			A. DOILDING			(X3) DATE SURVEY COMPLETED	
(X4) ID		345473			C 01/21/2021		
(X4) ID	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		1/21/2021	
(X4) ID				6001 WILORA LAKE ROAD			
	AKE HEALTHCARE CEN	IIER		CHARLOTTE, NC 28212			
TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
E 000	Initial Comments		E 00	ο			
F 000	exited on 01/19/2021. obtained offsite on 01 Therefore, the exit da facility was found in o §483.73 related to E-0	at an unannounced infection Control Survey and Additional information was /20/2021 and 01/21/2021. te was 01/21/2021. The compliance with 42 CFR 0024 (b)(6), ents for Long Term Care FU2411.	F 00	0			
	Complaint Investigation 01/19/2021. Addition offsite on 01/20/2021 the exit date was 01/2 found in compliance w infection control regul the CMS and Centers Prevention (CDC) reco prepare for COVID-15	at an unannounced affection Control Survey and on and exited on al information was obtained and 01/21/2021. Therefore, 21/2021. The facility was with 42 CFR §483.80 ations and has implemented of or Disease Control and commended practices to D. Two of the 11 complaint stantiated resulting in a					
F 686 SS=D	Treatment/Svcs to Pro CFR(s): 483.25(b)(1)( §483.25(b) Skin Integ §483.25(b)(1) Pressu Based on the compre resident, the facility m (i) A resident receives professional standard pressure ulcers and d	event/Heal Pressure Ulcer (i)(ii) rity re ulcers. hensive assessment of a	F 68	6		2/17/21	

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 02/12/2021 // APPROVED ). 0938-0391	
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345473	B. WING			C 01/21/2021		
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	AKE HEALTHCARE CEN	NIER		С	HARLOTTE, NC 28212			
(X4) ID PREFIX TAG			ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 686	(ii) A resident with pre	ey were unavoidable; and	F	686				
	<ul> <li>with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.</li> <li>This REQUIREMENT is not met as evidenced by:</li> <li>Based on observation, staff, hospice nurse and nurse practitioner interviews, and record review, the facility failed to obtain treatment orders and document assessments of a sacral pressure ulcer for 1 of 3 sampled residents with pressure ulcers (Resident #1).</li> <li>The findings included:</li> <li>Resident #1 was readmitted to the facility on 01/07/2021 with diagnoses which included a long-term mental disorder and hypertension.</li> </ul>							
					1. The facility failed to obtain treatmen orders and document assessments for Resident #1 with a sacral pressure ulce Wound Nurse obtained a treatment ord from Nurse Practitioner on 1/19/21 and Resident #1 was seen by VOHRA Wou	er. der		
					Physician on 1/27/21. The Wound Nurse was reeducated on 1/19/21 by the Director of Nursing to measure wounds weekly to include			
					Hospice residents and to ensure documentation of assessments weekly			
	01/07/2021 document a sacral pressure ulce The necrotic sacral pr The hospital discharg measurements or ord sacral pressure ulcer.				2. On 1/25/21 Nursing Management, to include Director of Nursing, Unit Manag and Wound Nurse completed 100% sk sweeps on current residents to identify wounds and ensure treatment orders in place. Nursing Management also reviewed resident with wound Treatment	ger, in 1		
	01/07/2021 document with memory problem documented the press ulcer. There was no	ence of a sacral pressure			Administration Record to ensure orders place and correct. Issues identified wer corrected and/or treatment orders obtained for wounds. 3. The Director of Nursing implemented wound/ Skin referral form for nurses to	e		
	Resident #1's care pla	an revised on 01/07/2021 ence of a pressure ulcer on			notify the wound nurse of any new skin issues. this training completed on 2/8/2 Designated mail box was implemented	1.		

