCD started at the end of July 2023 and the previous RCD's appointment calendar had the time the appointments were scheduled, but did not list who the appointments were for. -She contacted the previous RCD and the staff member who drove the van to try to figure which residents had appointments, but they were unable to help her. -She did not contact the doctor to see who had appointments scheduled. -The RCD and SCC were responsible for making the residents' appointments. Attempted telephone interview with Resident #6's PCP on 11/30/23 at 11:18am was unsuccessful. _____ The facility failed to ensure there was a physician's order to use Resident #6's VNS magnet, an assessment by his neurologist every six months and communication with his neurology clinic after any sustained head trauma, which resulted in possible damage to his VNS, hospitalization with admission to the neurology ICU for increased seizure monitoring and placement of a feeding tube due to somnolence (excess sleepiness). This failure resulted in substantial risk of serious physical harm and neglect to the resident and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in	D 273		

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D 273	Continued From page 10 accordance with G.S. 131D-21 on November 29, 2023. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 31, 2023.	D 273		
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 (#1, #2 and #5) with physician's orders for a pureed diet (#2) and a low concentrated sweets diet (#1 and #5). The findings are: 1. Review of Resident #1's current FL2 dated 11/01/23 revealed: -Diagnoses included insulin dependent diabetes mellitus. -Resident #1 had an order for a low concentrated sweet diet.	D 296		

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Review of the diet book in the kitchen revealed Resident #1 was ordered a pureed diet.

Review of the facility's week-at-glance menu revealed the regular diet's lunch meal for 11/29/23 was a beef patty with mushroom sauce, baked sweet potato, corn, baked roll and ice cream.

Observation of Resident #1's lunch meal service on 11/29/23 at 11:46am revealed:
-Resident #1 was served coffee with a sugar substitute, water, milk, a slice of bread, a packet of regular grape jelly, hamburger patty with mushroom sauce, baked sweet potato, creamed corn and chocolate ice cream.
-Resident #1 requested a second helping and he was served half of a hamburger patty with mushroom gravy, sweet potatoes and creamed corn.
-A resident that sat at the table with Resident #1 gave him an extra slice of bread.

Based on observation of the lunch meal service on 11/29/23, it could not be determined if Resident #1 was served the correct therapeutic diet due to no therapeutic diet menu available for staff guidance.

Refer to interview with a cook on 12/01/23 at 10:15am.

Refer to interview with the lead cook on 11/28/23 at 10:00am.

Refer to telephone interview with the Administrator on 12/01/23 at 2:55pm.

Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 11/30/23 at

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D 296	Continued From page 12 11:18am was unsuccessful. 2.Review of Resident #2's current FL2 dated 11/22/23 revealed: -Diagnoses included dementia and cognitive impairment. -She was constantly disoriented. -Her current level of care was the Special Care Unit (SCU). -She had a diet order for a pureed diet. -She had an order for mighty shakes two times a day. Review of the diet book in the kitchen revealed Resident #2 was ordered low concentrated sweets diet. Review of the facility's week-at-glance menu revealed the regular diet's lunch meal for 11/29/23 was a beef patty with mushroom sauce, baked sweet potato, corn, baked roll and ice cream. Observation of Resident #2's lunch meal service on 11/29/23 at 11:35am revealed she was served pureed beef, pureed sweet corn, pureed sweet potatoes, iced tea, water and ice cream. Based on observation of the lunch meal service on 11/29/23, it could not be determined if Resident #2 was served the correct therapeutic diet due to no therapeutic diet menu available for staff guidance. Refer to interview with a cook on 12/01/23 at 10:15am. Refer to interview with the lead cook on 11/28/23 at 10:00am.	D 296		

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Refer to telephone interview with the Administrator on 12/01/23 at 2:55pm.

Attempted telephone interview with Resident #2's PCP on 11/30/23 at 11:18am was unsuccessful.

3.Review of Resident #5's current FL2 dated 03/13/23 revealed:
-Diagnoses included vascular dementia.
-He was constantly disoriented.
-His current level of care was the SCU.
-He had a diet order for a diabetic normal diet.

Review of Resident #5's physician's orders dated 04/12/23 revealed a carborhydrate controlled diet.

Review of the diet book in the kitchen revealed Resident #5 was ordered a carbohydrate controlled diet.

Review of the facility's week-at-glance menu revealed the regular diet's lunch meal for 11/29/23 was a beef patty with mushroom sauce, baked sweet potato, corn, baked roll and ice cream.

