	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		E SURVEY IPLETED	
				<u> </u>		с		
		345473	B. WING			08	3/21/2015	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
				60	001 WILORA LAKE ROAD			
	AKE HEALTHCARE (JENTER		C	HARLOTTE, NC 28212			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TION SHOULD BE COMPLET THE APPROPRIATE DATE		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS		F	281			9/29/15	
	The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and							
	physician interview	eview, staff interview and / the facility failed to follow an :tion of a wound culture for 1 of			Resident # 20 no longer resides at the facility.			
	1 resident (Resider Findings included: Resident #20 was	nt #20). admitted to the facility on			Residents with wounds have the potent to be affected by the alleged deficient practice.	tial		
	7/11/2015 and disc on 8/2/2015. Diagr	charged to an acute care facility noses included Ulcers of the			The Director of Clinical Services			
	Failure, Diabetes,	Venous Thrombosis, Heart Venous insufficiency,			completed a review on 8-28-15 of curre residents with wounds to validate that a	any		
	Noninfectious Lym				wound culture orders received within th			
		18/2015 revealed Resident #20			past 30 days were obtained, collected,			
		act. She required extensive o staff members for bed			documented and results reported to the physician with any new orders carried of			
		ing, extensive assistance from			as indicated by the licensed nurse. No	Jui		
		for personal hygiene, total			further deficient practice was identified	as		
		o staff members with toileting,			a result of the audit.			
	and transferring (m	noves between surfaces)						
	-	e or twice in the 7 day look back			The Director of Clinical Services			
	•	20 was coded on the MDS as			reeducated licensed nurses currently			
		r open lesions, no pressure			staffing the facility by 9-28-15 on the			
		ous and arterial ulcers.			policy and procedure of obtaining, collecting, documenting and reporting			
		the Care Plan for Resident #20 ategory of skin/wound. The			wound cultures results to the prescribin	a		
		he disease process of leg			physician and carrying out new orders	ษ		
		an approaches included obtain			timely as indicated by the licensed nurs	e.		
		agnostic work as ordered. The			Any licensed nurse who did not receive			
		ed 7/11/2015 included the			the training by 9-28-15 will receive prior			
		will show signs of healing and			the next scheduled shift. The Nurse			
	remain free from in	fection through the next			Manager will maintain a log of all wound	d		
	review.				culture orders to validate that wound		1	

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

09/14/2015

		MEDICAID SERVICES				38-03
	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>		(X3) DATE SURVI COMPLETED	
			A. BUILDING	<u> </u>	с	
		345473	B. WING		08/21/20)15
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				6001 WILORA LAKE ROAD		
WILORA	LAKE HEALTHCARE CEI	NIEK		CHARLOTTE, NC 28212		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COM	(X5) IPLETIO DATE
F 281	Continued From page	a 1	F 28	21		
1 201			F 20			
	A record review of a p	l laboratory order for a left		cultures were obtained, collected documented and results reported		
	leg wound culture and	-		prescribing physician with any ne		
	-	e was unavailable for an		carried out as indicated by the lic		
	interview.			nurse. The Director of Clinical Se		
		4 AM an interview with		will conduct a weekly wound mee		
		led she was unable to find		inclusive of a Nurse Manager, Mi		
	-	records showing that the		Data Set (MDS) Nurse and Dieta		
		otained. She reported the lab		Manager to review residents with		
		der was missed, and the lab		to verify that wound cultures are		
	did not have results.			completed timely and accurately	per	
A	A nurse note dated 8	/2/2015 included (in part)		physician orders. The physicians	s; weekly	
	Resident (#20) was noted with increased	noted with increased		wound rounding notes will also b	e	
		(#20) sent to Emergency		reviewed during the weekly wour		
		ation. At 10:30 PM the nurse		meeting to validate that all wound		
		he hospital and documented		orders were accurately identified	and	
		eing admitted to intensive		transcribed, as indicated.		
		d to infection in wounds				
	bilaterally.			The Director of Clinical Services/		
		e hospital records dated		Manager trained Licensed nurse		
		for Resident #20 revealed		currently working at the facility or		
		acute care hospital with . Resident #20 had a history		¿Red Line¿ system (a system whi night shift audits each record for		
	of diabetes type II, ch			transcription of orders and misse		
		tremity wounds with a history		by 9/28/15.		
		pathogens. Resident #20				
		emity ulcerations in February		The Director of Clinical Services	or Unit	
	-	e burn center. She was		Manager will conduct Quality		
		nospital and was residing in		Improvement monitoring of 5 resi	dent	
	-	ity. Per family she was not		records, MARs, and TARs for cor		
	on antibiotics in the n			with appropriate transcription and	t i	
		ent records from 8/2/2015		documentation of physician order		
		en purulent thick fluid in her		medication/treatment documenta	tion and	
		Physician noted he did " not		the presence of the Red Line		
	-	ad appropriate wound care		documentation 3 times a week for		
		". The Microbiology culture		weeks, then 3 records 3 times a		
		ined at the hospital and		4 weeks, then 3 records 1 time a		
		included heavy growth of		4 weeks. The quality monitoring		
	Pseudomonas Aerug	inosa (bacteria) scant	1	documented on a Quality Assura	nce and	

Facility ID: 923567

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345473	B. WING				C 21/2015
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
				6	001 WILORA LAKE ROAD		
	AKE HEALTHCARE CEN	NIER		c	HARLOTTE, NC 28212		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 281	and one colony of Sta Methicillin Resistant (ter Baumannii (pathogen),	F	281	Performance Improvement Monitoring Tool. The Director of Clinical Services will complete Quality Improvement monitor of physicians; orders for residents with wounds 5x/week for 4 weeks, 1x/week 2 months, then monthly for 3 months to validate that any wound cultures for residents with wounds were obtained, collected, documented and results reported to the prescribing physician w any new orders carried out as indicated the licensed nurse. The Quality Improvement monitoring will be documented on a Quality Assurance an Performance Improvement Monitor Too The Director of Clinical Services will report audit results monthly to the Qua Assurance Performance Improvement (QAPI) committee for 6 months or until substantial compliance is obtained. The QAPI committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, an make changes to the corrective action	n for o ith d by nd ol. lity e	
F 309 SS=G	483.25 PROVIDE CA HIGHEST WELL BEII		F	309	necessary.		9/29/15
	provide the necessary or maintain the higher mental, and psychoso	eceive and the facility must y care and services to attain st practicable physical, ocial well-being, in comprehensive assessment					