Facility ID: 923567

If continuation sheet Page 2 of 5

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	02/12/202 APPROVE 0938-039	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
	345473		B. WING		C 01/21/2021		
NAME OF PROVIDER OR SUPPLIER WILORA LAKE HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE	-		
				6001 WILORA LAKE ROAD			
				CHARLOTTE, NC 28212			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	TION SHOULD BE COMPLETIC THE APPROPRIATE DATE		
F 686	Continued From page	e 2	F 686				
	the sacrum. Interver		1 000	out side the wound nurse door fo	or any		
		tments as ordered, assess,		referral. The wound nurse is now	•		
	record monitor wound			to assess all new			
		ation to include measurement		admissions/readmissions within	24 hours		
	of area of skin break	down's width, length, depth,		of admission.			
	and type of tissue.			The Director of Nursing and/or R			
				Manager will re-educate License			
	Resident #1's readmi			on the clinical guidelines for skin			
	•	d no orders for treatment of		wounds. Also on new wound/ski			
	-	Icer. Resident #1 received		form and protocol. The wound nu			
	admission to hospice	care on 01/14/2021.		responsible to notify the wound of any new skin issues and obtain t			
	Observation with the	wound nurse on 01/19/2021		order as directed.	leatment		
		Resident #1's sacrum					
		ean dressing. The wound		On admission/re-admission the I	icensed		
	-	acral dressing. Resident		nurse will evaluate the resident	s skin,		
	#1's sacral pressure	ulcer was approximately 5		document/describe wounds, and	initiate		
	centimeters (cm.) by 7 cm. with a darkened			treatment orders, if needed. The			
	center approximately	1 cm. by 2 cm.		education will be completed by 2			
				This education will be provided to			
		und nurse on 01/19/2021 at		employees as part of new hire of			
		the absence of treatment 1's sacral pressure ulcer.		contract staff and agency staff, the education will be provided prior t			
		nounced she obtained orders		work. Current staff will be educated	-		
		or a wet to dressing sacral		to their next scheduled shift.			
	• • • •	vound nurse explained she		During Clinical morning meeting	the		
		ent orders since Resident #1		Director of Nursing, Wound Nurs			
	•	e and thought the hospice		Manager, and MDS will review n	ew		
		nent orders. The wound		admissions/readmissions to ensu			
	•	ent #1's sacral pressure		residents admitted with wounds	have		
		easured since admission on		treatment orders and	und in		
	01/07/2021.			documentation/description of wo			
	Interview with Nurse	Aide (NA) #1 on 01/19/2021		place.			
		Resident #1 required total		4. The Director of Nursing and/or	r Nursing		
		NA #1 reported Resident		designee to perform Quality Imp	-		
		sing. If the dressing became		monitoring of 5 residents with wo			
		ed the nurse who changed		have treatment orders and docu			
		eported the dressing was		assessments to be completed 2	times a		

Event ID: FU2411

Facility ID: 923567

If continuation sheet Page 3 of 5

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				OMB NO. 0938-039			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345473		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED C	
		NAME OF PROVIDER OR SUPPLIER					
WILORA LAKE HEALTHCARE CENTER							
SUMMARY ST	ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)	
		PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETION	
Continued From page	e 3	F 68	86				
changed daily by the	nurse.			week for 4 weeks, then weekly x 2			
- · · ·				months, and then 1 x monthly for 3			
				months.			
			•	e on			
-			consist of but not limited to Executive				
			Director, Director of Nursing, Staff				
appeared to slightly in			-	ger,			
			Social Services, Medical Director,				
pressure ulcer.							
During an interview w			direct Care giver. Quality Improvement				
			Quality Monitoring schedule modified				
•			based on findings.				
			AOC Date: 2/17/21				
unstageable. The hospice nurse estimated the							
he cleansed and changed the sacral dressing. The hospice nurse explained Resident #1's							
-							
end of life care. The hospice nurse reported the							
documentation of the	sacral pressure ulcer.						
-							
(NP) on 01/19/2021 at 12:58 PM revealed the NP							
	•						
	t assessments of the						
	CORRECTION ROVIDER OR SUPPLIER AKE HEALTHCARE CEI SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page changed daily by the During an interview w at 12:20 PM, Nurse # Resident #1 on 01/07 she completed a full I Resident #1 and orall the sacral wound to t explained she change daily and relied on the orders for the dressin reported Resident #1 appeared to slightly in dry dressing changes not measure or docur pressure ulcer. During an interview w 01/19/2021 at 12:35 I reported Resident #1 care on 01/14/2021 at nurse visit on 01/15/2 reported Resident #1 care on 01/14/2021 at nurse visit on 01/15/2 reported he assessed unstageable. The ho wound measured 12 eschar tissue center. he cleansed and chan The hospice nurse ex- hospice care consisted end of life care. The facility would be resp documentation of the Telephone interview w (NP) on 01/19/2021 at was aware of Reside and relied on the faci orders and document	CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         ASSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 3 changed daily by the nurse.         During an interview with Nurse #1 on 01/19/2021 at 12:20 PM, Nurse #1 revealed she admitted Resident #1 on 01/07/2021. Nurse #1 reported she completed a full body assessment on Resident #1 and orally reported the presence of the sacral wound to the wound nurse. Nurse #1 explained she changed Resident #1's dressing daily and relied on the wound nurse to obtain orders for the dressing change. Nurse #1 reported Resident #1's sacral pressure ulcer appeared to slightly improve with the daily wet to dry dressing changes. Nurse #1 reported she did not measure or document a description of the pressure ulcer.         During an interview with the hospice nurse on 01/19/2021 at 12:35 PM, the hospice nurse reported Resident #1 was admitted to hospice care on 01/14/2021 and received the first skilled nurse visit on 01/15/2021. The hospice nurse reported he assessed the sacral wound as unstageable. The hospice nurse estimated the wound measured 12 cm. by 8 cm. with a dark eschar tissue center. The hospice nurse reported he cleansed and changed the sacral dressing. The hospice nurse explained Resident #1's hospice care consisted of pain management and end of life care. The hospice nurse reported the facility would be responsible for treatment and documentation of the sacral pressure ulcer.         Telephone interview with the Nurse Practitioner (NP) on 01/19/2021 at 12:58 PM revealed the NP was aware of Resident #1's sacral pressure ulcer and rel	CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING         345473       B. WING	CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING	CORRECTION     IDENTIFICATION NUMBER:     A. BUILDING       345473     B. WING       COVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       AKE HEALTHCARE CENTER     BUILDING       Changed daily by the nurse.     DROVIDER OR SUPPLIER       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID       Continued From page 3     ID       changed daily by the nurse.     F686       During an interview with Nurse #1 on 01/19/2021 at 12:20 PM, Nurse #1 revaled she admitted Resident #1 and orally reported the presence of the sacral wound to the wound nurse. Nurse #1 reported Resident #1's dressing daily and relied on the wound nurse to obtain orders for the dressing change. Nurse #1 reported she did nurse visit on 01/15/2021. The hospice nurse reported Resident #1's acral pressure ulcer appeared to slightly improve with the daily wet to dry dressing changes. Nurse #1 reported she did nurse with the hospice nurse erported Resident #1's acral pressure ulcer appeared to slightly improve with the daily wet to dry dressing change. Nurse #1 reported she did nurse with on 01/15/2021. The hospice nurse erported Resident #1's hospice nurse erported Resident #1's hospice nurse erported the gasersed the sacral wound as unstageable. The hospice nurse reported he cleansed and changed the sacral dressing, The hospice nurse explained Resident #1's hospice care consisted of pain management and end of life care. The hospice nurse reported he cleansed and changed the sacral pressure ulcer.       Telephone interview with the Nurse Practitioner (NP) on 01/15/2021 at 12:55 PM revealed the NP was aware of Resident #1's hospice care consisted of pain management and end	CORRECTION         IDENTIFICATION NUMBER:         A BUILDING         Continued           345473         B. WING         B. WING         0           CONDER OR SUPPLER         STREET ADDRESS, CITY, STATE, 2P CODE         601 WILCOR LAKE ROAD         CHARLOTTE, NC 28212         0           SUMMARY STREMENT OF DEFICIENCIES         ID         PROVIDER'S PLAN OF CORRECTION         CARLOTTE, NC 28212         0           Continued From page 3         Changed daily by the nurse.         During an interview with Nurse #1 on 01/19/2021         In Executive Director Street ADDRESS, CITY, STATE, 2P CODE         0           Continued From page 3         Changed daily by the nurse.         During an interview with Nurse #1 on 01/19/2021         F 686           Week for 4 weeks, then weekly x 2 months, and then 1 x monthly for 3 months.         The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 21/17/21. The Executive Director is responsible for induced the plan of corrector is start pressure ulcer appeared to signify improve with the daily wet to dry dressing change. Nurse #1 reported she did nor of Secutive Director, Housekeeping Services, Director Hursing, Staff           During an interview with the hospice nurse reported the sacral working with a dark eschar tissue center. The hospice nurse reported the first skilled nurse with on 1/15/2021. The hospice nurse reported the sacral working schedule modified based on findings.           Nurse gintensive with the Auge reported the preproting schedule modified based on findings.	