Observation of Resident #5's lunch meal service on 11/29/23 at 11:35am revealed:
-He was served beef with gravy, corn, sweet potatoes, unsweetened, with only cinnamon on them, glass of milk, unsweetened tea and water.
-He refused his dessert of fruit.

Based on observation of the lunch meal service on 11/29/23, it could not be determined if Resident #5 was served the correct therapeutic diet due to no therapeutic diet menu available for staff guidance.

Refer to interview with a cook on 12/01/23 at

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D 296	Continued From page 14 10:15am. Refer to interview with the lead cook on 11/28/23 at 10:00am. Refer to telephone interview with the Administrator on 12/01/23 at 2:55pm. Attempted telephone interview with Resident #2's PCP on 11/30/23 at 11:18am was unsuccessful. _____ Interview with a cook on 12/01/23 at 10:15am revealed: -She served what was on the regular diet menu to all of the residents and pureed food for any residents who were ordered a pureed diet. -She did not have access to therapeutic diet menus since the facility changed menu companies a couple of months ago. Interview with the lead cook on 11/28/23 at 10:00am revealed: -The facility changed menu companies two to three months ago and the new menu company did not provide therapeutic diet menus. -She pureed the food listed on the regular diet menu for residents that were ordered a pureed diet. -She knew residents that were on diabetic diets were supposed to be served sugar free beverages, sugar free desserts and different portion sizes of certain foods. -Since she did not have a therapeutic diet menu for a low concentrated sweets diet or a carbohydrate controlled diet, residents ordered that diet received a regular diet with sugar free beverages. Telephone interview with the Administrator on 12/01/23 at 2:55pm revealed:	D 296		

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D 296	Continued From page 15 -The facility changed menu providers in September 2023 and she had not checked to see if there were any therapeutic diet menus in the kitchen since contracting with the new company. -The facility did not currently have a Dietary Manager so she would have expected the lead cook to inform her the kitchen did not have access to therapeutic diet menus in September 2023.	D 296		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure clarification of a medication order for 1 of 3 sampled residents (Resident #1) related to an order for a medication to lower blood glucose levels. The findings are: Review of Resident #1's current FL2 dated 11/01/23 revealed:	D 344		

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-Diagnoses included insulin dependent diabetes mellitus.
-There was an order to check the resident's fingerstick blood sugar (FSBS) four times daily, before meals and at bedtime.
-There was an order for novolog (a fast acting insulin to lower blood glucose levels), inject per sliding scale three times daily: FSBS: 140-180 = 1 units, 181-220 = 2 units, 221-260 = 3 units, 261-300 = 4 units, 301-340 = 5 units.

Review of Resident #1's September 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for novolog inject per sliding scale three times daily at 7:00am, 11:00am and 4:00pm: FSBS: 140-180 = 1 unit, 181-220 = 2 units, 221-260 = 3 units, 261-300 = 4 units, 301-340 = 5 units.
-There was no entry indicating how much insulin to administer if Resident #1's FSBS was greater than 340.
-There were 9 instances out of 90 opportunities when Resident #1's FSBS was greater than 340 and 5 units of sliding scale insulin was documented as administered.

Review of Resident #1's October 2023 eMAR revealed:
-There was an entry for novolog inject per sliding scale three times daily at 7:00am, 11:00am and 4:00pm: FSBS: 140-180 = 1 unit, 181-220 = 2 units, 221-260 = 3 units, 261-300 = 4 units, 301-340 = 5 units.
-There was no entry indicating how much insulin to administer if Resident #1's FSBS was greater than 340.
-There were 3 instances out of 93 opportunities when Resident #1's FSBS was greater than 340 and 5 units of sliding scale insulin was

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documented as administered.

Review of Resident #1's November 2023 eMAR revealed:
-There was an entry for novolog inject per sliding scale three times daily at 7:00am, 11:00am and 4:00pm: FSBS: 140-180 = 1 unit, 181-220 = 2 units, 221-260 = 3 units, 261-300 = 4 units, 301-340 = 5 units.
-There was no entry indicating how much insulin to administer if Resident #1's FSBS was greater than 340.
-There were 3 instances out of 82 opportunities when Resident #1's FSBS was greater than 340 and 5 units of sliding scale insulin was documented as administered.