Facility ID: 923567

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES					NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		ATE SURVEY OMPLETED
		345473	B. WING				C 08/21/2015
NAME OF PF	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	AKE HEALTHCARE CEI	NTER		6001 WILORA LAKE ROAD			
				C	CHARLOTTE, NC 28212		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 309	Continued From page	e 3	F	309			
		「 is not met as evidenced					
	by: Based on record rev physician interview, f observation the facilit			Resident # 20 no longer resides in the facility.	e		
	wound care as orderer residents (Resident # infection and hospital			A medication error report was completed by the Director of Clinical Services on 8-20-15 for resident #10 and resident			
	(OxyContin) to allevia	duled pain medication ate chronic pain, for 5 3 residents (Resident #10) ng.			continue to have medications administered timely per physicians; orders.		
	Findings Included: 1) Resident #20 was	admitted to the facility on arged to an acute care facility			Current residents have the potential to affected by the alleged deficient practi A skin assessment was completed on	ce.	
	on 8/2/2015. Diagnos	ses included Ulcers of the mous Thrombosis, Heart			each resident by a licensed nurse by 9-23-15 utilizing the Weekly Skin Integ Review form. Any identified skin issue	grity	
		edema. /2015 revealed Resident #20 t. She required extensive			both pressure and non-pressure were assessed and documented onto the Pressure Ulcer Record or Non-Pressu		
	assistance from two s mobility and dressing	staff members for bed , extensive assistance from			Skin Condition Record by a licensed nurse and reported to the residents;		
	assistance from two s and transferring (mov	personal hygiene, total staff members with toileting, ves between surfaces)			physician and new treatment orders w obtained, implemented and document as appropriate. Residents with press	ed ure	
k	period. Resident #20	r twice in the 7 day look back was coded on the MDS as pen lesions, no pressure			and non-pressure wounds were discu- at a wound meeting on 9-24-15 with the Nurse Manager, the Minimum Data Se	ne	
		s and arterial ulcers. e Care Plan for Resident #20 gory of skin/wound. The			Nurse and the Dietitian to ensure necessary treatment and services to promote healing, prevent infection and	d	
	etiology included the ulcers. The care plan	disease process of leg goal dated 7/11/2015 ent ' s wound will show signs			prevent new sores from developing ar place for identified residents.		
	of healing and remain	2) The resident will not			The Director of Clinical Services completed a review by 8-21-15 of the		

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		MEDICAID SERVICES				. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE COMP	LETED
		345473	B. WING		08/2	C 21/2015
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
				6001 WILORA LAKE ROAD		
WILORA I	LAKE HEALTHCARE CE	NTER		CHARLOTTE, NC 28212		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 309	Continued From page	a /	F 30	0		
	approaches included lab/diagnostic work a treatments as ordere administer medication A record review of Re record for July includ change dressings da Saline, apply Aquace Kerlix and compressi record was initialed for the 14th of the month A record review of Re record dated 7/16/20	s ordered, administer d, weekly skin checks, and ns as ordered. esident #20 ' s treatment ed a treatment order to ily to both legs with Normal I and Santyl to both legs with on bandages. The treatment for the 12th of the month and h. esident #20 ' s treatment 15 through 7/31/2015		medication storage carts to ensu- physician ordered medications wailable for administration. Med- were refilled as appropriate to e availability. Each resident residi facility was reassessed for pain documented on the Pain Assess form by a licensed nurse by 8-2 unmanaged pain identified was to the physician and new orders by the licensed nurse as approp- complete Medication Administra Record to medication storage ca- was also completed by the Omr	vere dications nsure ng in the and sment 8-15. Any reported received oriate. A tion art review hicare	
	Santyl, Calcium Algin dressing once daily to medial thigh, 3) left la and 5) left medial thig 30 minutes prior to w treatments were initia completed on all 5 sit 7/16/2015 -7/19/2015 care was provided or	aled indicating the task was tes for the dates of 5. No indication the wound to 7/20/2015. The treatments		Nurse on 9-9-15 and any needer medications were ordered to en compliance with medication ava The Director of Clinical Services reeducated licensed nurses curr staffing the facility by 9-28-15 of accurate completion of and sche weekly Skin Integrity Reviews a initiation of a Pressure Ulcer Re	sure ilability. rently n the edule of nd cord	
	treatment record india treatment was discor were no further treatment that treatment had be 's medical record for Resident #20 's trans on 8/2/2015. A record review of Re record dated 8/1/201 included an order dat solution, Santyl, Calc protective dressing o	tinued on 7/24/2015. There ment records or indication een provided in Resident #20 care from 7/25/2015 until sfer to an acute care hospital esident #20 ' s treatment 5 through 8/31/2015 ted 7/17/2015. Dakin ' s		and/or a Non-Pressure Skin Con Record for any wounds identifie education also included timely p notification, obtaining and startin treatment orders and transcription the residents? Treatment Admin Record (TAR). Any nurses not reeducated by 9-28-15 will be e prior to reporting to work for the scheduled shift. Residents will h weekly skin assessment complet licensed nurse to identify skin of Any skin issues identified will be to the physician by the licensed	d. The hysician ng new on onto histration ducated ir next have a eted by a poncerns. e reported	

Facility ID: 923567

If continuation sheet Page 5 of 27

ICAID SERVICES PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MULT			OMB NO. 0938-0
	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
345473	B. WING			C 08/21/2015
		STREET ADDRES	S, CITY, STATE, ZIP CODE	•
NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFI TAG	(EA	CH CORRECTIVE ACTION SHOULD	BE COMPLET
al thigh. The order was /1/2015 and 8/2/2015 as completed and the tten and no additional und in the Resident #20 same handwriting. an Orders documented 23/2015 included to Dakin 's solution to left medial thigh. and apply protective dditional verbal order Santyl clarification. The applied directly to he written verbal order 30 days. cian order dated ratory order for a left sitivity. No results record. rse notes dated 15 (the dates available valed on 7/13/2015 a timent to areas, seen pecial delivery of ated 7/14/2015, 0/2015, 7/22/2015, and ing intact to bilateral ent). The daily note dressing intact right g serous bloody binforced. The daily heluded the wound punds and pain prior to the dressing bit for 7/24/2015 vas provided prior to reatment to wound per	F	new treatr implement Treatment Pressure I Skin Conc nurse mar week with measure a condition of and Non-F The Direct Minimum Manager a identified i meeting to and servic promote h prevent ne The Direct reeducate staffing the the need t as prescril the reorde emergenc timeliness the availal pharmacy Director of medication document administer licensed n training by next scheo will also e	nent orders obtained, ted and transcribed onto the Administration Record and Ulcer Record/Non-Pressure lition Record as appropriate hager will make rounds each the wound physician to ass and document the wound as on the Pressure Ulcer Reco Pressure Skin Condition Rec tor of Clinical Services, the Data Set Nurse, the Dietary and Nurse Manager will disc residents during a weekly w o ensure necessary treatment as are being provided to ealing, prevent infection and as sores from developing. To of Clinical Services d licensed nurses currently e facility by 9-28-15 concern o administer medications tim bed. The education include r process, the use of the y kit supply of medications, of medication administratio bility and use of the back up notifying the physician and ation of medications not red per physicians order. An use who did not receive of 248-15 will. The licensed nu- valuate residents pain upon	A A hess, rd cord. cord. cuss ound nt d hing mely d the n, od d
	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION) al thigh. The order was /1/2015 and 8/2/2015 as completed and the tten and no additional and in the Resident #20 same handwriting. an Orders documented 23/2015 included to Dakin ' s solution to left medial thigh. and apply protective dditional verbal order Santyl clarification. The applied directly to he written verbal order 30 days. cian order dated ratory order for a left sitivity. No results record. rse notes dated 15 (the dates available aled on 7/13/2015 a tment to areas, seen pecial delivery of ated 7/14/2015, 0/2015, 7/22/2015, and ing intact to bilateral ent). The daily note dressing intact right g serous bloody inforced. The daily neluded the wound bunds and pain rior to the dressing ote for 7/24/2015	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION) ID PREFID TAG F 3 al thigh. The order was (1/2015 and 8/2/2015) as completed and the tten and no additional und in the Resident #20 same handwriting. an Orders documented 23/2015 included to Dakin 's solution to left medial thigh. and apply protective dditional verbal order Santyl clarification. The applied directly to he written verbal order 30 days. cian order dated ratory order for a left sitivity. No results record. rse notes dated 15 (the dates available aled on 7/13/2015 a tment to areas, seen pecial delivery of ated 7/14/2015, 0/2015, 7/22/2015, and ing intact to bilateral ent). The daily note dressing intact right g serous bloody inforced. The daily notude the wound punds and pain rior to the dressing ote for 7/24/2015 vas provided prior to	STREET ADDRESS 6001 WILORA LL CHARLOTTE, NT OF DEFICIENCIES ID P ID PREFIX TAG CROS al thigh. The order was rag (1/2015 and 8/2/2015 implement as completed and the Treatment tten and no additional nurse mar an Orders documented week with 23/2015 included to measure at Dakin 's solution to condition and service left medial thigh. and Non-F and apply protective The Direct diditional verbal order Minimum Santyl clarification. The Manager at applied directly to identified fr he written verbal order promote h sitivity. No results reeducate record. The Direct read or 7/13/2015 a the need t tment to areas, seen as prescril pcial delivery of the need t ated 7/14/2015, mergenc //2015, 7/22/2015, and impliness ing intact right Director o	STREET ADDRESS, CITY, STATE, ZIP CODE 6001 WILORA LAKE ROAD CHARLOTTE, NC 28212 NT OF DEFICIENCIES THE PRECEDED BY FULL NT OF DEFICIENCY ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) al thigh. The order was (1/2015 and 8/2/2015 his completed and the then and no additional und in the Resident #20 same handwriting, an Orders documented 32/2015 included to Dakin 's solution to left medial thigh. and apply protective diditional verbal order same handwriting, and orders documented and papity protective diditional verbal order statory order for a left sitivity. No results record. rse notes dated ent to areas, seen pecial delivery of alated 71/4/2015, 1/2015, 7/22/2015, and ing intact to bilateral ent). The daily undt to the dressing inforced. The daily condition and pain inforced. The daily condition and pain inforced. The daily condition and pain inforced. The daily condition and pain inforced. The daily condition on the Pressure Ulcer Reco and Non-Pressure Skin Condition as measure and document the wound ₂ s condition on the Pressure Ulcer Reco and Non-Pressure Skin Condition as measure and Non-Pressure Skin Condition Record and apply protective the worthen verbal order the worthen verbal order the order dated ata order dated ata order dated the reorder proces, the used the tea and services are being provided to promote healing, prevent infection an prevent new sores from developing. The Director of Clinical Services the need to administeration time as prescribed. The education sint as prescribed. The education sint as prescribed. The education sint