If continuation sheet Page 4 of 5

CENTERS FOR MEDICARE & MEDICAID SERVICES       OMB NO. 0938-039         STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETED         NAME OF PROVIDER OR SUPPLIER       345473       B. WING       C         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       01/21/2021         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       6001 WILORA LAKE ROAD CHARLOTTE, NC 28212         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG       ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY)       (X5) COMPLETION DATE			ND HUMAN SERVICES				FORM	APPROVED
345473     B. WING     01/21/2021       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     6001 WILORA LAKE ROAD       WILORA LAKE HEALTHCARE CENTER     6001 WILORA LAKE ROAD     CHARLOTTE, NC 28212       (X4) ID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE     (X5) COMPLETION DATE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY COMPLETED			
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 PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG       (X5) COMPLETION DATE		345473	B. WING					
WILORA LAKE HEALTHCARE CENTER       CHARLOTTE, NC 28212         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION       (X5)         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG       PREFIX       (EACH CORRECTIVE ACTION SHOULD BE       COMPLETION DATE	NAME OF P	ROVIDER OR SUPPLIER	•	•				
PREFIX TAG         (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         PREFIX TAG         (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE         COMPLETION DATE	WILORA I	NTER						
	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL				(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR	ЗE	COMPLETION
F 686       Continued From page 4       F 686         Interview with the Director of Nursing (DON) on 01/19/2021 at 1:05 PM revealed the wound nurse should have obtained treatment orders from the NP or hospice practitioner and document an assessment which should include a description and measurement of Resident #1's sacral pressure ulcer.       F 686	F 686	Interview with the Dir 01/19/2021 at 1:05 Pl should have obtained NP or hospice practiti assessment which sh and measurement of	ector of Nursing (DON) on M revealed the wound nurse I treatment orders from the ioner and document an nould include a description	F	686			

Facility ID: 923567

If continuation sheet Page 5 of 5