Interview with Resident #1 on 12/01/23 at 2:07pm revealed:
-He received insulin because he had diabetes.
-He was unsure how much insulin staff administered to him.

Interview with Resident #1's Primary Care Provider (PCP) on 11/29/23 at 8:30am revealed:
-Resident #1 was followed by an outside endocrinologist for his diabetes and insulin orders.
-She instructed facility staff several times to follow up with Resident #1's endocrinologist for guidance on his blood sugar levels and insulin orders.

Telephone interview with a representative with the facility's contracted pharmacy on 11/30/23 at 4:01pm revealed:
-Resident #1 had a current order to receive novolog insulin three times daily with meals: FSBS: 140-180 = 1 unit, 181-220 = 2 units, 221-260 = 3 units, 261-300 = 4 units, 301-340 = 5

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D 344	Continued From page 18 units. -Resident #1 had orders for Novolog insulin because of his diagnosis of diabetes mellitus. -If Resident #1 received too little insulin he could have symptoms of thirst, frequent urination, and weakness. Interview with a medication aide (MA) on 12/01/23 at 2:13pm revealed she was trained by a previous Resident Care Director (RCD) when she was hired to give the maximum sliding scale insulin dose of 5 units if Resident #1's FSBS was greater than 340. Interview with the RCD on 12/01/23 at 3:48pm revealed: -It was her responsibility to get orders clarified when necessary. -She was not made aware Resident #1's sliding scale insulin order needed clarified. -She tried to do a random sampling of eMAR audits, approximately five residents, weekly. -There were times she got behind and did not complete the eMAR audits. Telephone interview with the Administrator on 12/01/23 at 2:55pm revealed: -The MAs and the RCD were responsible to get orders clarified when needed. -The RCD was responsible to audit medication orders and residents' eMARs weekly but she was unsure if she had completed them. Attempted telephone interview with Resident #1's endocrinologist on 12/01/23 at 9:07am was unsuccessful.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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D 358	Continued From page 19 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 review, the facility failed to ensure medications were administered as ordered for 3 of 5 sampled residents (#1, #3 and #5) related to a medication to help lower blood glucose levels (#1, #5) and a medication to treat major depressive disorder (#3). The findings are: 1. Review of Resident #5's current FL2 dated 03/13/23 revealed diagnoses included diabetes mellitus with chronic kidney disease and vascular dementia. Review of Resident #5's signed physician orders dated 06/09/23 revealed Fiasp 100 unit/ml, (used to control high blood sugar), Flextouch, inject sliding scale insulin (SSI) three times daily before breakfast, dinner, and bedtime per sliding scale: fingerstick blood sugar (FSBS) 80-150 = 3 units, 151-200 = 4 units, 201-250 = 5 units, 251-300 = 6 units, 301-350 = 7 units, 351-400 = 8 units, 401-450 = 9 units, 451-500 = 10 units, greater than 501 = 11 units. Review of Resident #5's September 2023 electronic medical record (eMAR) revealed:	D 358		

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-His FSBS on 09/06/23 at bedtime was 71 and he received 6 units of Fiasp 100 units/ml when he should have received 0 units.
-His FSBS on 09/26/23 before breakfast was 155 and he received 3 units of Fiasp 100 units/ml when he should have received 4 units.

Review of Resident #5's current signed physician order dated 09/27/23 revealed Novolog 100 unit/ml, (a rapid acting insulin) Flexpen, inject SSI three times daily before breakfast, lunch, and dinner per sliding scale: FSBS: 80-150= 3 units, 151-200 = 4 units, 201-250 = 5 units, 251-300 = 6 units, 301-350 = 7 units, 351-400 = 8 units, 401-450 = 9 units, 451-500 = 10 units, greater than 501 = 11 units.

Review of Resident #5's October 2023 eMAR revealed:
-His FSBS on 10/02/23 before breakfast was 147 and he received 4 units of Novolog 100 units/ml, when he should have received 3 units.
-From 10/05/23-10/31/23 there was documentation that FSBS were checked 54 times and no SSI was administered on 81 opportunities.

Review of Resident #5's November 2023 eMAR revealed from 11/01/23-11/29/23 there was documentation that FSBS were checked 40 times and no SSI was administered on 85 opportunities.

