PRINTED: 06/03/2022 FORM APPROVED

Division of Health Service Regulation

	AN OF CORRECTION IDENTIFICATION NUMBER			(X3) DATE SURVEY COMPLETED		
741012741	or contraction	IDENTIFICATION NO.	A. BUILDING:		J JOHN EE	125
		HAL060166	B. WING		05/13	3/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE STEELE CREEK	13600 S TR				
(VA) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	TE, NC 28278	PROVIDER'S PLAN OF CORRECTION	N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 000	Initial Comments		D 000			
	Services conducted a complaint investigation	Department of Social an annual survey and on on 05/10/22- 05/13/22. igation was initiated by the Department of Social				
D 056	10A NCAC 13F .0305	5(f)(4) Physical Environment	D 056			
	(f) The requirements closets are: (4) Housekeeping storage (A) A housekeeping of floor receptor, shall be per 60 residents or por (B) There shall be setting cleaning agent and other substances	parate locked areas for nts, bleaches, pesticides, s which may be hazardous if nandled. Cleaning supplies				
	failed to ensure a lock hazardous personal of the Special Care Unit	ns and interviews, the facility ked area was in place for care items for residents in t (SCU).				
	2:30pm revealed: -Rooms 415, 419 and doors open and easily -In room 422, body lo	between 9:15am and d 422, were unlocked with y accessible to the hallway. btion containing alcohol, two d shampoo was visible and				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	B. WING		05/13/2022
NAME OF PROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	, , , , , , , , , , , , , , , , , , , ,
WIOKOURE STEEL E OREEK	13600 S T	RYON ST		
WICKSHIRE STEELE CREEK	CHARLO	TTE, NC 28278		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 056 Continued From page	21	D 056		
easily accessible in a bathroomIn room 415, several wash, mouthwash, not therapeutic foot crear accessible in an unlo bathroom, and a residence the bedIn room 419, barrier containing alcohol was accessible in an unlo bathroomResidents were obset the hallways, opening residents' rooms and -A resident was obset from the medication of the medicat	bottles of body lotion, body ail polish remover, and m was visible and easily cked cabinet in the dent was observed lying on cream and body wash is visible and easily cked cabinet in the dent was observed lying on cream and body wash is visible and easily cked cabinet in the erved walking up and down is doors leading into entering these rooms. The rooms on 05/11/22 3:00pm on the SCU di 422, were unlocked with any accessible to the hallway. It is not containing alcohol, two dishampoo were visible and in unlocked cabinet in the lottles of body lotion, body ail polish remover, and m was visible and easily cked cabinet in the lottles and easily cked cabinet in the lerved walking up and down doors leading into residents' nese rooms.	D 056		

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 2 of 83

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7 50.25				
		HAL060166	B. WING		05/	13/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
WICKSHIP	RE STEELE CREEK		TRYON ST				
			OTTE, NC 28278				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE	
D 056	Continued From page	e 2	D 056				
	resident's room that v	vas not her room.					
	between 10:00am and revealed: -Rooms 415 and 422 open and easily acces room 419 was unlock open and easily accellar room 422, body lower uncapped razors and easily accessible in a bathroomIn room 415, several wash, mouthwash, not therapeutic foot crear accessible in an unlock bathroom.	tion containing alcohol, two shampoo were visible and n unlocked cabinet in the bottles of body lotion, body ail polish remover, and m was visible and easily cked cabinet in the cream and body wash is visible and easily					
	Review of the Material Safety Data Sheets (MSDS) for personal care products, moisture barrier ointments and nail care products on the items left unsecured on 05/10/22, 05/11/22 and 05/12/22 revealed:						
	lotion could lead to al mental status and had -The shampoos and I vomiting, diarrhea, se gastrointestinal injury warning labels.	otions could cause nausea, rious eye damage and if ingested and all had					
	labeled with external toxicity and had warn	-					
	Interview with a hous	ekeeper on 05/12/22 at					

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 3 of 83

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL060166	B. WING		05/1	3/2022
NAME OF PROVIDER OF	R SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIRE STEEL	E CREEK	13600 S TI CHARLOT	RYON ST TE, NC 28278			
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
11:20am -Housek could ke -She did because -She kep -She sav daily, tak Interview 05/12/22 -She wa to be loc -There w other res things al -If she sa higher si Interview (SCC) o -Staff we in their r -Razors shelvesShe did because prn (whe -The MA passed I Interview 05/13/22 -She we in bed al -She wa up and t -She did	rep in their room in the that was not be that was not be that was not be that was not be that was a resident rooms, and ate food if aw razors, she helf so resident view of the that was a resident room, and toiletries of the that was a resident room. The was a resident room, and toiletries of the that was a resident with the Spon 05/12/22 at the retrained on the that was a resident room. The that was a resident room, and toiletries of the that was not that we have sore the that we have sore the that with a Media of the that was not that was not not know where the that was not not know where was not the that was not that wa	not trained on what residents oms. e rooms for personal items her job. eeping cart always locked. oing in and out of rooms ing things. onal care aide (PCA) on revealed: what personal items needed e SCU. t who went in and out of picked things up, moved it was left in the rooms. e would move them up on a ints could not reach them. ecial Care Coordinator 11:45am revealed: what residents could have should be kept on the top nat staff were trained on now meone coming in and doing d) training. ooms at times when they	D 056			

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 4 of 83

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL060166	B. WING		05/13/2022
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	
WICKSHI	RE STEELE CREEK	13600 S TI CHARLOT	RYON ST TE, NC 28278		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 056	2:20pm revealed: -He did not know how checked for hazardsA supervisor should being checkedHe had not informed could be brought into	often the rooms should be see overseeing the rooms family members on what the SCU.	D 056		
D 164	Diabetic Residents An adult care home s the care of residents of unlicensed staff prior insulin as follows: (1) Training shall be increased pha practitioner. (2) Training shall incleased facts about in the management of (b) insulin action; (c) insulin storage; (d) mixing, measuring for insulin administration.	thall assure that training on with diabetes is provided to to the administration of provided by a registered remacist or prescribing ude at least the following: diabetes and care involved if diabetes; g and injection techniques ion; evention of hypoglycemia including signs and initoring; universal ions;	D 164		

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 5 of 83

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL060166	B. WING		05	3/13/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	·		
WICKSHIE	RE STEELE CREEK		TRYON ST				
		CHARLO	TTE, NC 28278				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 164	Continued From page	5	D 164				
	facility failed to ensure Aides (Staff A and Sta- insulin and obtained f residents, completed	as evidenced by: and record reviews, the e 2 of 3 sampled Medication aff C), who administered inger stick blood sugars for training on the care of or to the administration of					
	The indings are.						
	Review of Staff A's, medication aide (MA), personnel record revealed: -There was a hire date of 02/21/22. -There was no documentation Staff A had completed training of diabetic residents.						
	Staff A documented th	March 2022 eMAR revealed ne administration of sliding dent on 03/21/22, 03/23/22, 2.					
		April 2022 eMAR revealed ne administration of sliding dent on 04/04/22.					
	8:48am revealed: -She was hired by the February 2022 as a p and MAShe had not taken th Aide examShe had not received	ersonal care aide (PCA) e North Carolina Medication d any training related to ation by a facility Registered any other licensed al.					

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 6 of 83

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED
		HAL060166	B. WING		05	5/13/2022
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
WICKSHII	RE STEELE CREEK		TTE, NC 28278			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 164	medication administra and the Business Off -On 04/04/22, she was medications at the farwere available to ass Refer to interview wit Coordinator (RCC) of Refer to interview wit 05/13/22 at 2:04pm. 2. Review of Staff C's personnel record reverthere was a hire data. There was no docunt completed training of Review of resident's Staff C documented the scale insulin to a resi 03/06/22, 03/10/22, 03/24/22, 03/28/22, 03/24/22, 03/24/22, 03/28/22, 03/25/22. Review of resident's Staff C documented the scale insulin to a resi 04/11/22, 04/16/22, 004/25/22. Telephone interview was 2:35pm revealed: -She was employed the care aide (PCA) and February 2022In February 2022, shadministration training former Special Care of the scale insuling the special care aide car	ation training from other MAs ice Manager (BOM). as scheduled to administer cility, no additional MA's ist her. th the Resident Care no 05/13/22 at 8:30am. th the Administrator on s, medication aide (MA), ealed: the of 10/02/21. mentation Staff C had	D 164			