Facility ID: 923567

If continuation sheet Page 6 of 27

						10.0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED
			A. BUILDING	·		С
		345473	B. WING		n	8/21/2015
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
				6001 WILORA LAKE ROAD		
WILORAL	AKE HEALTHCARE CEN	NTER		CHARLOTTE, NC 28212		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 309	Continued From page	2.6	E 20	00		
1 309	· · · · · · · · · · · · · · · · ·		F 30		upcontrolled	
	Resident #20 ' s med	ssments were found in		condition and report any new pain to the physician to ensure		
		ound care specialist initial		appropriate interventions are i		
		6/2015. Five Lymphedemic		to alleviate residents pain. The		
		ed 1) right shin 2) right		Clinical Services will monitor t		
		iteral shin, 4) left upper shin,		controlled emergency kits sup	-	
		gh. Surgical excisional		to ensure adequate back-up n		
	debridement of subcu			are available if needed.		
	performed on all 5 sit	es.				
	A record review of a v	wound care specialist		The Director of Clinical Servic	es or Nurse	
	evaluation dated 7/23	3/2015 revealed no change		Manager will complete Quality		
		s. There were treatment		Improvement monitoring of the	-	
	-	e 4) left upper shin and 5) left		skin assessments, Pressure L		
	-	ntinuing the Santyl. Surgical		Records and/or Non-Pressure	-	
		nt of subcutaneous tissue		Condition Records and Treatn		
	was performed on all			Administration Record if indica		
	A record review of a v			random residents 3x/week for	,	
)/2015 revealed no change		x/week for 2 months, then 1x/		
		or 5 and improved noted to		months to validate compliance	e with the	
	site 2 for decreased s	Surface area. PM an interview with the		alleged deficient practice.		
				The Director of Clinical Service	on or Nuree	
	-	t physician revealed on		The Director of Clinical Servic		
		20 's wound care was not		Manager will complete a Qual Improvement monitoring of 5 r		
		continued the Santyl on two // whether wound sites.		Medication Administration Red		
	-	ecifically discussed with the		medication storage carts.		
		and the facility corporate		incultation storage carts.		
	nurse at Resident #20	• •		5x/week for 4 weeks, 1 x/weel	c for 2	
		nd sites needed the Santyl		months, then monthly for 3 m		
		und the nurse could apply		ensure compliance with medic		
		e supply. The physician		administration and availability		
	-	concern from the facility		supply. Quality Improvement	•	
	-	eed of the Santyl. The		will be documented on a Qual		
		e was not at the facility		Assurance and Performance	•	
		whether the nursing staff		The Director of Clinical Servic	es will	
		ound care to Resident #20.		report audit results monthly to	the Quality	
	The wound care nurs	e was unavailable for an		Assurance Performance Impro	ovement	
	interview.			(QAPI) committee for 6 month	s or until ined. The	

Facility ID: 923567

If continuation sheet Page 7 of 27

						<u>D. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · /	E SURVEY PLETED
			A. BUILDING			С
		345473	B. WING			/21/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				6001 WILORA LAKE ROAD		
WILORAL	AKE HEALTHCARE CEI	NIER		CHARLOTTE, NC 28212		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 309	Continued From page	a 7	F 30			
1 000		rsing (DON) revealed her	F 30	QAPI committee will evaluate the		
	knowledge that Resid			effectiveness of the		
	•	er and above dry dressing.		monitoring/observation tools for		
		viewing records she asked		maintaining substantial compliance	e, and	
	the wound nurse to s	tart using the weekly		make changes to the corrective a		
		l and the pressure ulcer		necessary.		
		log before she went on				
		DON only reports she				
		at the facility for 2 weeks acility procedure or practice.				
		9 PM an interview with the				
		Human Resources revealed				
	the facility was in transition with staffing and					
	current nurse positior	ns were being supplemented				
		er facilities. The primary				
) during her admission was				
	unavailable.					
		4 AM an interview with a aled she was unable to find				
		records showing that daily				
	wound care treatmen Resident #20.	ts were completed for				
		nursing home to hospital				
		/2/2015 and a Situation,				
	-	ment, Recommendation				
		dated 8/2/2015 revealed to have an altered				
		is sent to the hospital for an				
	evaluation.	is sent to the hospital for all				
		/2/2015 included (in part)				
	Resident (#20) was n					
	-	#20) sent to Emergency				
		ation. At 10:30 PM the nurse				
		ne hospital and documented				
		eing admitted to intensive				
	bilaterally.	d to infection in wounds				
	-	e hospital records dated				
	8/2/2015 to 8/8/2015					

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If continuation sheet Page 8 of 27