Interview with a medication aide (MA) on 11/30/23 at 9:30am revealed:
-There was a spot to put the SSI on the eMAR when the resident was getting Fiasp but after the change to Novolog there was not a place to put the SSI.
-She made the staff aware of this issue in a staff meeting but could not remember if the Special Care Unit Coordinator (SCC) or the Administrator

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were there.
-She documented the SSI on a diabetic log daily and the logs went to the Resident Care Director's (RCD) office.
-If she made an error on giving SSI, she probably would not know it because she was not aware of anyone checking the eMARs.

Interview with the SCC on 12/01/23 at 2:30pm revealed:
-The Pharmacy put the orders on the eMARs.
-She was not aware the eMAR did not have a spot to document the SSI.
-She had not audited charts yet as she was still learning her job.
-It was her responsibility to audit the Special Care Unit charts.
-She was aware a SSI log was completed daily but did not know where the missing logs were.

Interview with the RCD on 12/01/23 at 2:53pm revealed:
-She was not aware the SSI was not documented on the eMAR.
-She did random audits weekly on physician orders and eMARs.
-The SCC was being trained to audit the charts.

Telephone interview with the Administrator on 12/01/23 at 2:55pm revealed:
-She was not aware the SSI was not documented on the eMAR.
-There had not been any auditing of the SSI on the eMARs that she was aware of.
-She did a random audit of the eMARs weekly.
-The RCD, MA and SCC will be auditing the eMARs for SSI.

Telephone interview with a Pharmacist from the facility's contracted pharmacy on 12/01/23 at

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D 358	Continued From page 22 9:24am revealed: -Resident #5's SSI order was Novolog Flexpen 100 unit/ml, check FSBS before each meal and inject SSI per sliding scale: 80-150= 3 units, 151-200 = 4 units, 201-250 = 5 units, 251-300 = 6 units, 301-350 = 7 units, 351-400 = 8 units, 401-450 = 9 units, 451-500 = 10 units, greater than 501 = 11 units. -Novolog Flexpen 100 unit/ml, 5 pens were filled on 10/04/23. -She was not aware there was not a spot on the eMAR for SSI documentation. -If not enough SSI was given, he could have nausea and vomiting, drowsiness and maybe some agitation. -If too much SSI was given, the resident could be disoriented. Attempted telephone interview with Resident #5's Endocrinologist on 12/01/23 at 11:01am was unsuccessful. Attempted telephone interview with Resident #5's Primary Care Provider (PCP) on 12/01/23 at 11:05am was unsuccessful. 2. Review of Resident #1's current FL2 dated 11/01/23 revealed: -Diagnoses included insulin dependent diabetes mellitus. -There was an order to check the resident's fingerstick blood sugar (FSBS) four times daily, before meals and at bedtime. -There was an order for novolog (a rapid acting insulin used to lower elevated blood sugar levels) inject 12 units daily with breakfast and give half the dose if FSBS was less than 90. -There was an order for novolog inject 10 units twice daily with lunch and supper and give half the dose if FSBS was less than 90.	D 358		

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-There was an order for novolog inject per sliding scale three times daily: FSBS: 140-180 = 1 units, 181-220 = 2 units, 221-260 = 3 units, 261-300 = 4 units, 301-340 = 5 units.

Review of Resident #1's Primary Care Provider's (PCP) orders dated 06/21/23 revealed:
-There was an order to check the resident's fingerstick blood sugar (FSBS) four times daily, before meals and at bedtime.
-There was an order for novolog (a rapid acting insulin used to lower elevated blood sugar levels) inject 12 units daily with breakfast and give half the dose if FSBS was less than 90.
-There was an order for novolog inject 10 units twice daily with lunch and supper and give half the dose if FSBS was less than 90.
-There was an order for novolog inject per sliding scale three times daily: FSBS: 140-180 = 1 units, 181-220 = 2 units, 221-260 = 3 units, 261-300 = 4 units, 301-340 = 5 units.

Review of Resident #1's September 2023 electronic Medication Administration Record (eMAR) revealed:
-There was an entry to check Resident #1's FSBS before meals and at bedtime, at 6:30am, 11:30am, 4:30pm and 8:00pm from 09/01/23 to 09/18/23 and at 6:00am, 11:00am, 4:00pm and 8:00pm from 09/19/23 to 09/30/23.
-There was an entry to inject novolog 12 units daily with breakfast and give half the dose if FSBS was less than 90 scheduled at 8:00am.
-There was an entry to inject novolog 10 units twice daily with lunch and supper and give half the dose if FSBS was less than 90 scheduled at 12:00pm and 6:00pm from 09/01/23 to 09/27/23 and at 11:00am and 4:00pm from 09/28/23 to 09/30/23.
-There was an entry for novolog inject per sliding