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 7 of 83

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		HAL060166	B. WING		05/13/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE STEELE CREEK	13600 S TF				
		CHARLOT	TE, NC 28278			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE	
D 164	Continued From page	e 7	D 164			
	-She did not know wh training the former SC -She was scheduled t Medication Aide exan	nat medication administration CC had prior to training her. to take the North Carolina n on 05/08/22. le started to administer				
	Refer to interview with the Resident Care Coordinator (RCC) on 05/13/22 at 8:30am. Refer to interview with the Administrator on 05/13/22 at 2:04pm Interview with the RCC on 05/13/22 at 8:30am revealed: -The RCC worked with the Special Care Unit Coordinator (SCC) and Administrator to ensure					
		ropriate training for their				
		stered Nurse (RN) was ling diabetic training for the				
	-The Administrator wa the Corporate RN to s for staff.	as responsible for notifying schedule required training				
	of diabetic residents to injections.	ld have training on the care pefore administering insulin				
	-The RCC and SCC a maintaining staff train					
	2:04pm revealed: -The Corporate RN is diabetic training for th -He and the RCC, SC Manager are respons Corporate RN to sche -He expected diabetic	responsible for providing the staff. CC and Business Office tible for contacting the edule required training. Training be completed prior insulin or checking blood				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 8 of 83

PRINTED: 06/03/2022 FORM APPROVED

Division of Health Service Regulation

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL060166	B. WING		05/13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
WICKSHII	RE STEELE CREEK	13600 S T CHARLO1	RYON ST ITE, NC 28278		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 164	Continued From page sugars. -The RCC and SCC a maintaining staff train	are responsible for	D 164		
D 273	. ,		D 273		
	facility failed to ensure meet the routine and 2 of 7 sampled reside not receiving a blood month (March 2022) is clots and signs of blemissed doses of a meretention, a medication treat anxiety and a vital The findings are: 1. Review of Residen revealed diagnoses in disease and hypertent Review of Resident # summary dated 11/05-Resident #1 was hosembolism (blood clot-Discharge medication)	and record reviews, the e referral and follow-up to acute health care needs for ints (#1, and #7) related to thinning medication for a ncreasing the risk for blood eding in April 2022 (#1) and edication to treat fluid on for mood, a medication to amin supplement (#7). It #1's FL2 dated 09/28/21 included coronary artery sion. I's hospital discharge in the size of			

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 9 of 83

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL060166	B. WING		05/13/2022		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
WICKSHIRE STEELE CREEK 13600 S T			TRYON ST				
Wiokoiiii	NE OTELLE ONLEN	CHARLO	OTTE, NC 28278				
(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 CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPL	ETE	
D 273	Continued From page	9	D 273				
	take 5mg twice daily l	peginning 11/12/21.					
	-Resident #1 was pre medication to decreastablet dailyAn INR blood test was and monthly thereafted. Review of the PCP's 03/29/22 revealed: -Warfarin 5mg one ta Resident #1.	ranote dated 03/28/22 raban was discontinued. scribed warfarin (a se blood clotting) 5mg one as to be done in one week er. order for Resident #1 dated blet daily was prescribed for have an INR blood test in					
	medication administration record (eMAR) revealed: -There was an entry for rivaroxaban 10mg dailyThere was no entry for warfarin 5mg, one tablet						
	-There was no entry for warfarin 5mg, one tablet daily. Review of Resident #1's April 2022 eMAR revealed: -There was an entry for rivaroxaban 10mg daily with a discontinue date of 04/12/22There was an entry for warfarin one tablet four times daily at 8:00am, 12:00pm, 4:00pm, and 8:00pmThere was no dosage indicated for the warfarin entryThe entry was documented as administered 14 instances from 04/12/22 to 04/15/22, 19 instances from 04/18/22 to 04/22/22, and 4 instances on 04/25/22.						

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 10 of 83

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C		. ,	E SURVEY PLETED
		HAL060166	B. WING		05	5/13/2022
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
WICKSHII	RE STEELE CREEK		TRYON ST TTE, NC 28278			
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	-Her INR result dated was 8.91 (therapeutic critically high, and wat PCP's officeHer INR result dated was high, greater that facilityHer INR result dated was high, greater that was high, greater that Review of Resident # 04/15/22 revealed: -Resident #1's INR was to be have -A stat (urgent) INR was (04/18/22)Facility staff were to taking rivaroxaban as 03/29/22. Review of Resident # 04/25/22 revealed: -Resident #1 had an eler warfarin was plangled -Resident #1 was to be stool, fatigue, dizzine chest pain. Review of Resident # 04/26/22 revealed: -"Please continue to be revealed of Resident #1 was to be revealed of Resident #1 was to be revealed"Please make sure regiven"The INR was to be revealed of Resident #1 was to be revealed of Resident #1 was to be revealed.	e1's INR results revealed: d 04/15/22 revealed the INR e range 2.0-3.0) which was as reported to Resident #1's d 04/19/22 revealed the INR in 10 and was reported to the d 04/26/22 revealed the INR in 10. d PCP's order dated as 8.91. deld until further notice. d as to be done on Monday make sure patient was not d it was discontinued on delevated INR close to 10. ded on hold. de monitored for blood in her ass, shortness of breath and delevated INR close to 10. ded on hold. de monitored for blood in her ass, shortness of breath and delevated INR close to 10. decen on hold. delevated INR close to 10. delevated INR clo	D 273	DEFICIENT		
	notified of the high IN					

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 11 of 83

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (COMPLI	ETED		
		HAL060166	B. WING		05/1	3/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE		
MICKENIE	RE STEELE CREEK	13600 S	TRYON ST			
WICKSHIP	NE STEELE OREEK	CHARLO	TTE, NC 28278			
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	e 11	D 273			
	monitored for bleedin					
	05/13/22 at 10:07am					
	 -Resident #1 was ble before she was sent 	eding for about a week				
		blood on the resident's arm				
	on 04/18/22.					
		e Business Office Manager				
	(BOM) who was previously the facility's lead MA, and was told to report it to the Special Care					
	Coordinator (SCC) be	ecause the RCC was off.				
	 She was not sure wholeeding to. 	no the SCC reported the				
	-On 04/20/22, she wit #1's buttocks and in h	tnessed blood on Resident's ner brief.				
		the SCC who looked at the				
		ause she could not identify				
		g, she could not send the				
	would just send her b	al because the hospital back to the facility.				
	-The SCC stated the	resident was probably				
	picking at her arm an bottom.	d wiping the blood on her				
		he resident's brief 2-3 times				
	that shift, along with he to the bleeding.	ner clothes and bedding, due				
		to look at resident at least				
	two separate times a	nd she argued with her				
	about where the bloo					
		ported to the MA Resident the MA sent her to the				
	hospital immediately.					
	Interview with a MA or	on 5/11/22 at 4:10pm				
		the date but observed				

Division of Health Service Regulation

Resident #1's brief soaked with urine and it was

STATE FORM 6899 RH7E11 If continuation sheet 12 of 83

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		HAL060166	B. WING		05	5/13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
WICKSHII	RE STEELE CREEK	13600 S T	RYON ST			
Wickerin	NE OTELLE ONLEN	CHARLO	TTE, NC 28278			
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	: 12	D 273			
	was blood on her she -She reported it to the (RCC)She was told by the	Resident Care Coordinator RCC not to send the al and that she would call				
	2:35pm revealed: -On 04/26/22, she wa Resident #1 had bloo bedOn 04/26/22, she cal #1 sent to the emerge	eding from her nose, mouth,				
	summary dated 05/04 -Resident #1 was hos 05/04/22 for gastroint -Resident #1's Interna (INR) blood test resul	pitalized from 04/26/22 to estinal bleeding. ational Normalized Ratio t (a test that measures the was greater than 13.1, beutic level (2.0-3.0).				
	revealed: -A staff member informone Resident #1's bed but staff member or where -She observed the spand looked as though -The staff member can regarding another sponshe looked at the secondary.	she could not recall what it was. ot and it was dark red, dry it had been there awhile. me to her a second time ot, but she could not recall if				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 13 of 83