					(VO) 5 47			
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	· · ·	E SURVEY PLETED		
			A. BUILDIN	G		С		
		345473	B. WING					
		040470		STREET ADDRESS, CITY, STATE, ZIP CO		8/21/2015		
NAME OF PR	ROVIDER OR SUPPLIER			6001 WILORA LAKE ROAD				
WILORA L	AKE HEALTHCARE CEI	NTER		CHARLOTTE, NC 28212				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE		
F 309	Continued From page	- 8	F 3	ng				
		acute care hospital with						
		. Resident #20 had a history						
	of diabetes type II, ch							
		tremity wounds with a history						
		pathogens. Resident #20						
	-	emity ulcerations in February						
		e burn center. She was						
	discharged from the l	nospital and was residing in						
	a skilled nursing facil	ity. Per family she was not						
	on antibiotics in the n	ursing facility. The						
		ent records from 8/2/2015						
	-	en purulent thick fluid in her						
		Physician noted he did " not						
		ad appropriate wound care						
		". The Microbiology culture						
		ined at the hospital and						
		included heavy growth of						
		inosa (bacteria), scant ter Baumannii (pathogen),						
	and one colony of Sta							
	-	(bacteria). She was admitted						
		ock secondary to wound						
	infections.							
		admitted to the facility on						
	,	ses included Dementia,						
	-	Fracture, and Chronic Pain.						
		et dated 8/17/2015 revealed						
	Resident #10 was se	verely cognitively impaired						
		ndent on staff (two person						
		for her activities of daily						
		vas assessed as frequently						
		he pain had made it hard to						
		ited her day to day activities.						
		Sheet dated 8/1/2015						
	-	r Resident #10 included an						
		narcotic pain medication) 10						
		Extended Release, every 12 by mouth twice daily. It was						

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	-	ND HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/18/201 // APPROVE). 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,					SURVEY PLETED
		345473	B. WING					21/2015
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	Ē		
	AKE HEALTHCARE CE	NTER	6001 WILORA LAKE ROAD					
	, , , , , , , , , , , , , , , , , , ,				CHARLOTTE, NC 28212			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 309	Continued From page	e 9	F	309				
1 000		e pharmacy controlled	1	503				
		record for Resident #10 's						
		that the last dose on the						
	active card stock was at 9:00 AM.	s administered on 8/16/2015						
		inistration Record (MAR)						
		igh 8/31/2015 for Resident						
		6/2015 the 9:00 PM dose of						
	-	dministered, indicated by						
		was no indication on the to why the dose was not						
	administered.	to why the dose was not						
		ated 8/16/2015 at midnight						
		uded: May hold OxyContin						
	-	one dose. Follow up with						
		n the morning 8/17/2015.						
	Resident #10 reveale	2015 through 8/31/2015 for						
		M and the 9:00 PM doses of						
		administered indicated by						
		was no indication on the						
		to why the doses were not						
	administered.							
		2015 through 8/31/2015 for ed an as needed medication						
		taminophen (narcotic pain						
		5 mg tablet take one by						
		as needed for pain. The						
		nitials that on 8/17/2015 two						
		ered to Resident #10. On the						
	back of the MAR the	re was one entry for (in part) waiting for script						
	from MD (physician)							
		8/18/2015 for resident #10 in						
		was for Oxycodone 10 mg						
	tablet ER 1 by mouth							
		aled a concern dated						
		ent #10 for medications were						
	received late. On 8/2	21/2015 at 9:45 AM an						

Facility ID: 923567

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345473	B. WING				C 21/2015
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
				6	6001 WILORA LAKE ROAD		
WILORA	LAKE HEALTHCARE CEN	NIER			CHARLOTTE, NC 28212		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	interview with Reside (RP) revealed Reside fracture in her right sh operable so she had reported Resident #11 for comfort and her sh She reported resident covered up her right si in her right shoulder. filed grievances for R her medications. The facility daily and it wo medications ordered, to Resident #10. A record review of the medication utilization OxyContin revealed it and the first dose adm 8/19/2015. On 8/20/2015 at 4:30 #1, a relief nurse from Resident #10 's nursi did know the reason t 8/16/2015. Resident #10 's prim 8/16/2015 was unava primary nurse for day unavailable. The prim for the evening shifts was a contract nurse On 8/20/2015 at 4:40 #2 (a relief nurse from Resident #10 's nursi did not give Resident 18th because it was r Nurse #3 processed a 8/18/2015. She could	nt #10 ' s Responsible Party ont #10 had a chronic noulder that was not chronic pain. The RP 0 needed to be positioned noulder protected in care. t #10 rubbed, guarded and shoulder and verbalized pain The RP reported she had esident #10 not receiving RP reported she was at the uld take up to a week to get in stock, and administered e pharmacy controlled record for Resident #10 ' s t was received on 8/18/2015 ninistered was on PM an interview with Nurse a sister facility, who was e on 8/16/2015 reported she the OxyContin was held on ary nurse the evening of ilable for an interview. The shift on 8/17/2015 was hary nurse on the schedule for 8/17/2015 and 8/18/2015 and unavailable. PM an interview with Nurse h a sister facility) who was e on 8/18/2015 reported she the OxyContin on the she of a with schedule for 8/18/2015 reported she man sister facility) who was e on 8/18/2015 reported she man sister facility) who was e on 8/18/2015 reported she man sister facility) who was e on 8/18/2015 reported she man interview with Nurse of a sister facility who was e on 8/18/2015 reported she man interview with Nurse of a sister facility who was e on 8/18/2015 reported she man interview with Nurse of a sister facility who was e on 8/18/2015 reported she man interview with Nurse of a sister facility who was e on 8/18/2015 reported she man interview with Nurse of a sister facility who was e on 8/18/2015 reported she man of the order on the order use she did not have access	F	309			

Facility ID: 923567

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		MEDICAID SERVICES		PLE CONSTRUCTION		O. 0938-039			
	CORRECTION	IDENTIFICATION NUMBER:	· ,	G	· · · ·	IPLETED			
						С			
		345473	B. WING		08	3/21/2015			
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE					
	AKE HEALTHCARE CE	NTED		6001 WILORA LAKE ROAD					
WILOKAL	ARE REALINCARE CE	NIER		CHARLOTTE, NC 28212					
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CO (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE DEFICIENCY			SHOULD BE COMPLETIC				
F 309	Continued From page	e 11	F 30	99					
		ported Resident #10 will							
		s in pain if you ask her.							
		ilable for an interview.							
		24 PM an interview with the							
		nager Nurse #4 revealed							
		as not administered the							
	of the MAR the reaso	er initials and write on back							
	medication.								
		5 PM an observation of							
	Resident #10 was ma	ade during care where she							
		ht shoulder, verbalizing to							
		h her right arm [during							
	movement].								
		AM an interview with the Resident #10 had a hard							
		ion) for OxyContin 10 mg							
		The regulatory law only							
		y to dispense a 14 day							
		medication, 28 tablets were							
		y. On 8/18/2015 a hard script							
	-	ntin and 28 tablets were							
	dispensed to the faci	IIty.) AM an interview with							
		ity Nurse Practitioner (NP)							
		t aware that Resident #10							
		ng her scheduled pain							
		ving the order written on							
		was managed by the on call							
		ose name was transcribed on							
		he did not personally get a staff. She further reported							
	-	/16/2015. The NP shared							
	she felt the facility ha								
	-	ig medications timely and the							
	-	prrected. She reported there							
		on between nurses and other							
		eported the residents are in							
	a skilled nursing facil	ity and a level of care is							