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scale three times daily: FSBS: 140-180 = 1 units, 181-220 = 2 units, 221-260 = 3 units, 261-300 = 4 units, 301-340 = 5 units.
-On 09/01/23 at 8:00am, the resident's FSBS was 87 and the resident received 12 units of novolog insulin when the orders stated he should have received 6 units.
-On 09/04/23 at 8:00am, the resident's FSBS was 198 and the resident received 11 units of novolog insulin when the orders stated he should have received 14 units.
-On 09/05/23 at 12:00pm, the resident's FSBS was 84 and the resident received 10 units of novolog insulin when the orders stated he should have received 5 units.
-On 09/07/23 at 8:00am, the resident's FSBS was 147 and the resident received 12 units of novolog insulin when the orders stated he should have received 13 units.
-On 09/07/23 at 4:30pm, the resident's FSBS was 175 and the resident received 12 units of novolog insulin when the orders stated he should have received 11 units.
-On 09/12/23 at 8:00am, the resident's FSBS was 299 and the resident received 14 units of novolog insulin when the orders stated he should have received 16 units.
-On 09/15/23 at 12:00pm, the resident's FSBS was 75 and the resident received 10 units of novolog insulin when the orders stated he should have received 5 units.
-On 09/17/23 at 8:00am, the resident's FSBS was 200 and the resident received 12 units of novolog insulin when the orders stated he should have received 14 units.
-On 09/18/23 at 6:00pm, the resident's FSBS was 195 and the resident received 11 units of novolog insulin when the orders stated he should have received 12 units.
-On 09/19/23 at 12:00pm, the resident's FSBS

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was 76 and the resident received 10 units of novolog insulin when the orders stated he should have received 5 units.
-On 09/22/23 at 8:00am, the resident's FSBS was 190 and the resident received 12 units of novolog insulin when the orders stated he should have received 14 units.
-On 09/23/23 at 8:00am, the resident's FSBS was 111 and the resident received no novolog insulin, with a notation it was "withheld per DR/RN orders", when the orders stated he should have received 12 units.
-On 09/27/23 at 8:00am, the resident's FSBS was 246 and the resident received 13 units of novolog insulin when the orders stated he should have received 15 units.
-On 09/30/23 at 8:00am, the resident's FSBS was 67 and the resident received 12 units of novolog insulin when the orders stated he should have received 6 units.

Review of Resident #1's October 2023 eMAR revealed:
-There was an entry to check Resident #1's FSBS before meals and at bedtime, at 6:00am, 11:00am, 4:00pm and 8:00pm.
-There was an entry to inject novolog 12 units daily with breakfast and give half the dose if FSBS was less than 90 scheduled at 8:00am.
-There was an entry to inject novolog 10 units twice daily with lunch and supper and give half the dose if FSBS was less than 90 scheduled at 11:00am and 4:00pm.
-There was an entry for novolog inject per sliding scale three times daily: FSBS: 140-180 = 1 units, 181-220 = 2 units, 221-260 = 3 units, 261-300 = 4 units, 301-340 = 5 units.
-On 10/02/23 at 8:00am, the resident's FSBS was 205 and the resident received 16 units of novolog insulin when the orders stated he should have

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MILL CREEK MANOR	1902 ORA DRIVE STATESVILLE, NC 28625

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received 14 units.
-On 10/03/23 at 8:00am, the resident's FSBS was 206 and the resident received 11 units of novolog insulin when the orders stated he should have received 14 units.
-On 10/05/23 at 8:00am, the resident's FSBS was 86 and the resident received no novolog insulin, with a notation it was "withheld per DR/RN orders", when the orders stated he should have received 6 units.
-On 10/06/23 at 11:00am, the resident's FSBS was 162 and the resident received 12 units of novolog insulin when the orders stated he should have received 11 units.
-On 10/08/23 at 4:00pm, the resident's FSBS was 232 and the resident received 14 units of novolog insulin when the orders stated he should have received 13 units.
-On 10/12/23 at 8:00am, the resident's FSBS was 83 and the resident received no novolog insulin, with a notation it was "withheld per DR/RN orders", when the orders stated he should have received 6 units.
-On 10/21/23 at 11:00am, the resident's FSBS was 78 and the resident received no novolog insulin, with a notation it was "withheld per DR/RN orders", when the orders stated he should have received 5 units.
-On 10/22/23 at 11:00am, the resident's FSBS was 77 and the resident received no novolog insulin, with a notation it was "withheld per DR/RN orders", when the orders stated he should have received 5 units.