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	I ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING: _	A. BUILDING:		
	HAL060166	B. WING		05/13/2022	
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
WICKSHIRE STEELE CREEK	13600 S	TRYON ST			
WIGHT OF LELE ONLER	CHARLO	TTE, NC 28278			
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
D 273 Continued From page 13	3	D 273			
did not notify the resident could not identify where from. -She was not sure if she on a blood thinning medi resident was not on her esident was not on her esident was not on her esident was able the bleeding. Interview with the RCC or revealed: -She could not recall the Resident #1's room by a because the resident was blood spots on her sheet on her bottom and she fewere related to the wetners.	the blood was coming knew Resident #1 was ication because the unit. I the RCC and Resident to identify the source of the but was called to nother staff member is wet and there were it. Wet and had an abrasion elt the spots of blood less and the abrasion. follow up was necessary ided to be kept dry. leeding to Resident #1's in the thick with the spots of blood in the abrasion. follow up was necessary ided to be kept dry. leeding to Resident #1's in the dates. If you had a restart in the dates in the spots of blood in the dates. If a Resident #1's PCP on aled: If Resident #1's PCP on aled: If the spots of blood it. If Resident #1's PCP on aled: If the spots of blood it. If th	D 273			

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 14 of 83

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVINON COMPLETE AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A PUBLICATION OF CORRECTION COMPLETE					
			A. BUILDING: _			
		HAL060166	B. WING		05	13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHII	RE STEELE CREEK		RYON ST TTE, NC 28278			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF	CORRECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	2 14	D 273			
D 2/3	day instead of once of -Each time he was not gave an order to hold -He did not give any of warfarin to restart. -Possible outcomes of prescribed doses of a included internal blee. Interview with the Adr 2:05pm revealed: -A couple PCAs ment bleeding to the SCC to where the bleeding of the expected a reside any resident was bleed. b. Review of Resident dated 02/04/22 reveating one tablet twice.	aily as prescribed. otified of high INR results, he Resident #1's warfarin. orders for Resident#1's of taking higher than enticoagulant medications ding and death. ministrator on 05/13/22 at cioned Resident #1's out she could not determine riginated. ent's PCP to be notified if eding. t #1's signed PCP's orders led an order for apixaban	D 273			
	-There was an adden Resident #1's family vanticoagulant medica -An order for rivaroxa	ban (a medication to ng) 10mg one tablet daily				
	03/01/22 revealed: -The apixaban was di -Resident #1 was pre one tablet daily. Review of Resident # revealed:	order for Resident #1 dated scontinued. scribed rivaroxaban 10mg 1's March 2022 eMAR or rivaroxaban 10mg one				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 15 of 83

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	I ` '	E SURVEY PLETED
			A. BUILDING: _			
		HAL060166	B. WING		05	5/13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		13600 S T	RYON ST			
WICKSHII	RE STEELE CREEK		TTE, NC 28278			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	DE CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	COMPLETE DATE
D 273	Continued From page	e 15	D 273			
	-The rivaroxaban enti 03/03/22 and a discor- The rivaroxaban was administered 11 insta 03/31/22. -There were 18 instar documented with a co	ry had a start date of ntinue date of 04/12/22. s documented as nces from 03/03/22 to nces the rivaroxaban was ode "09" indicating the dministered and to see the				
	revealed: -There was an entry f tablet daily with a disc -The rivaroxaban was administered 4 times and discontinued on 0 -There were 7 instance documented with a co	or rivaroxaban 10mg one continue date of 04/12/22. s documented as from 04/01/22 to 04/11/22,				
	from 03/03/22 to 04/1 -There were 22 instar not administered becareceived or was on or -On 03/23/22, the me with a family member rivaroxaban was too wanted to speak with an alternative medical MA would notify the Fivisited the facilityThere were two insta 04/05/22, when there why the medication was discounted to the progress note dismedication was discounted to the second to the progress of the control of the progress of t	ause it had not been reder. dication aide (MA) spoke reand was informed the expensive and the family Resident #1's PCP about tion. The note indicated the PCP on 03/24/22 when he reaces, on 04/04/22 and reason was not administered.				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 16 of 83

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE			URVEY ETED
AND PLAN	OF CORRECTION	A. BUILDING:		EIED		
		HAL060166	B. WING		05/1	3/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
MICKSHIE	RE STEELE CREEK	13600 S T	RYON ST			
WICKSHIP	RE STEELE CREEK	CHARLOT	TE, NC 28278			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 273	Continued From page	e 16	D 273			
		an was not administered as				
	Resident #1's pharma revealed: -The pharmacy filled and family members particleThey received an ordinary one tablet daily on 03The prescription was family had not come to the property of the prescription was family had not come to the p	der for rivaroxaban 10mg d/04/22. In not filled because the to pick it up.				
	Telephone interview with Resident #1's family member on 05/12/22 at 11:52am revealed: -She picked up Resident #1's medications from the pharmacy and delivered them to the facility. -She had not picked up the rivaroxaban medication because of cost. -She thought the resident was still getting her previous anticoagulant medication while waiting					
	blood clotting) order in -The facility had not in resident did not receiva- -Facility staff gave he occasions they had man residents ran out of th	nformed her of any times the ve anticoagulant medication. In the impression on multiple medications available if meir medication, such as its from another resident who				
	revealed: -She would call the pl resident's medication administration.	was not available for edication, she might contact when a resident's				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 17 of 83

DIVISION	of Health Service Regu	liation	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		HAL060166	B. WING		05/43/2022	
		TALUOU 100			05/13/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		13600 S 7	RYON ST			
WICKSHIP	RE STEELE CREEK	CHARLO	TTE, NC 28278			
040.15	SLIMMADV ST.	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	1 0/5	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(- /	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		
				DEFICIENCY)		
D 273	Continued From page	2 17	D 273			
D 210	Continued From page	- 11	5273			
	Interview with the RC	C on 05/12/22 at 9:15am				
	revealed:					
		for the facility about seven				
	weeks ago and her re	esponsibility was to staff the				
	building.					
	·	vious day (05/11/22) it was				
	•	ollow up with the pharmacy				
	_	CP if a medication was not				
	administered.					
	-MAs were trained if a					
		er, they were to document it				
	-	ovide a reason why the				
	medication was not g					
		low up with the pharmacy				
	•	n a medication was not				
	available for administ					
		ere was a report that could				
		to see what medications				
	were not administered	a to residents.				
	Talambana intensiass.	with Decident #415 DCD on				
		with Resident #1's PCP on				
	05/11/22 at 4:19pm re	evealed. escribed anticoagulant				
	medications because					
		ral pulmonary emboli (blood				
	clots in the lungs).	rai pulitionary emboli (blood				
	o ,	continued Resident #1's				
		rivaroxaban at the request				
	of the family.	Transaban at the request				
	•	e rivaroxaban had not been				
	picked up from the ph					
		Resident #1's rivaroxaban				
	was not administered					
	-Possible outcomes of					
		ition as ordered included				
		d death from a pulmonary				
	embolism.					

Division of Health Service Regulation

Interview with the Administrator on 05/13/22 at

STATE FORM 6899 RH7E11 If continuation sheet 18 of 83

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
		HAL060166	B. WING		05/13/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
WICKSHIE	RE STEELE CREEK		TRYON ST TTE, NC 28278		
()(1) ID	OUR MARK OTATEMENT OF DEFINITION			PROVIDER'S PLAN OF CORRECTIO	N (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 273	Continued From page	÷ 18	D 273		
D 273	2:05pm revealed: -He expected the MA resident's PCP after the medicationMedication carts were the night shift MA to eavailable for administedHe was not sure if the was not administration. a. Review of Resident Provider's (PCP) order an order for furosemic retention) 40mg, take Review of Resident #Medication Administration 05/01/22 to 05/13/22 -There was an entry for tablets to be administration 05/01/22 and 05/14 two tablets were document administeredOn 05/09/22 to 05/13 tablets were document reurosemide was not administered 7 of 13 due to medication not observation of Residualiable for administration.	or the RCC to notify the he first missed dose of a se to be audited weekly by ensure medications were ration. e medication cart audits d. t #7's current FL2 dated agnosis that included frank t #7's Primary Care or dated 04/14/22 revealed de (used to treat fluid two tablets daily. T's May 2022 electronic fation Record (eMAR) from revealed: or furosemide 40mg, two fered daily at 8:00am. 04/22, furosemide 40mg, two field as not administered. documented as popportunities in May 2022 available. ent #7's medication ration on 05/11/22, 05/12/22 defined as not furosemide defined as not furosemide defined as not furosemide defined as not not on 05/11/22, 05/12/22 defined was no furosemide	D 273		
		vith a Pharmacist for the narmacy on 05/13/22 at			