Facility ID: 923567

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
-	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		SURVEY PLETED
		345473	B. WING				21/2015
	ROVIDER OR SUPPLIER	ITER		60	TREET ADDRESS, CITY, STATE, ZIP CODE 001 WILORA LAKE ROAD HARLOTTE, NC 28212		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309 F 314 SS=D	required. " It is inexcu scheduled pain medic is not acceptable to ur medication as a subst chronic pain. " On 8/21/2015 at 11:22 corporate staff revealed in-serviced on the pro- receiving medications nursing staff was to for ordering the medication acceptable to go 3 da medication. There wa nurses write why they on the back of the MA 483.25(c) TREATMEN PREVENT/HEAL PRE Based on the compre- resident, the facility m who enters the facility facility facility facility facility facility facility failed to promote residents (Resident # 2 pressure ulcer. Findings Included: Resident #20 was addi	usable to be out of a cation for even one dose. It se an as needed pain titution for coverage of B AM an interview with the ed the nursing staff was recdure for ordering and b. The expectation for the ollow the procedure for on timely. It was not ys without chronic pain s the expectation that the or did not give a medication vR. NT/SVCS TO ESSURE SORES hensive assessment of a nust ensure that a resident or without pressure sores assure sores unless the ndition demonstrates that e; and a resident having es necessary treatment and ealing, prevent infection and		314	Resident # 20 no longer resides in the facility. Current residents have the potential to affected by the alleged deficient practic A skin assessment was completed on each resident by a licensed nurse by	be	9/29/15

Event ID: N6KV11

Facility ID: 923567

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	S FOR MEDICARE &				STRUCTION		NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		STRUCTION	· · ·	ATE SURVEY
			A. BUILDING	J			С
		345473	B. WING				08/21/2015
NAME OF PR	ROVIDER OR SUPPLIER				TADDRESS, CITY, STATE, ZIP CODE		00/21/2013
					VILORA LAKE ROAD		
WILORA L	AKE HEALTHCARE CEI	NTER			LOTTE, NC 28212		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETIC
F 314	Continued From page	e 13	F 31	14			
	on 8/2/2015. Diagnos	ses included Ulcers of the		9/2	23/15 utilizing the Weekly Skin Inte	grity	
		nous Thrombosis, Heart			eview form. Any identified skin issu	• •	
	Failure, Diabetes, Ve				th pressure and non-pressure wer	е	
	Noninfectious Lymph				sessed and documented onto the		
	The MDS dated 7/18/			essure Ulcer Record or Non-Press			
		. She required extensive			in Condition Record by a licensed		
	assistance from two s				irse and reported to the residents¿		
		, extensive assistance from			sistence implemented and decumer		
		personal hygiene, total staff members with toileting,			tained, implemented and documer appropriate. Residents with press		
		ves between surfaces)			id non-pressure wounds were disc		
	• •	r twice in the 7 day look back			a wound meeting on 9-24-15 with		
	-	was coded on the MDS as			urse Manager, the Minimum Data S		
	•	pen lesions, no pressure			urse and the Dietitian to ensure		
	ulcers, and no venou			ne	cessary treatment and services to		
	A record review of the	e Care Plan for Resident #20		pro	omote healing, prevent infection ar	nd	
		gory of skin/wound. The		pro	event new sores from developing a	are in	
		7/11/2015 included the		pla	ace for identified residents.		
		lop additional skin integrity					
	-	through the next review.			e Director of Clinical Services		
		esident #20 ' s ADL report			educated licensed nurses by 9-28-		
	revealed she was trai				e accurate completion of and sche		
	Surfaces 8 out of 16 0 7/30/2015.	days between 7/14/2015 and			weekly Skin Integrity Reviews and tiation of a Pressure Ulcer Record		
	An admission data co	allection form dated			id/or a Non-Pressure Skin Conditio		
		skin tear drawn in a diagram			ecord for any wounds identified. Th		
	above the sacrum.				lucation also included timely physic		
		ound care specialist initial			tification, obtaining and starting ne		
	evaluation dated 7/16				atment orders and transcription or		
	Lymphedemic leg wo	und sites.			e residents¿ Treatment Administrat		
		wound care specialist			ecord (TAR). Any nurses not		
		3/2015 revealed no change			educated as of 9-28-15 will be edu		
	to the five leg wound				ior to reporting to work for their ne		
		wound care specialist			heduled shift. Residents will have		
		0/2015 revealed a chief			eekly skin assessment completed b	-	
		on the buttocks. History:			ensed nurse to identify skin concer		
		stage 2 pressure wound of		Ar	ny skin issues identified will be repo	unea	
	the right butteeles of a	at least 1 day duration. There		4-	the physician by the licensed nurs	0 000	

Facility ID: 923567

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		MEDICAID SERVICES				<u>8-03</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		345473	B. WING		C 08/21/20 [/]	15
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/21/20	10
				6001 WILORA LAKE ROAD		
WILORA L	AKE HEALTHCARE CEN	NTER		CHARLOTTE, NC 28212		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMP	(X5) PLETIC DATE
F 314	Continued From page	<u>ə</u> 14	F 31	4		
		s 3.5 X 3.5 X 0.1 centimeters		implemented and transcribed or	nto the	
		hage. Dressing: Hydrogel		Treatment Administration Recor		
	and dry protective dre			Pressure Ulcer Record/Non-Pre		
	There were no treatm			Skin Condition Record as appro	priate. A	
	Resident #20 " s med	lical record from 7/30/2015		nurse manager will make round		
		sident #20 ' s discharge to		week with the wound physician		
	acute care.			measure and document the wou		
		e was unavailable for an		condition on the Pressure Ulcer		
	interview.	PM and interview with the		and Non-Pressure Skin conditio The Director of Clinical Services		
		rsing (DON) reported after		Minimum Data Set Nurse, the D		
		e asked the wound nurse to		Manager and Nurse Manager w	-	
	-	/ pressure ulcer record and		identified residents during a wee		
		ality improvement log before		meeting to ensure necessary tre		
		. The interim DON only		and services are being provided		
		ad only been at the facility for		promote healing, prevent infection		
	2 weeks and was not practice.	sure of facility procedure or		prevent new sores from develop	ang.	
	P	e weekly pressure ulcer		The Director of Clinical Services	s or Nurse	
	record and the pressu			Manager will complete Quality		
	-	Resident #20 included one		Improvement monitoring of the	weekly	
		5 for Resident #20 ' s 5		skin assessments, Pressure Ulo	er	
		und sites. The stage 2 right		Records and/or Non-Pressure S		
		er was not added to the		Condition Records and Treatme		
	logs.	9 PM an interview with the		Administration Record if indicate random residents 3x/week for 4		
		Human Resources revealed		x/week for 2 months, then 1x/m	,	
	-	isition with staffing and		months to validate compliance v		
		ns were being supplemented		alleged deficient practice. Qualit		
		er facilities. [The primary		Improvement monitoring will be		
		during her admission was		documented on a Quality Assura		
	unavailable]			Performance Monitor Tool. The		
		4 AM an interview with		Clinical Services will report audi		
		ng] revealed she was unable		monthly to the Quality Assurance		
	-	edical records showing that tments were completed for		Performance Improvement (QAI committee for 6 months or until	1)	
	Resident #20.			substantial compliance is obtain	ed. The	
				QAPI committee will evaluate th		
			1	effectiveness of the		