Review of Resident #1's November 2023 eMAR revealed:
-There was an entry to check Resident #1's FSBS before meals and at bedtime, at 6:00am, 11:00am, 4:00pm and 8:00pm.
-There was an entry to inject novolog 12 units

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daily with breakfast and give half the dose if FSBS was less than 90 scheduled at 8:00am.
-There was an entry to inject novolog 10 units twice daily with lunch and supper and give half the dose if FSBS was less than 90 scheduled at 11:00am and 4:00pm.
-There was an entry for novolog inject per sliding scale three times daily at 7:00am, 11:00am and 4:00pm: FSBS: 140-180 = 1 units, 181-220 = 2 units, 221-260 = 3 units, 261-300 = 4 units, 301-340 = 5 units.
-On 11/01/23 at 11:00am, the resident's FSBS was 75 and the resident received no novolog insulin, with a notation it was "withheld per DR/RN orders", when the orders stated he should have received 5 units.
-On 11/01/23 at 4:00pm, the resident's FSBS was 196 and the resident received 11 units of novolog insulin when the orders stated he should have received 12 units.
-On 11/02/23 at 11:00am, the resident's FSBS was 59 and the resident received no novolog insulin, with a notation it was "withheld per DR/RN orders", when the orders stated he should have received 5 units.
-On 11/09/23 at 11:00am, the resident's FSBS was 86 and the resident received no novolog insulin, with a notation it was "withheld per DR/RN orders", when the orders stated he should have received 5 units.
-On 11/13/23 at 4:00pm, the resident's FSBS was 222 and the resident received 12 units of novolog insulin when the orders stated he should have received 13 units.
-On 11/20/23 at 11:00am, the resident's FSBS was 77 and the resident received 10 units of novolog insulin when the orders stated he should have received 5 units.
-On 11/21/23 at 11:00am, the resident's FSBS was 67 and the resident received 10 units of

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novolog insulin when the orders stated he should have received 5 units.
-On 11/24/23 at 8:00am, the resident's FSBS was 113 and the resident received no novolog insulin, with a notation it was "withheld per DR/RN orders", when the orders stated he should have received 12 units.
-On 11/26/23 at 11:00am, the resident's FSBS was 79 and the resident received 10 units of novolog insulin when the orders stated he should have received 5 units.

Interview with Resident #1 on 12/01/23 at 2:07pm revealed:
-He received insulin because he had diabetes.
-He was unsure how much insulin staff administered to him.

Interview with Resident #1's PCP on 11/29/23 at 8:30am revealed:
-Resident #1 was followed by an outside endocrinologist for his diabetes and insulin orders.
-She had instructed facility staff several times to follow up with Resident #1's endocrinologist for guidance on his blood sugar levels and insulin orders.

Telephone interview with a representative with the facility's contracted pharmacy on 11/30/23 at 4:01pm revealed:
-Resident #1 had a current order to receive novolog insulin 12 units daily with breakfast and to give a half dose if his FSBS was less than 90.
-Resident #1 had a current order to receive novolog insulin 10 units twice daily at lunch and supper and to give a half dose if his FSBS was less than 90.
-Resident #1 had a current order to receive novolog insulin three times daily with meals:

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FSBS: 140-180 = 1 unit, 181-220 = 2 units, 221-260 = 3 units, 261-300 = 4 units, 301-340 = give 5 units.
-Resident #1 had orders for Novolog insulin because of his diagnosis of diabetes mellitus.
-If Resident #1 received more insulin than ordered he could have a low blood sugar level and pass out.
-If Resident #1 received too little insulin he could have symptoms of thirst, frequent urination, and weakness.

Interview with a medication aide (MA) on 12/01/23 at 2:13pm revealed:
-She should have given Resident #1 half his dose of novolog insulin on 11/02/23 and 11/09/23 at 11:00am.
-She was unsure why she held Resident #1's novolog insulin on 11/02/23 and 11/09/23 at 11:00am.
-She read the medication orders on the eMAR prior to administering medications but was unsure if she administered Resident #1's insulin incorrectly or if she documented the administration incorrectly.