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 19 of 83

NAME OF PROVIDER OR SUPPLIER STEELT ADDRESS, CITY, STATE, ZIP CODE 1880 S TRYON ST CHARLOTTE, NC 28278 MA ID PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX PROVIDER'S PLAN OF CORRECTION PREFIX P	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE S COMPLI		
MORKSHIRE STELLE CREEK 13600 S TRYON ST CHARLOTTE, NC 28278 13600 S TRYON ST CHARLOTTE, NC 26100 S TRYON SHOULD BE CROSS-REPERVACION SHOULD BE AND SHOULD BE AND SHOULD BE CROSS			HAL060166	B. WING		05/1	3/2022
(XA) ID (XA) I	NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PREFIX TAG (LEACH DEFICIENCY MUST BE PRECEDED BY FULL TAGG REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 19 12:45pm revealed possible outcomes of not receiving furosemide included fluid buildup, swelling and increase in blood pressure. b. Review of Resident #7's PCP order dated 02/01/12/2 revealed an order for infelipine ER (used to treat high blood pressure) somotic release tablet 60mg, 1 tablet twice daily. Review of Resident #7's May 2022 eMAR from 05/01/12/2 to 05/13/22 revealed: -There was an entry for infelipine 60mg to be administered daily at 8:00am and 8:00pmOn 05/01/22 to 05/06/122, nifedipine 60mg was administered once dailyOn 05/01/22 to 05/13/22, nifedipine 60mg was administered once dailyOn 05/01/22 to 05/13/22, nifedipine 60mg was documented as not administered once dailyOn 05/10/22 to 05/13/22, nifedipine 60mg was documented as not administered floor once dailyOn 05/10/22 to 05/13/22, nifedipine 60mg was documented as not administered note dailyOn 05/10/22 to 05/13/22, nifedipine 60mg was documented as not administered note dailyOn 05/10/22 to 05/13/22 to 05/13/22 and 05/13/22 and 05/13/22 revealed there was no nifedipine 60mg was documented as not administered note with the precedence of the facility's contracted pharmacy on 05/13/22 at 12:45pm revealed possible outcomes of not receiving infedipine included heart rate and blood	WICKSHIP	RE STEELE CREEK					
12:45pm revealed possible outcomes of not receiving furosemide included fluid buildup, swelling and increase in blood pressure. b. Review of Resident #7's PCP order dated 02/01/22 revealed an order for nifedipine ER (used to treat high blood pressure) osmotic release tablet 60mg, 1 tablet twice daily. Review of Resident #7's May 2022 eMAR from 05/01/22 to 05/13/22 revealed: -There was an entry for nifedipine 60mg to be administered daily at 8:00am and 8:00pm. -On 05/01/22 to 05/02/22, nifedipine 60mg was documented as not administered. -On 05/04/22 to 05/06/22, nifedipine 60mg was administered once daily. -On 05/09/22, nifedipine 60mg was administered once daily. -On 05/10/22 to 05/13/22, nifedipine 60mg was documented as not administered. -Nifedipine was not documented as administered 16 of 25 opportunities in May 2022 due to medication not available. Observation of Resident #7's medication available for administration on 05/11/22 and 05/13/22 revealed there was no nifedipine 60mg tablets available for administration. Telephone interview with a Pharmacist for the facility's contracted pharmacy on 05/13/22 at 12:45pm revealed possible outcomes of not receiving nifedipine included heart rate and blood	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETE
c. Review of Resident #7's PCP order dated 02/01/22 revealed an order for aripiprazole (used to treat mood) 2mg daily.	D 273	12:45pm revealed por receiving furosemide swelling and increase b. Review of Resider 02/01/22 revealed an (used to treat high blorelease tablet 60mg, Review of Resident # 05/01/22 to 05/13/22 -There was an entry fradministered daily at -On 05/01/22 and 05/documented as not at -On 05/04/22 to 05/06 administered once da -On 05/09/22, nifedipionce dailyOn 05/10/22 to 05/13 documented as not at -Nifedipine was not do 16 of 25 opportunities medication not available for administrand 05/13/22 revealed 60mg tablets available. Telephone interview v facility's contracted ph 12:45pm revealed por receiving nifedipine in pressure issues.	ssible outcomes of not included fluid buildup, in blood pressure. In #7's PCP order dated order for nifedipine ER tood pressure) osmotic 1 tablet twice daily. It **T's May 2022 eMAR from revealed: It or nifedipine 60mg to be 8:00am and 8:00pm. It is compared to the second to the second pressure of the second pressur	D 273			

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 20 of 83

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	(X2) MULTIPLE CONSTRUCTION (X3)		
			A. BUILDING:		
		HAL060166	B. WING		05/13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
MICKELII	RE STEELE CREEK	13600 S	TRYON ST		
WICKSIII	NE STEELE ONLER	CHARLO	OTTE, NC 28278		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 273	Continued From page	20	D 273		
	05/01/22 to 05/13/22 -There was an entry f administered daily at -On 05/09/22, aripipra as not administeredOn 05/09/22 to 05/13 documented as not ad- Aripiprazole was not administered 4 of 13 of due to medication not Observation of Residuavailable for administ and 05/13/22 revealed 2mg tablets available Telephone interview v facility's contracted ph 12:45pm revealed pos	or aripiprazole 2 mg, to be 9:00am. azole 2mg was documented 8/22, aripiprazole 2mg was dministered. documented as opportunities in May 2022 available. ent #7's medication ration on 05/11/22, 05/12/22 d there was no aripiprazole			
	02/01/22 revealed an to treat anxiety) 0.5mg. Review of Resident # 05/01/22 to 05/13/22 -There was an entry f administered daily at -On 05/09/22 to 05/13 was documented as r -Clonazepam 0.5mg v 25 opportunities in Manot available. Observation of Reside available for administration of the state of the s	7's May 2022 eMAR from revealed: or clonazepam 0.5mg to be 9:00am and 4:00pm. 8/22, clonazepam 0.5mg not administered. was not administered 9 of ay 2022 due to medication			

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 21 of 83

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			_			
		HAL060166	B. WING		05/13/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE STEELE CREEK	13600 S TF	RYON ST TE, NC 28278			
0/0.15	STIMMADA ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	d over	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 273	Continued From page	21	D 273			
	0.5mg tablets availab	le for administration.				
	facility's contracted pl	with a Pharmacist for the harmacy on 05/13/22 at ssible outcomes of not nincluded anxiety or				
		t #7's PCP order dated order for fluvoxamine (used 00mg daily.				
	05/01/22 to 05/13/22 -There was an entry f at 9:00am -On 05/09/22, fluvoxa documented as not ar -On 05/11/22 to 05/13 was documented as r -Fluvoxamine 100mg	or fluvoxamine 100mg daily amine 100mg was dministered. 8/22, fluvoxamine 100mg				
		ration on 05/11/22, 05/12/22 d there was no fluvoxamine				
	facility's contracted pl 12:45pm revealed po	with a Pharmacist for the charmacy on 05/13/22 at ssible outcomes of not e included depression,				
		#7's PCP's order dated order for Metoprolol (used essure) 25mg daily.				
	Review of Resident #	7's May 2022 eMAR from				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 22 of 83

HAL060166 B. WING		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED
WICKSHIRE STEELE CREEK 13600 S TRYON ST CHARLOTTE, NC 28278			HAL060166	B. WING		0:	5/13/2022
CHARLOTTE, NC 28278			13600 S	TRYON ST	, ZIP CODE		
OUNDATEMENT OF DEFICIENCIES			CHARLO	OTTE, NC 28278			
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273 Continued From page 22 05/01/22 to 05/13/22 revealed: -There was an entry for metoprolol tartrate 25mg to be administered daily at 9.00amOn 05/11/22 to 05/13/22, metoprolol 25mg was documented as not administeredMetoprolol 25mg was not administeredMetoprolol 25mg was not administered at 0.13 opportunities in May 2022 due to medication not available. Observation of Resident #7's medication available for administration on 05/11/22, 05/12/22 and 05/13/22 revealed there was no metoprolol 25mg tablets available for administration. Telephone interview with a Pharmacist for the facility's contracted pharmacy on 05/13/22 at 12-45pm revealed possible outcomes of not receiving metoprolol included heart rate and blood pressure issues. g. Review of Resident #7's PCP order dated 02/01/22 revealed an order for Vitamin D (used as a supplement) 50mcg 1 daily. Review of Resident #7's May 2022 eMAR from 05/01/22 to 05/13/22 revealed: -There was an entry for Vitamin D 50mcg to be administered as not administeredOn 05/09/22 Vitamin D 50 mcg was documented as not administeredOn 05/01/22 to 05/13/22, Vitamin D 50mcg was documented as not administeredVitamin D 50mcg was not administered.	D 273	05/01/22 to 05/13/22 -There was an entry f to be administered da -On 05/11/22 to 05/13 documented as not a -Metoprolol 25mg wa opportunities in May 2 available. Observation of Resid available for administ and 05/13/22 reveale 25mg tablets availabl Telephone interview v facility's contracted pl 12:45pm revealed po receiving metoprolol i blood pressure issues g. Review of Residen 02/01/22 revealed an as a supplement) 50r Review of Resident # 05/01/22 to 05/13/22 -There was an entry f administered daily at -on 05/04/22 Vitamin as not administeredOn 05/09/22 Vitamin as not administeredOn 05/11/22 to 05/13 documented as not a -Vitamin D 50mcg wa opportunities in May 2 available. Observation of Reside	revealed: for metoprolol tartrate 25mg faily at 9:00am. 8/22, metoprolol 25mg was dministered. s not administered 4 of 13 2022 due to medication not ent #7's medication ration on 05/11/22, 05/12/22 d there was no metoprolol e for administration. with a Pharmacist for the harmacy on 05/13/22 at ssible outcomes of not included heart rate and s. It #7's PCP order dated order for Vitamin D (used mcg 1 daily. F7's May 2022 eMAR from revealed: for Vitamin D 50mcg to be 9:00am. D 50mcg was documented 8/22, Vitamin D 50mcg was dministered. Is not administered 5 of 13 2022 due to medication not ent #7's medication	D 273			