Facility ID: 923567

TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY COMPLETED	
		345473	B. WING _		C 08/21/2015	
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZI 6001 WILORA LAKE ROAD CHARLOTTE, NC 28212	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COMPLE O THE APPROPRIATE DATE	
F 314 F 333 SS=G	Continued From page 483.25(m)(2) RESID SIGNIFICANT MED	ENTS FREE OF	F 3	monitoring/observation t maintaining substantial o make changes to the con necessary.	compliance, and	
		ure that residents are free of				
	by: Based on record rev interview the facility f scheduled pain medi opportunities (Reside Findings included: 1) Resident #10 was 6/6/2013. Her diagno Insomnia, Upper arm Chronic Pain. The Minimum Data S Resident #10 was se and was totally deper physical assistance) living. Resident #10 we experiencing pain. Th sleep at night and lim Record review of a g concern dated 8/18/2 medications were record The Physician Order through 8/31/2015 fo order for OxyContin (mg (milligram) tablet	cation (OxyContin), for 5 ent #10). admitted to the facility on ses included Dementia, Fracture Chronic, and tet dated 8/17/2015 revealed verely cognitively impaired ndent on staff (two person for her activities of daily was assessed as frequently ne pain had made it hard to nited her day to day activities. rievance log revealed a 2015 for Resident #10 for		A medication error report by the Director of Clinical resident #10 on 8-20-15 continue to have pain me administered timely per p All residents with pain me have the potential to be alleged deficient practice Clinical Services comple 8-21-15 of the Medication Records and medication ensure physician ordered medications were availa administration. Medication as appropriate to ensure resident residing in the fare reassessed for pain and the Pain Assessment for nurse by 8-28-15. Any u identified was reported to and new orders received nurse as appropriate. A Medication Administration medication storage cart	I Services for and resident will edications obysicians orders. edication orders affected by the e. The Director of ted a review on n Administration storage carts to d pain ole for ons were refilled availability. Each acility was also documented on m by a licensed nmanaged pain o the physician I by the licensed complete n Record to	

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	PLE CONSTRUCTION	OMB NO. 093 (X3) DATE SURV	
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	COMPLETED	
					С	
		345473	B. WING		08/21/20)15
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	P CODE	
	AKE HEALTHCARE CEN	NTED		6001 WILORA LAKE ROAD		
				CHARLOTTE, NC 28212		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COM D THE APPROPRIATE	(X5) /PLETIC DATE
F 333	Continued From page	e 16	F 33	33		
		nistration Record (MAR)		completed by the Omnica	are Nurse on	
		gh 8/31/2015 for Resident		9-9-15 and any needed n		
		/2015 the 9:00 PM dose of		ordered to ensure compli		
		dministered indicated by		medication availability.		
		was no indication on the				
		o why the dose was not		The Director of Clinical S		
	administered.			reeducated licensed nurs	-	
		ted 8/16/2015 at midnight			9-28-15	
		uded: May hold OxyContin		concerning the need to a		
	-	ne dose follow up with the morning 8/17/2015.		medications timely as pre education included the re		
	-	e pharmacy controlled		the use of the emergency	-	
		record for Resident #10 's		medications, the timeline		
		hat the last dose on the		administration, the availa		
	-	administered on 8/16/2015		the back up pharmacy, n	-	
	at 9:00 AM.			physician and Director of		
	The MAR dated 8/1/2	2015 through 8/31/2015 for		if a medication is not ava		
	Resident #10 reveale	-		documentation of medica	ations not	
	8/18/2015 the 9:00 A	M and the 9:00 PM doses of		administered per physicia	ans order. The	
	OxyContin were not a	administered indicated by		education included the ne	eed to timely	
	-	als. There was no indication		reorder medications and		
		AR as to why the dose was		supplies when the par lev	-	
	not administered.			supply. Any licensed nur		
		e MAR dated 8/1/2015		receive training by 9-28-1		
	-	r Resident #10 revealed an		education prior to the nex		
	as needed medication			shift. The licensed nurse pain medications timely p		
		ninophen (narcotic pain 5 mg tablet take one by		orders and document ad		
		as needed for pain. The		initialing on the Medicatio	3	
	record indicated by si	-		Record. The Director of C		
	8/17/2015 two doses	-		and/or will monitor the co		
		back of the MAR there was		emergency kits supply we		
	one entry for 8/17/20	15 that read (in part) waiting		adequate back-up medic	-	
	for script from MD (pr	nysician) for OxyContin.		available if needed.		
		8/18/2015 for resident #10 in				
		was for Oxycodone 10 mg		The Director of Clinical S		
	-	twice daily quantity #60.		Manager will complete a	-	
		e pharmacy controlled		Improvement monitoring	-	
	medication utilization	record for Resident #10 ' s		Medication Administration	n Records and	

Facility ID: 923567

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TATEMENT C	F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURV	38-039 ΈΥ
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COMPLETED	C
					C	
		345473	B. WING		08/21/20	015
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
WILORA L	AKE HEALTHCARE CEI	NTER		6001 WILORA LAKE ROAD		
				CHARLOTTE, NC 28212		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COM THE APPROPRIATE	(X5) /IPLETIOI DATE
F 333	Continued From page	e 17	F 33	33		
	OxyContin revealed i and the first dose adr	t was received on 8/18/2015 ninistered was on		medication storage carts.		
	8/19/2015.			5 x/week for 4 weeks, 1 x	week for 2	
		PM an interview with Nurse		months, then monthly for		
	-	n a sister facility) who was		ensure compliance with m		
		e on 8/16/2015 reported she		administration and availab		
	on 8/16/2015.	son the OxyContin was held		day supply. Quality Impro		
		ary nurse the evening of		Quality Assurance and Pe		
		ailable for an interview. The		Improvement Monitor Too		
		/ shift on 8/17/2015 was		of Clinical Services will re		
	unavailable. The prim	nary nurse on the schedule		monthly to the Quality Ass	surance	
	for the evening shifts	for 8/17/2015 and 8/18/2015		Performance Improvemer	nt (QAPI)	
	was a contract nurse			committee for 6 months o		
		PM an interview with Nurse		substantial compliance is		
		n a sister facility) who was e on 8/18/2015 reported she		QAPI committee will evalue effectiveness of the	late the	
		#10 her OxyContin on the		monitoring/observation to	ole for	
		not available. She reported		maintaining substantial co		
		a new order on day shift		make changes to the corr	•	
	-	I not verify when the order		necessary.		
		use she did not have access				
		ic pharmacy ordering				
		ported Resident #10 will				
		in pain if you ask her.				
		lable for an interview.				
		4 PM an interview with the ager Nurse #4 revealed the				
		g medications was when the				
	-	by the staff would re-order				
	medications in the co	emputer or fax a request to				
		equest for re-order should				
	-	d 3 to 4 days before the card				
		lication. If the staff sent a fax				
		nedication order would arrive				
		5:00 PM the staff would call				
		ne medication was out. The a record of medications				
	TACHILY OURS HOLKERD					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345473	B. WING				C 21/2015
NAME OF P	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
WILORA I	AKE HEALTHCARE CEN	ITER			6001 WILORA LAKE ROAD CHARLOTTE, NC 28212		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 333	nurse would have to or medication was missi nurse did not request manager reported he facility electronic phar [business] hours the r orders to the pharmaon reported when a med the nurse was to circle back of the MAR the r medication. On 8/21/2015 at 9:34 pharmacy revealed R script (legal prescripti filled on 7/21/2015. The allowed the pharmacy supply of a narcotic m provided to the facility was filled for OxyCon dispensed to the facility was filled for OxyCon dispensed to the facility medication. The needed to be position shoulder protected in #10 rubs, guards, cov to her right shoulder. filed grievances for R her medications. The facility daily and it wo medications ordered, to Resident #10. On 8/21/2015 at 11:09 Regional Director of H because of staffing ch scheduled to work at	call the pharmacy. If a ng for 3 days it meant the the order in time. The unit did not have access to the macy ordering system, after nurses fax medication cy. The unit manager ication was not administered e her initials and write on reason for not giving the AM an interview with the esident #10 had a hard on) for OxyContin 10 mg he regulatory law only / to dispense a 14 day hedication, 28 tablets were // On 8/18/2015 a hard script tin and 28 tablets were fy. AM an interview with ponsible Party (RP) 0 had a chronic fracture in t was not operable so she e RP reported Resident #10 ed for comfort and her care. She reported resident rers up, and verbalized pain The RP reported she had esident #10 not receiving RP reported she was at the uld take up to a week to get in stock, and administered PPM an interview with the Human Resources revealed	F	333	3		