Interview with the Resident Care Director (RCD) on 12/01/23 at 3:48pm revealed:
-The MAs were trained upon hire to read each medication order on the eMAR before administration of a medication.
-She tried to do a random sampling of eMAR audits, approximately five residents, weekly.
-There were times she got behind and did not complete the eMAR audits.

Telephone interview with the Administrator on 12/01/23 at 2:55pm revealed:
-She expected medications to be administered as ordered.

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-The RCD was responsible to audit resident eMARs weekly but she was unsure if she had completed them.

Attempted telephone interview with Resident #1's endocrinologist on 12/01/23 at 9:07am was unsuccessful.

3. Review of Resident #3's current FL2 dated 06/21/23 revealed diagnoses included major depressive disorder.

Review of Resident #3's physician's orders dated 11/06/23 revealed:
-An order to discontinue trazadone 50 mg (a medication used to treat major depressive disorder and difficulties with sleep).
-An order for trazadone 100 mg before bedtime, hold if asleep or sedated.

Review of Resident #3's November 2023 electronic medication administration record (eMAR) revealed:
-An entry dated 11/07/23 for trazadone 100 mg every night at bedtime, hold if sedated or drowsy or asleep, scheduled at 8:00pm.
-Trazadone 100 mg was documented as administered from 11/08/23 to 11/13/23, on 11/16/23 and from 11/27/23 at 8:00pm.
-Trazadone 100 mg was documented as not administered from 11/14/23 to 11/15/23 and from 11/17/23 to 11/20/23, with comments stating "other -see note".
-There was documentation Resident #3 was out of the facility November 21, 2023 through November 27, 2023.

Review of Resident #3's November 2023 progress notes revealed there were not any notes related to why trazadone 100 mg was not

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administered.

Review of Resident #3's medications on the medication cart on 11/29/23 at 10:54am revealed trazadone 100 mg was not available to be administered.

Interview with Resident #3 on 12/01/23 at 10:20am revealed she wasn't sure if she had missed any doses of trazadone since the facility handled her medications.

Interview with a medication aide (MA) on 12/01/23 at 2:10pm revealed:
-She used the code "other-see note" on Resident #3's eMAR when the medication was not available to administer.
-The Administrator did not want the MAs to document that the medication was not in the facility, so she did not write a note and continued passing medications.
-The MAs were able to order medication through the eMAR system if the wi-fi was connected; however, the wi-fi connection was often unreliable.
-She did not tell the Resident Care Director (RCD) that Resident #3 did not have any trazadone 100 mg in the facility since she was able to order the medication on her own.

Interview with the RCD on 12/01/23 at 3:47pm revealed:
-If a medication was not available to administer the MA should have ordered the medication through the eMAR system or called the pharmacy to order the medication.
-While waiting for medication to arrive from the pharmacy, the MA should have chosen the code "waiting on pharmacy" on the eMAR.
-If the wi-fi connection prevented an MA from

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ordering the medication through the eMAR, the pharmacy should have been called that day to order the medication.
-She audited the medication cart on Mondays and Wednesdays by selecting a sample of five residents and comparing the medications with the physician's orders.
-She was not aware Resident #3's trazadone 100 mg had not been available to administer for several days.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/30/23 at 9:17am revealed:
-Resident #3 had an order for trazadone 100 mg at bedtime, hold if sedated or asleep.
-The pharmacy dispensed 35 tablets of trazadone 100 mg to the facility on 11/07/23.
-The facility called the pharmacy after Thanksgiving requesting trazadone because Resident #3 went home for Thanksgiving with her medications, and she returned to the facility without her trazadone.
-The pharmacy dispensed 8 tablets of trazadone 100 mg to the facility on 11/29/23.

Telephone interview with the Administrator on 12/01/23 at 2:55pm revealed:
-She expected the MAs to administer medications as ordered by the physician.
-If a medication was not available to be administered then the MA should have ordered the medication from the pharmacy.
-If a medication could not be ordered the MA should have informed the RCD.
-Resident #3's missing trazadone should have been identified on a weekly medication cart audit by the RCD.