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 23 of 83

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	SURVEY
ANDILAN	SI CONNECTION	IDENTIFICATION NOWIDER.	A. BUILDING: _		COM	LLILD
		HAL060166	B. WING		05	/13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIP	RE STEELE CREEK		RYON ST			
		CHARLO	TTE, NC 28278			
(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 CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	e 23	D 273			
		d there was no Vitamin D				
		technician on 05/11/22 at signed refill orders for the				
	facility's contracted pl					
	revealed: -The MA was response medicationsThe process was to redays prior to the med -She did not know Refer medications as or -There was no document the PCP of Resident: -MAs were trained if a available to administe on the eMAR and promedication was not geromedication was not geromedication.	refill the medications 3-5 ications running out. esident #7 was not getting rdered. nentation the MA's notified #7's missed medication. a medication was not er, they were to document it wide a reason why the iven. ow up with the pharmacy n a medication was not				
	revealed: -If the medication was checked to make sure the eMAR and expect that nightIf the medication did	s not on the cart, she the the refill was completed on ted the medication to be in not come in during the the RCC or the Special				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 24 of 83

PRINTED: 06/03/2022 FORM APPROVED

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	I DENTIFICATION NUMBER:		
			A. BUILDING: _			
		HAL060166	B. WING		05/1	3/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHII	RE STEELE CREEK	13600 S TF				
			TE, NC 28278			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETE DATE
D 273	Continued From page	e 24	D 273			
	Care Coordinator (SC	CC) aware the next morning. SCC made the PCP aware				
	11:30am and 05/13/2 -He expected the PCI medications were not residentsHe was unaware Re- orders for seven med -He expected the RC- who would be making medications were not -Medication carts wer the night shift MA to e available for administ -He was not sure if th were being completed -He started running re not feel he was captu on the reports.	sident #7 had no signed refill ications. C and SCC to coordinate of the PCP aware when available. The to be audited weekly by ensure medications were ration. The medication cart audits directly as a second of the				
	resident with physicia of bleeding due to be medication and havin with an INR of greate bleeding in her under not sent to the hospits she was bleeding from her brief, whereby reddays for gastrointestir two units of blood. T	ontact the physician for a an orders to monitor for signs ing on an anticoagulant g critically high lab results, r than 10, who had signs of garments and bed and was all until six days later when m her nose, mouth and in quiring hospitalization for 8 hall bleeding and received this failure resulted in and constitutes a Type A1				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 25 of 83

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3) DATE SI COMPLE		
		HAL060166	B. WING		05	5/13/2022
	ROVIDER OR SUPPLIER	13600 S	ADDRESS, CITY, STATE TRYON ST OTTE, NC 28278	E, ZIP CODE		
(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	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	e 25	D 273			
	this violation. CORRECTION DATE	131D-34 on 05/12/22 for				
D 276	10A NCAC 13F .0902	2(c)(3-4) Health Care	D 276			
	following in the reside (3) written procedure a physician or other liand (4) implementation of	ssure documentation of the				
	facility failed to imple	and record reviews, the ment physician's orders for 1 ts (Resident #8) regarding a				
	The findings are:					
	revealed diagnoses in	8's FL2 dated 03/04/21 ncluded diverticulitis ction in the colon) and				
		8's Primary Care Provider's ed 05/02/22 revealed: noist cough.				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 26 of 83

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	HAL060166	B. WING		05/13/2022	
NAME OF PROVIDER OR SUPPLIER WICKSHIRE STEELE CREEK	13600 S T	DRESS, CITY, STA	TE, ZIP CODE		
	CHARLO	TTE, NC 28278			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 276 Continued From page	26	D 276			
-She had a chest x-ray lobe pneumoniaHe prescribed a Z-Pa antibiotic) and prednis decrease inflammation. Review of Resident #8 Medication Administra revealed: -There was an entry for tablets on 05/04/22There was an entry for tablet daily from 05/05There was no entry for tablet daily from 05/05There was no entry for linterview with a medicat 4:55pm revealed: -Resident #8 left with for (05/11/22) for a leave of Resident #8 took the need while she was as (05/11/22)She documented the resident on a "Leave of Release Form"She did not administed medications today (05 resident left before the Review of Resident #8 Medication Release For revealed prednisone 2 released to the resident. Telephone interview we the facility's contracted 1:10pm revealed: -They received an ord.	k (azithromycin, an one (a medication to n) 20mg one tablet daily. B's May 2022 electronic tion Record (eMAR) or azithromycin 250mg two or azithromycin 250mg one h/22 to 05/07/22. or prednisone. Family that morning of absence. medications she would way with her today medications given to the of Absence Medication er Resident #8's morning h/11/22) because the emorning medication pass. B's Leave of Absence form dated 05/11/22 fong seven tablets were	D 276			

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 27 of 83

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE	SURVEY
			A. BOILDING.			
		HAL060166	B. WING		05	/13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE STEELE CREEK	13600 S T				
	I		TE, NC 28278	T		
(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	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 276	Continued From page	27	D 276			
	-Prednisone 20mg, seven tablets were dispensed on 05/03/22.					
	(RCC) on 05/12/22 at -She started working weeks ago and was s system. -The Special Care Coenter the Z-Pak order eMAR system better. -Both she and the SC the prednisone, and it system. -A new system put in 2022 to have a second orders in the eMAR s work and she was un -The MA that received pharmacy was responded.	for the facility about seven still learning the eMAR coordinator (SCC) helped here because she knew the coordinate to the end of the end of April and staff member view new system for accuracy did not sure why.				
	2:05pm revealed: The MAs, RCC, and Senter new orders into order was receivedThe MAs were responsion of new medications were	SCC were all responsible to the eMAR system when the ensible to compare the label with the order in the eMAR dication arrived from the				
	pharmacyMedication carts wer the night shift MA, con available to the reside -He was not sure if th being completed and	e to be audited weekly by mparing the medications				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 28 of 83

PRINTED: 06/03/2022 FORM APPROVED

Division of Health Service Regulation

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		HAL060166	B. WING		05/13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
WICKSHIF	RE STEELE CREEK	13600 S TR CHARLOT	YON ST TE, NC 28278		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 276	Continued From page	28	D 276		
	PCP on 05/13/22 at 1	2:14pm was unsuccessful.			
D 358	10A NCAC 13F .1004 Administration	(a) Medication	D 358		
	(a) An adult care hom preparation and admin prescription and non-ply staff are in accordad (1) orders by a licens which are maintained (2) rules in this Section and procedures. This Rule is not met a TYPE A1 VIOLATION Based on observation reviews, the facility farmedications as ordered.	need prescribing practitioner in the resident's record; and on and the facility's policies as evidenced by:			
	a medication to treat of treat fluid retention, a medication to treat an and for 2 of 6 resident record review including to decrease blood close	ations to treat hypertension, depression, a medication to medication to treat mood, a xiety and a supplement; ts (#1 and #2) sampled for ag errors with a medication tting (#1), and medication to and decrease anxiety (#2).			
	The findings are:				
	by the observation of opportunities during the	ne 9:00am medication n the Special Care Unit n medication pass on			