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		345473	B. WING				C 21/2015
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					6001 WILORA LAKE ROAD		
WILORA L	AKE HEALTHCARE CEN	ITER			CHARLOTTE, NC 28212		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 333	be the nurse on staff corporate policy but the provide building spect from sister facilities has electronic pharmacy at to fax an order. There on staff who were avait medications. The Direct responsible for ordering and narcotics. On 8/21/2015 at 9:30 Resident #10 ' s facilit revealed she was not had not been receiving medication. In review 8/16/2015, the order of service. The NP [who the order] reported she call from the facility sta she was on call on 8/ she felt the facility sta she was on call on 8/ she felt the facility fac ordering and receiving problem never got co was no communication disciplines. The NP re a skilled nursing facilit required. " It is inexco scheduled pain medic is not acceptable to u medication as a subst chronic pain. " On 8/21/2015 at 11:22 corporate staff revealed in-serviced 7/23/2015 ordering and receiving expectation for the nu- procedure for ordering	ties. Her expectation would would be familiar with he building would need to ific orientation. The nurses ad building specific access. They had the ability were nursing supervisors alable to order the ector of Nursing was ng house stock medications AM an interview with ty Nurse Practitioner (NP) aware that Resident #10 g her scheduled pain ing the order written on was managed by the on call se name was transcribed on the did not personally get a taff. She further reported 16/2015. The NP shared d a big problem with g medications timely and the rrected. She reported there on between nurses and other eported the residents are in ty and a level of care is usable to be out of a cation for even one dose. It se an as needed pain titution for coverage of 8 AM an interview with the ed the nursing staff was on the procedure for	F	333	3		

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/18/20 FORM APPROVE OMB NO. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345473	B. WING		08/21/2015
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
WILORA L	AKE HEALTHCARE CEI	NTER		6001 WILORA LAKE ROAD CHARLOTTE, NC 28212	
		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF	RECTION (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETIO
F 333	Continued From page	20	F 33	33	
	1.3	sician for a hard script and			
	fax the hard script to	•			
		ne new prescription to be in			
	9	e medication card stock was eptable to go 3 days without			
	chronic pain medicati	on. There was the			
	-	urses write why they did not			
E 514	give a medication on 483.75(I)(1) RES	The back of the MAR.	F 5 ²	14	9/29/15
SS=D		TE/ACCURATE/ACCESSIB	10		0,20,10
	LE				
	The facility must mair	ntain clinical records on each			
		e with accepted professional			
	-	es that are complete; ed; readily accessible; and			
	systematically organized				
	The clinical record m	ust contain sufficient			
	information to identify	the resident; a record of the			
		its; the plan of care and			
	services provided; the preadmission screen	ng conducted by the State;			
	and progress notes.	<u> </u>			
	This REQUIREMENT	is not met as evidenced			
	by:				
		iew and staff interview the ain a complete medical		Resident #10 continues to rece	
	record by not docume	•		OxyContin twice daily as sched Hydrocodone continues to be	
	medication omissions	on two medications		administered on an as needed	-
	· •) and by not documenting		physicians; orders with the rea	
		stering a pain medication ed on an as needed basis		needed documented in the med record. The licensed nurse rece	
	for 1 of 1 resident (Re	esident #10) in line with the		order on 8-21-15 to discontinue	
	•	and the documentation tool ration Record) provided by		#10 Muro eye drops.	
	(weucation Auministi	ation Record provided by			

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				E CONCEDUCTION		IB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING			С
		345473	B. WING			08/21/2015
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY	, STATE, ZIP CODE	00/21/2010
				6001 WILORA LAKE R	OAD	
WILORA L	AKE HEALTHCARE CEI	NTER		CHARLOTTE, NC 28	3212	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVID	ER'S PLAN OF CORRECTION	(X5)
PRÉFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	· ·	RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETIC DATE
F 514	Continued From page	e 21	F 51	4		
	the facility.		_	All residents ha	ve the potential to be	
	Findings included:				alleged deficient practice.	
		mitted to the facility on			- '	
	6/6/2013. Her diagno	ses included Dementia.			ledication Administration	
	•	rievance log revealed a			s) and Treatment	
		015 regarding Resident #10			Records (TARs) for the	
	receiving her medicat				vas completed by the	
		esident #10 's Medication			cal Services and the	
		d (MAR) dated 8/1/2015 to n order for Muro-128 2%			by 9-10-15. Other areas mentation were noted and	
		oth eyes twice daily (for			possible within current	
		8/17/2015 the 9:00 PM dose		standards of pra		
		I as indicated by circled				
		the 9:00 AM and the 9:00		The Director of	Clinical Services	
		ere not administered as			nsed nurses by 9-28-15 on	1
	indicated by circled ir	nitials. There was no written			ntain accurate, complete	
	indication on the back	k of the MAR as to why the		medical records	s. This education included	
	doses were missed.			appropriate doc	umentation of the reason	
		nistration Record (MAR)			nedication administration	
		gh 8/31/2015 for Resident			e documentation of	
		2015 the 9:00 PM dose of			ssions. Any licensed	
		illigram) tablet Extended			ated by 9-28-15 will be	
		e daily every 12 hours			to their next working shift.	
		ation) was not administered			that the licensed nurse dministration of ordered	
	-	d initials. There was no k of the MAR as to why the			nitialing on the Medication	
	dose was not adminis	-			Record (MAR). For as	
		PM an interview was			tions, the licensed nurse	
		e #1 (a relief nurse from a			the medical record the	
		as Resident #10 's nurse for			inistration. When a	
		5. Nurse #1 reported she did		medication is no	ot given as ordered, the	
		OxyContin was held in the			will indicate this by circling	
	PM on 8/16/2015.				the front of the MAR and	
	-	ary nurse during the evening			eason for omission in the	
		available for an interview.		medical record.		
		2015 through 8/31/2015 for				
	Resident #10 reveale				Clinical Services or Nurse	
	o/ 10/2015 the 9:00 A	M and the 9:00 PM doses of	1	Manager will co	nouci Quality	1

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/18/2015 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345473	B. WING				C 21/2015
NAME OF P	ROVIDER OR SUPPLIER	·		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WILORA	AKE HEALTHCARE CEI	NTER			01 WILORA LAKE ROAD HARLOTTE, NC 28212		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 514	circled initials. There back of the MAR as t administered. A record review of the through 8/31/2015 for order for Hydrocodom pain medication) 5 m mouth every 4 hours record indicated, by it doses were administe back of the MAR ther 8/17/2015 that was tr waiting for script from OxyContin. The primary nurse for on 8/17/2015 was un The primary nurse for on 8/17/2015 was a com 0 n 8/20/2015 at 4:40 conducted with Nurse sister facility who was 8/18/2015. She repo Resident #10 her Ox it was not available. S reason on the back o On 8/20/2015 at 11:2 conducted with the se Nurse #4. The nurse was not administered initials and write on th reason for not giving On 8/21/2015 at 11:0 Regional Director of I because of staffing cl scheduled to work at facilities. Corporate p	was no indication on the o why the doses were not e MAR dated 8/1/2015 r Resident #10 revealed an he-Acetaminophen (narcotic g-325 mg take one tablet by as needed for pain. The nitial, that on 8/17/2015 two ered to Resident #10. On the re was one entry for anscribed (in part) as n MD (physician) for r Resident #10 for day shift available. r Resident #10 on the hing shifts for 8/17/2015 and tract nurse and unavailable. PM an interview was e #2 a relief nurse from a s Resident #10 ' s nurse on rted she did not give ycontin on the 18th because She did not document the f the MAR. 4 PM an interview was econd shift unit manager ereported when a medication the nurse was to circle her he back of the MAR the the medication. 9 PM an interview with the Human Resources revealed hanges the nurses the facility are from sister iolicies and practices were ities. Her expectation would	F	514	Administration Records for accuracy a completeness of medication documentation 5x/ week for 4 weeks, 1x/week for 2 months, then 1x/month months. The Quality Improvement monitoring will be documented on a Quality Assurance and Performance Improvement Monitor Tool. The Direct of Clinical Services will report audit re monthly to the Quality Assurance Performance Improvement (QAPI) committee for 6 months or until substantial compliance is obtained. Th QAPI committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, a make changes to the corrective action necessary.	for 3 or sults ne	