Attempted telephone interview with Resident #3's

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D 358	Continued From page 33 Primary Care Provider (PCP) on 11/30/23 at 11:18am was unsuccessful.	D 358		
D 463	10A NCAC 13F .1306 Admission To The Special Care Unit 10A NCAC 13F .1306 Admission To The Special Care Unit In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit: (1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served. (2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit. (3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a pre-admission screening was completed upon admission for 1 of 3 sampled residents (#4) who resided in the Special Care Unit (SCU). The findings are: Review of Resident #4's current FL2 dated	D 463		

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D 463	Continued From page 34 11/22/23 revealed: -Diagnoses included early dementia and cognitive impairment. -He was intermittently disoriented. -The recommended level of care was the SCU. -His current level of care is the SCU. Review of Resident #4's resident register revealed an admission date of 07/26/23. Review of Resident #4's record revealed there was no SCU pre-admission screening. Telephone interview with Resident #4's guardian on 11/29/23 at 2:24pm revealed: -He was showing signs of agitation and forgetfulness when he was in assisted living. -He was in the best place because of his early dementia and agitation. Interview with the Special Care Unit Coordinator (SCC) on 12/01/23 at 2:30pm revealed: -She was not aware Resident #4 did not have a pre-admission screening. -She had not audited any SCU charts yet but would be auditing them monthly. Interview with the Resident Care Director (RCD) on 12/01/23at 2:53pm revealed: -She was not aware Resident #4 did not have a pre-admission screening. -She had not audited the SCU charts for pre-admission screening. -The SCC would be auditing the SCU charts monthly. -It was the responsibility of the RCD to audit the charts until the SCC finished her training. Telephone interview with the Administrator on 12/01/23 at 2:55pm revealed:	D 463		

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D 463	Continued From page 35 -She was not aware Resident #4 did not have a pre-admission screening. -It was the responsibility of the RCD and SCC to audit the charts. -The charts should be audited monthly but sometimes it did not get done.	D 463		
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 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised 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 residents (#4 and #5) residing in the Special Care Unit (SCU) had a resident profile within 30 days of admission and quarterly thereafter.	D 464		

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D 464	Continued From page 36 The findings are: 1. Review of Resident #4's current FL2 dated 11/22/23 revealed: -Diagnoses included early dementia and cognitive impairment. -He was intermittently disoriented. -The recommended level of care was the SCU. Review of Resident #4's resident register revealed he was admitted on 07/26/23. Review of Resident #4'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 08/02/23. Refer to interview with the Special Care Unit Coordinator (SCC) on 12/01/23 at 2:30pm. Refer to interview with the Resident Care Director (RCD) on 12/01/23 at 2:53pm. Refer to telephone interview with the Administrator on 12/01/23 at 2:55pm. 2. Review of Resident #5's current FL2 dated 03/13/23 revealed: -Diagnoses included vascular dementia. -He was constantly disoriented. -The recommended level of care was the SCU. Review of Resident #5's resident register revealed he was admitted on 04/10/23. Review of Resident #5's record revealed: -There was a care plan completed 04/12/23. -There was a SCU resident profile completed on 04/10/23.	D 464		

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D 464	Continued From page 37 -There was no SCU resident profile completed quarterly after the admission SCU Resident Profile. Refer to interview with the SCC on 12/01/23 at 2:30pm. Refer to interview with the RCD on 12/01/23 at 2:53pm. Refer to telephone interview with the Administrator on 12/01/23 at 2:55pm. _____ Interview with the SCC on 12/01/23 at 2:30pm revealed: -She was not aware Resident #4 did not have a resident profile completed on admission and quarterly therafter. -She was not aware Resident #5 did not have a resident profile completed quarterly. -She had not audited any SCU charts yet but would be auditing them monthly. -The resident profile for Resident #5 was in a folder waiting to be signed by the Primary Care Physician (PCP). Interview with the RCD on 12/01/23at 2:53pm revealed: -She took over very quickly in July 2023 when the last RCD left and did not know Resident #4 did not have a resident profile completed on admission and quarterly thereafter. -She was not aware Resident #5 did not have a resident profile completed quarterly. -She had not audited the SCU charts for resident profiles. -The SCC would be auditing the SCU charts for the resident profiles monthly. -It was the responsibility of the RCD to audit the	D 464		

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D 464	Continued From page 38 charts until the SCC finished her training. Telephone interview with the Administrator on 12/01/23 at 2:55pm revealed: -She was not aware Resident #4 did not have a resident profile completed on admission and quarterly therafter. -She was not aware Resident #5 did not have a resident profile completed quarterly. -She was not aware a resident profile had to be done on SCU residents quarterly. -It was the responsibility of the RCD and SCC to audit the charts. -The charts should be audited monthly but sometimes it did not get done.	D 464		