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 29 of 83

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	CONSTRUCTION	(X3) DATE S COMPL	
		HAL060166	B. WING		05/	13/2022
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE. ZIP CODE	1 03/	13/2022
		13600 S T	, ,	,		
WICKSHII	RE STEELE CREEK	CHARLOT	TE, NC 28278			
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 358	Continued From page	e 29	D 358			
	Review of Resident #1's FL2 dated 09/28/21 revealed diagnoses included coronary artery disease and hypertension.					
	summary dated 11/05 -Resident #1 was hos embolism (blood clot -Discharge medicatio (a medication to decr	spitalized with a pulmonary in the lung). ns included apixaban 5mg ease blood clotting); take six days and then take 5mg				
	Provider's (PCP) orde	1's signed Primary Care ers dated 02/04/22 revealed 5mg one tablet twice daily.				
	03/01/22 revealed: -There was an adden Resident #1's family vanticoagulant (a med clotting) medicationAn order for rivaroxa	ng) 10mg one tablet daily				
	03/01/22 revealed: -The apixaban was di -Rivaroxaban 10mg of prescribed for Resident Review of Resident # 03/28/22 revealed: -The rivaroxaban was -Resident #1 was pre	one tablet daily was ent #1. ent's PCP's visit note dated e discontinued.				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 30 of 83

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETE						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _			
		HAL060166	B. WING		05/	13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE		
MICKELIII	DE OTEELE ODEEK	13600 S	TRYON ST			
WICKSHII	RE STEELE CREEK	CHARLO	TTE, NC 28278			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	÷ 30	D 358			
2 000	-An International Norr test (a test that meas	malized Ratio (INR) blood ures the time for blood to n one week and monthly				
	03/29/22 revealed: -The rivaroxaban was -Warfarin 5mg one ta Resident #1.	order for Resident #1 dated s discontinued. blet daily was prescribed for have an INR blood test in				
	Review of Resident #1's INR results dated 04/07/22 revealed an INR of 1.92 (therapeutic range 2.0-3.0).					
	Review of Resident #1's PCP's visit note dated 04/11/22 revealed: -Rivaroxaban was discontinuedWarfarin 5mg one tablet daily was prescribedResident was to have an INR blood test in one week and monthly thereafter.					
	Review of Resident # 04/15/22 revealed the critically high.	1's INR results dated INR was 8.91 which was				
	-A stat (urgent) INR w (04/18/22). -"Please make sure p (rivaroxaban). -Rivaroxaban was dis Review of Resident #	as 8.91. eld until further notice. vas to be done on Monday eatient is not taking Xarelto" econtinued on 03/29/22.				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 31 of 83

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVIDED PLAN OF CORRECTION (X3) DATE SURVIDED PLAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVIDED PLAN OF CORRECTION (X3) DATE SURVIDED PLAN OF COMPLETED PLAN OF COMPLETE					
			72025			
		HAL060166	B. WING		05	5/13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	ΓE, ZIP CODE		
MICKELII	DE OTEEL E ODEEK	13600 S	TRYON ST			
WICKSHII	RE STEELE CREEK	CHARLO	TTE, NC 28278			
(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	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 31	D 358			
	10.					
	04/25/22 revealed: -Resident #1 had an e-The lab result was a -Warfarin had been p-The INR was to be re-Resident #1 was to be stool, fatigue, dizzine chest pain. Review of Resident #04/26/22 revealed the 04/26/22 revealed:	laced on hold. epeated that day (04/25/22). be monitored for blood in her ss, shortness of breath and et's INR results dated e INR was high, greater than				
		nold Coumadin" (warfarin).				
		nedication has not been				
		echecked on 04/29/22.				
	Medication Administrate revealed:	1's March 2022 electronic ation Record (eMAR) for apixaban 5mg one tablet				
	-The apixaban entry \ 03/02/22.	was discontinued on				
		or rivaroxaban 10mg one				
	-The rivaroxaban enti	ry had a start date of ntinue date of 04/12/22.				
	Review of Resident # revealed:	1's April 2022 eMAR				
	tablet daily.	or rivaroxaban 10mg one				
	∣ -The rivaroxaban entı	ry had a discontinue date of				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 32 of 83

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL060166	B. WING		05/13/2022
NAME OF D	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE ZIR CODE	1 00/10/2022
NAME OF T	TOVIDER OR SOLT EIER		TRYON ST	12, 211 GODE	
WICKSHIE	RE STEELE CREEK		TTE, NC 28278		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 32	D 358		
	-There were 7 instance documented with a comedication was not a nurse's notesThere was an entry fitimes daily, at 8:00am 8:00pm with a start da-There was no dosagentryThe warfarin entry wadministered from 14 04/15/22, 19 instance and 4 instances on 04-The warfarin entry windicating hold, 10 ins 04/17/22 and 9 instance 04/24/22The warfarin entry or	from 04/01/22 to 04/11/22. the rivaroxaban was ode "09" indicating the dministered and to see the for warfarin one tablet four in, 12:00pm, 4:00pm and interest and to see the electron of 04/12/22. The indicated for the warfarin instances from 04/12/22 to instances from 04/12/22 to instances from 04/12/22 to instances from 04/15/22 to instanc			
	04/29/22 at 11:30pm -There was a bottle la one tablet every day.	ıbeled warfarin 5mg, take			
	-The label indicated 6 03/29/22.	0 tablets were dispensed on			
	-There were 27 tablet	s remaining in the bottle.			
	2:35pm revealed: -She was responsible medication orders into filing system and tran into residents eMAR.	with a MA on 05/03/22 at for implementation of new to the facilities electronic scribe physician's orders ave a process to ensure staff			

Division of Health Service Regulation

transcribed physician's orders into the eMAR

STATE FORM 6899 RH7E11 If continuation sheet 33 of 83

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	SURVEY
AND FLAN OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMP	LETED
	HAL060166	B. WING		05	/13/2022
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
WICKSHIRE STEELE CREEK	13600 S	TRYON ST			
WIGHTING OFFICE GREEK	CHARLO	OTTE, NC 28278			
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
Resident #1 in the orivaroxaban medical medication dated 03 -She did not know warfarin 5mg medichad been placed in -On 04/11/22, she trorder dated 03/29/2 effective 04/11/22 alwarfarin 5mg on 04/2-She may have addomines daily), she did between the medical-she did not recall in pharmacy to fill ResmedicationShe was aware Rethinner medications of blood thinner medications. -She was aware Rethinner medications of blood thinner medications of blood thinner medicationsOn 04/26/22, she waide (PCA) that Resident price and on her bed with the emergence of the pharmacy dispersoriptions and faupThe pharmacy dispersoriptions and faupWarfarin 5mg, 60 target and the pharmacy dispersoriptions and faup.	22, she found an order for opier room to discontinue tion and start warfarin 5mg 3/29/22. I/hen or how Resident #1's ation order dated 03/29/22 the copier room. I/hen or how Resident #1's 2 to discontinue rivaroxaban and start Resident #1's 12/22 on the eMAR. I/led Resident #1's warfarin add' (once daily) or 'qid' (four not know the difference ation abbreviations. I/led of the interior of th	D 358			

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 34 of 83

	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _	A. BUILDING:		
		HAL060166	B. WING		05/13/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIP	RE STEELE CREEK	13600 S TF				
			TE, NC 28278			\dashv
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLET	Έ
D 358	Continued From page	e 34	D 358			
	-The label indicated w was to be administere	varfarin 5mg, one tablet daily ed to Resident #1.				
	the facility's contracted 9:12am revealed: -Resident #1 used and medicationsIf they received orded would profile or placed would not send the multiple send that the multiple send that the placed on resident else pharmacy staff would changesShe was unable to resident else profile.	with a representative from and pharmacy on 05/11/22 at a coutside pharmacy for her are for Resident #1, they the orders on her eMAR but redication to the facility. Staff could change orders MARs but if they did the not be able to see the attrieve Resident #1's profile of the facility for more than				
	at 1:50pm revealed: -On 04/26/22, a nurse Resident #1's family r resident was sent to t observed blood comir nose.	Attorney (POA) on 04/29/22 e from the facility called member to inform him the				
	05/11/22 at 1:20pm redid not administer Remedication correctly a with internal bleeding	vith Resident #1's PCP on				
	-	scribed anticoagulant				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 35 of 83