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	-	D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 1 FORM AF OMB NO. 09	PROVED	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SUF COMPLET	RVEY	
		345473	B. WING		C 08/21/2	2015	
NAME OF PF	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE			
WILORA L	AKE HEALTHCARE CEN	ITER		001 WILORA LAKE ROAD CHARLOTTE, NC 28212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	-	(X5) OMPLETION DATE	
F 514	corporate staff reveal	8 AM an interview with the ed there was the urses write why they did not	F 514				
F 520 SS=G	483.75(o)(1) QAA	ERS/MEET	F 520		9/2	29/15	
	assurance committee nursing services; a ph	in a quality assessment and consisting of the director of hysician designated by the other members of the					
	issues with respect to and assurance activit develops and implem	ent and assurance east quarterly to identify which quality assessment ies are necessary; and ents appropriate plans of ified quality deficiencies.					
		rds of such committee h disclosure is related to the ommittee with the					
		y the committee to identify ficiencies will not be used as					
	by: Based on staff interv	is not met as evidenced iew and record review the ment an appropriate plan of		The facility will follow all regulations related to the maintenance of an effect	ive		

Event ID: N6KV11

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-	
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	(X3) DATE SURVEY COMPLETED			
			A. BUILDING	с		
345473		B. WING	08/21/2015			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
				6001 WILORA LAKE ROAD		
WILORA	ILORA LAKE HEALTHCARE CENTER			CHARLOTTE, NC 28212		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPF DEFICIENCY)		CTION SHOULD BE COMPLE O THE APPROPRIATE DAT	
F 520	Continued From page	a 24	F 52	20		
1 020	action to correct 1 of 4 identified quality deficiency		F J2		Process	
		1 for failure to administer		Quality Assessment and Improvement committee		
	scheduled pain medi					
	Findings included:			All residents have the po	tential to be	
	Cross reference F30	9		affected by the alleged d		
	On 7/17/2015 the fac	ility received a citation for		The Quality Assurance a		
	failure to administer s	scheduled pain medication.		Improvement (QAPI) cor	nmittee; inclusive	
		l a plan of correction on		of the Executive Director	-	
		ompletion date for 8/12/2015.		Clinical Services, Medica		
		n included re-education of		Coordinator, Business O	-	
	nurses currently work			Maintenance Director, H		
		ed to follow up on resident		Director, Minimum Date		
		wellbeing such as pain.		Recreational Director an		
	A record review of the	-		Practitioner conducted a	-	
		(in part) Understand the		8-25-15 to discuss the do identified during the surv		
		prevent medication errors, to be accurate to prevent		discussed implementation		
		the need to complete RED		immediate plan of correct		
		ht, understands that the RED				
		ality check of the days '		The facility will follow all	regulations	
		an order are checked nightly,		related to the maintenan		
		ding of the need to notify		quality assessment and		
		, understand how to order		improvement program. T		
		ons per physician orders,		committee members wer		
	understand the time in which medications must			9-10-15 by the Regional		
		and how to request items		Operations on the need		
		rmacy, and understand that		and to review the results	and	
	omissions are considered medication errors.			effectiveness of all audits		
		ility was recited for F309 for		to revise the plan of corr		
	failure to administer scheduled pain medication and provide wound treatments as ordered. On 8/21/2015 at 11:28 AM an interview with the			necessary by the commi		
				maintain substantial com	ipliance.	
	corporate staff revealed the nursing staff was			The Quality Assurance a		
		ocedure for ordering and		Improvement Committee		
		s. The expectation for the		monthly and/or more free	-	
		ollow the procedure for		deemed necessary to re-		
	ordering the medicati	-		Improvement Monitoring		
	medication tablet levels got low they were to			to ensure continued sub		
	notify the physician for a hard script and fax the			compliance. The Executi	VE DIRECTOR WIII	

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CENTERS FOR MEDICARE & MEDICAID SERVICES		()(0)			OMB NO. 0938-039 (X3) DATE SURVEY		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345473			· ,	LE CONSTRUCTION		E SURVEY	
					с		
		B. WING		0	08/21/2015		
			STREET ADDRESS, CITY, STATE, ZIP CODE				
WILORA LAKE HEALTHCARE CENTER				6001 WILORA LAKE ROAD			
WILOKA	LARE REALINCARE CE	NIER		CHARLOTTE, NC 28212			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	RECTION SHOULD BE APPROPRIATE	ULD BE COMPLETIO		
F 520	Continued From pag	e 25	F 52	0			
. 020		armacy. The expectation was	1 52	serve as the QAPI coordinator	and be		
				responsible for the ongoing m			
	for the new prescription to be in the building before the medication card stock was empty. It was not acceptable to go 3 days without chronic pain medication. There was the expectation that the nurses write why they did not give a medication on the back of the medication			and improvement process.	Sintoring		
	administration record	d. In addition there was an					
	emergency supply ki	t (e kit) in the building that					
	was not utilized. QI was in process. We did the						
	staff education for sc	staff education for some reason there was a					
	breakdown. The QI started with a full house audit						
	on all resident charts and it was decreased to a						
		relief nurses should have					
		pharmacy procedure, using					
	the backup pharmac						
		20 PM the corporate nurse					
		Improvement (QI) committee					
	consisted of the man	.					
	Administrator and Medical Director. The committee met monthly. On 8/21/2015 at 12:54 PM an interview with the Administrator and chair of the QI committee reported the facility citation was in July. He reported the committee met on the last Thursday						
	-	committee meeting was not					
		sday of July (7/30/2015)					
		with the physician on the					
		The Administrator reported he					
		ne committee meeting					
		vas working on the Plan of					
	Correction. He reported the staff was in-serviced on the procedure of ordering and receiving						
	medications and the pharmacy helped facilitate						
		gement created memos with					
		ning medications after hours.					
	-	ining medications after hours					
	Land how to use the h	aakun nharmaay. Ha				1	
		backup pharmacy. He nt developed an audit tool					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 11/18/2015 1 APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	345473		B. WING			C 08/21/2015		
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP COD)E	00/	
WILORA LAKE HEALTHCARE CENTER				6001 WILORA LAKE ROAD CHARLOTTE, NC 28212				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD B		(X5) COMPLETION DATE
F 520	with the original citation included face to face demonstration. The a expectation was that and staff training the s	on. The staff in-service education and return dministrator reported his after the plan of correction staff would be able to follow ering and receiving correctly ported, it was not	F	520				

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