	or periornoise		(VO) MULTIPLE	CONCEDUCTION	L(V2) DATE C	LIDVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
, HILD I LANC	331112011314	.SERVIN IO ATOM HOMBER.	A. BUILDING: _			
		HAL060166	B. WING		05/1	3/2022
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZIP CODE		
		13600 S TF		,		
WICKSHIP	RE STEELE CREEK					
		CHARLOT	TE, NC 28278			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
IAG	TREGOLD TOTAL OTTE		IAG	DEFICIENCY)		
D 358	Continued From page	2 35	D 358			
	diagnosed with bilater	ral pulmonary emboli.				
		agulant medication was				
		at the request of the family.				
	•	in dose would need to be				
		er INR blood test results.				
	~	n 03/29/22 to discontinue				
		aban, start warfarin 5mg one				
		the resident's INR in one				
	week.	tile resident's INIX III one				
	-Resident #1 was see	on by a colleggue on				
	04/11/22 and his colle	•				
	warfarin order on Res					
		the order again on 04/11/22				
		ent #1's rivaroxaban, start				
		d check the resident's INR				
	in one week and mon	•				
		nt #1's INR blood test result				
	was high at 8.91.					
		an order on 04/15/22 to hold				
		n until further notice, get a				
		/ (04/18/22), and for the				
	facility to make sure F	Resident #1 was not taking				
	rivaroxaban.					
		n INR readings, greater than				
	,	2/22, and 04/25/22 and after				
		dered Resident #1's warfarin				
	to be held.					
		esults greater than 10 were				
		e did not know Resident				
		ng administered QID (four				
	times daily) instead of					
	-He did not give any o	orders for Resident #1's				
	warfarin to be restarte	ed after it was put on hold.				
		nt to the hospital for internal				
	bleeding.	·				
	•	of receiving a greater than				
		arfarin included internal				
	bleeding and death.					

Division of Health Service Regulation

Interview with the Resident Care Coordinator

STATE FORM 6899 RH7E11 If continuation sheet 36 of 83

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						
		HAL060166	B. WING		05/13/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE STEELE CREEK	13600 S T	RYON ST			
		CHARLOT	TE, NC 28278			
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	e 36	D 358			
	(RCC) on 05/12/22 at -The MAs were responsint the eMAR system -Resident #1 received outside pharmacyWhen a new medical was the MA's responsion the medication to system to ensure they -MAs were trained to label with the eMAR predicationShe had placed Resion two occasions but -She was unsure if shell hold on the warfarin the -She could not recall medication on hold but dateShe did not know hold indefinitely becare -Prior to the medication 04/12/22, there was resident to the system.	e 9:15am revealed: consible to enter new orders and her medications from an attion arrived at the facility, it disbility to compare the label atthe order in the eMAR ay matched. compare the medication arrived at the facility, it disbility to compare the label atthe order in the eMAR ay matched. compare the medication arrived at the dates. The entered a date for the atthe order in the				
Interview with the Administrator on 05/13/3 2:05pm revealed: -The MAs were responsible for putting neverther than the control of the control						
	orders into the eMAR -The RCC and the Sp	system. pecial Care Unit Coordinator				
	on the eMAR for accu	ole for reviewing new orders rracy, but he was not sure if				
	it was being done.	n Daaidant #4 .us				
	 The warfarin order for transcription error by 					
	•	nsible to compare the label				
	of new medications w	ith the order in the eMAR				
		dication arrived at the facility. The der was entered into the				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 37 of 83

DIVISION	n Health Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					1	
		HAL060166	B. WING		OF IA	3/2022
		HALUGU100			05/1	3/2022
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE STEELE CREEK	13600 S T	RYON ST			
WICKSHIP	RE STEELE CREEK	CHARLO	TTE, NC 28278			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
				BELLOIENST		
D 358	Continued From page	e 37	D 358			
	eMAR system, he did	not think there was a				
	second staff member	reviewing orders for				
	accuracy.	-				
	·					
	2. Review of Residen	t #2's current FL-2 dated				
	08/03/21 revealed:					
	-Diagnoses included	coronary artery disease,				
	hypertension, hyperlip					
cerebrovascular accident, recurrent urinary tract infections, chronic pain, glaucoma, and frail elderly.						
		2's current care plan dated				
	08/12/21 revealed:					
		rt and able to make her				
	needs known.					
		a rollator for ambulation.				
	-Resident #2 did not a	administer her own				
	medications.					
		prescribed medications for				
	mental health or beha	aviors.				
	Review of Resident #	2's facility progress notes				
	revealed:	,, ,				
	-On 04/04/22 at 8:26	pm, staff documented				
		erved in her bedroom on the				
	floor.					
	-Staff documented Re	esident #2 reported she had				
	fallen without any inju					
	-On 04/04/22 at 9:05p	om, staff documented				
	contacting Resident #	[‡] 2's physician to report a				
	medication error.					
		ation related to the type of				
		red to Resident #2 in error.				
	-Staff documented Re	esident #2's physician				
	reported Resident #2	should get sleepy and to				
	monitor Resident #2.					
	-There was no addition	onal documentation related				
	to the incident.					

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 38 of 83

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL060166	B. WING		05/1	3/2022
	ROVIDER OR SUPPLIER	13600 S TR	RESS, CITY, STARYON ST	TE, ZIP CODE		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Review of Resident # (ED) documentation of revealed: -Resident #2 "was add tonight which is not a resident was drowsy her head." -There was no addition related to the time the administered in errorThere was no addition related to the dosage administered to Resident #2 was stated facility on 04/05/22. Review of Resident # orders dated 02/01/22 clonazepam (a medication administrative revealed there was not linearly with Reside 12:00pm revealed: -She utilized a rollator -A medication aide (Not medication to her in the After she was adminimedication, she felt of feet and fell in her becomposed in the paranoid that staff wrong pill again." -She was not aware of the sident was not aware of the s	2's emergency department dated 04/05/22 at 2:11am ministered clonazepam medication she takes, and fell, hitting the back of small information documented eclonazepam was mall information documented of clonazepam dent #2 in error. The and discharged to the 2's current physician's 2 revealed no order for ation used to treat seizures, for anxiety) medication. 2's April 2022 electronic ation record (eMAR) of entry for clonazepam. and #2 on 04/12/22 at a for ambulation. IA) administered the wrong the afternoon on 04/04/22.	D 358			

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 39 of 83

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	SURVEY
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMP	LETED
		HAL060166	B. WING		05	/13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE STEELE CREEK	13600 S T	RYON ST			
- THORIGINA	COTELL ONLEN	CHARLO	TTE, NC 28278			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 39	D 358			
D 330	Observation of Resid 9:05am revealed: -Resident #2 was in t cartA MA attempted to a scheduled medication resistant and stated, my right medicationsA MA reassured Resident	he hallway at a medication dminister Resident #2's hs, and Resident #2 was "Are you positive these are " hident #2 the medications serve medication cup were hs prescribed by her with Resident #2's	D 336			
	-Resident #2 required medicationsOn 04/04/22 at 9:30 him that Resident #2 medication, clonazep -Resident #2 did not clonazepam.	have a physician's order for				
	informed she fell that -Resident #2 was ser after the fallResident #2 was eva 04/04/22 with no phys back to the facility on -Since the medication fearful of the facility s medications. Telephone interview of	aluated at the ED on sical injuries and discharged 04/05/22. n error, Resident #2 was taff administering her				
	revealed: -Resident #2 was not medication.	prescribed clonazepam				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 40 of 83

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL060166	B. WING		05/1	3/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHII	RE STEELE CREEK	13600 S TF CHARLOT	RYON ST TE, NC 28278			
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	04/04/22 related to a of another resident's to Resident #2 in error -On 04/04/22 he instr Resident #2 for abnord-He was not aware Refall on 04/04/22 until 0-If Resident #2 had be clonazepam 1mg in egrogginess and an unresident #2's medica 04/04/22 could have of fall on 04/04/22. Resident #2 had expadministration of her includent with a days 9:30am revealed: -Resident #2 constant medications since a mincident occurred in error -Resident #2 required staff that her dispense accurate before she with the dispense accurate before she with the february 2022 as a pma. -She had not taken the Aide examShe had not received	the facility in the evening of day shift MA administration clonazepam 1mg medication or. The facility staff to monitor or mal drowsiness. The facility staff or monitor or or contributed to Resident #2's or monitor or monitor or or contributed to Resident #2's or monitor or monitor or or contributed to Resident #2's or monitor or or contributed to Resident #2's or monitor or or or contributed to Resident #2's or monitor or or or contributed to Resident #2's or monitor or o	D 358			

Division of Health Service Regulation

medication administration training from other MAs

STATE FORM 6899 RH7E11 If continuation sheet 41 of 83

STATEMENT	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
		HAL060166	B. WING		05/1	3/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	-	
14/10/2011		13600 S T	RYON ST			
WICKSHIP	RE STEELE CREEK	CHARLO1	TE, NC 28278			
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page		D 358			
	medications at the fact available to assist her -On 04/04/22 between was in the process of residents' medications requested a medication-On 04/04/22 between administered a Clona Resident #2 in errorOn 04/04/22 shortly a shift MA counted a coasked about one clon not accounted forOn 04/04/22, she and controlled substance the controlled substance of the errorOn 04/04/22, the even of the errorOn 04/04/22, the BO the facility and was te immediately due to the telephone interview work of the error of the e	s scheduled to administer cility, no additional MAs were con 2:00pm and 3:00pm, she administering another so when Resident #2 con for pain. In 2:00pm and 3:00pm, she acepam 1mg tablet to cafter 7:00pm, the evening antrolled substance log and azepam 1mg tablet that was additionally administered anazepam 1mg to Resident centrally administered centrally administered centrally administered anazepam 1mg to Resident centrally administered centrally admi				
	she had given Reside error.	nt #2 a clonazepam 1mg in				

Division of Health Service Regulation

-On 04/04/22, she contacted the BOM to notify

STATE FORM 6899 RH7E11 If continuation sheet 42 of 83

DIVISION	n nealth Service Regu	ialion				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
			1			
		HAL060166	B. WING	-	05/1	3/2022
NAME OF D	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE 710 CODE		
NAIVIE OF FI	NOVIDER OR SUFFLIER			TIE, ZIF CODE		
WICKSHIE	RE STEELE CREEK	13600 S T				
		CHARLO	TE, NC 28278			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
D 358	Continued From page	42	D 358			
2 000	Continued From page	, T L				
	her of the medication	error and subsequently the				
	dayshift MA was instr	ucted to leave the facility				
	and not return to the f	acility.				
	-On the evening of 04	-				
	•	an regarding the medication				
		and he instructed her to				
	monitor Resident #2 f					
	_	/04/22, after notification to				
		an related to the medication				
	error, she checked or	Resident #2 and found				
	Resident #2 on the flo	oor in her room.				
	-On 04/04/22, Reside	nt #2 informed her that she				
	felt unsteady while sta	anding and fell.				
	•	nt #2 informed her that she				
		juries from the fall and				
		her to bed for the night.				
	•	•				
	-	sible party visited her on				
		0pm and requested that				
		o the ED for evaluation due				
	to the medication erro	or and fall.				
	Interview with the BO	M on 04/12/22 at 10:15am				
	revealed:					
	-She had been a MA	at the facility and recently				
	promoted to BOM.					
	-Staff A was hired as	a PCA and MA at the end of				
	February 2022.	-				
	•	y the BOM on medication				
		ures on or about 04/01/22.				
	=					
		training from other MAs at				
	the facility before Stat					
	administer medication	· · · · · · · · · · · · · · · · · · ·				
	-Staff A had not receive					
		g from a RN, Pharmacist, or				
	other licensed healtho	care professional prior to				
	administration of med	ications independently.				
		was scheduled to work as				
	the only dayshift MA.					
		s received a call from the				

Division of Health Service Regulation

nightshift MA related to the dayshift MA

STATE FORM 6899 RH7E11 If continuation sheet 43 of 83

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		HAL060166	B. WING		0.5	5/13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	·	
		13600 S	TRYON ST			
WICKSHII	RE STEELE CREEK	CHARLO	TTE, NC 28278			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	≥ 43	D 358		<u>, </u>	
D 358	administration of one Resident #2 in errorOn 04/04/22, she insleave the facility and -On 04/04/22, she insolity Resident #2's pmedication errorShe was not aware fall prior to instructing -On 04/04/22, she call inform him of Resider administration errorThe Administrator not contact Resident #2's Interview with the Administration errorThe BOM notified him 04/04/22 that Resident wrong medication by -The medication error nightshift MAResident #2 was not -On 04/04/22, he notion responsible party related administration errorOn 04/04/22, Resident -On 04/04/	clonazepam 1mg to structed the dayshift MA to not return to the facility. structed the nightshift MA to shysician related to the Resident #2 had sustained a the nightshift MA. Illed the Administrator to not #2's medication otified her that he would a responsible party. ministrator on 04/12/22 at m on the evening of nt #2 was administered the the dayshift MA. r was identified by the prescribed clonazepam.	D 358			
	did not want to be sel -On 04/04/22, Reside visited the facility and	nt to the ED for evaluation. ent #2's responsible party requested Resident #2 be				
	error and subsequent -The dayshift MA that medication in error or medication administra facility MAs and the E 04/04/22The dayshift MA that	e medication administration if fall. if administered Resident #2's if 04/04/22 had received ation training from other if administered Resident #2's if 04/04/22 had not received				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 44 of 83

Division	of Health Service Regu	lation •	1			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN	O CONNECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	LIED
		HAL060166	B. WING		05/1	3/2022
NAME OF D	ROVIDER OR SUPPLIER	PTDEET AS	DRESS, CITY, STA	TE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER		, ,	I E, ZIP CODE		
WICKSHIE	RE STEELE CREEK		RYON ST			
		CHARLO	TTE, NC 28278			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 358	Continued From page	. 11	D 358			
D 330	Continued From page	: 44	D 336			
	_	nistration training from a RN,				
	Pharmacist, or other					
		administration of Resident				
		04/04/22 because he did not				
	-	ealthcare professional to				
	train the dayshift MA.					
	PCAs and MAs.	for ensuring a RN trained				
		administered Resident #2's				
	-The dayshift MA that administered Resident #2's medication in error on 04/04/22 was instructed not to return to the facility on 04/04/22.					
		o, o o o				
	3. Review of Residen	t #7's current FL2 dated				
	08/07/21 revealed dia	agnosis included frank				
	hematuria.					
		t #7's physician orders				
		led there was an order for				
		tablets (a medication used				
	to treat fluid retention administered daily.	and swelling) to be				
	auministered daily.					
	Observation of the mo	edication pass on 05/11/22				
	at 8:50am revealed:	odiodion pace on 00/11/22				
	-The medication aide	(MA) prepared 7 oral				
	medications for Resid	lent #7.				
	-Furosemide was not	administered to Resident				
	#7.					
	Observation of Resid					
	available for administ					
	8:50am revealed furo administration.	semide was not available for				
	aummistration.					
	Review of Resident #	7's May 2022 electronic				
		ation Record (eMAR) from				
	05/01/22 to 05/13/22	, ,				
		for furosemide 40mg, 2				
	tablets to be administ					
	-Outside pharmacy p					

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 45 of 83

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL060166	B. WING		05	5/13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
WICKSHII	RE STEELE CREEK		TRYON ST			
			OTTE, NC 28278			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 45	D 358			
	administered dailyFurosemide was not administered 7 of 13 medication was unav Telephone interview v contracted pharmacy 12:58pm revealed the dispensed for Reside was 10/09/21 for 30 t Telephone interview v facility's contracted p 12:45pm revealed: -The pharmacy had r Resident #7's furoser -The pharmacy was u gone without furosem	opportunities due to ailable. with Resident #7's technician on 05/11/22 at elast time furosemide was int #7 from their pharmacy ablets. with a Pharmacist for the harmacy on 05/13/22 at ino signed refill orders for mide. unaware Resident #7 had				
	pressure. b. Review of Residen	and increase in blood				
	02/01/22 revealed the nifedipine ER Osmoti (used to treat high bloadministered 2 times	c Release Tablet 60 mg ood pressure), to be				
	at 8:50am revealed: -The MA prepared 7 of Resident #7.	edication pass on 05/11/22 oral medications for ocumented as administered				
	Observation of Resid available for administ 8:50am revealed nife administration.					

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 46 of 83

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE STATEMENT OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:		E SURVEY PLETED			
			_			
		HAL060166	B. WING		05	5/13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
WICKSHII	RE STEELE CREEK		TRYON ST			
	T		OTTE, NC 28278			
(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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 46	D 358			
	05/01/22 to 05/13/22 -There was an entry f administered twice da -Nifedipine was not do	7's May 2022 eMAR from revealed: for nifedipine 60 mg to be aily at 8:00am and 8:00pm. ocumented as administered adue to medication was				
	Telephone interview with Resident #7's contracted pharmacy technician on 05/11/22 at 12:58pm revealed the last time nifedipine was dispensed for Resident #7 from their pharmacy was 03/09/22 for 60 tablets.					
	facility's contracted pl 12:45pm revealed: -The pharmacy had n Resident #7's nifedipi -The pharmacy was u gone without nifedipir -Possible outcomes of	ınaware Resident #7 had				
	02/01/22 revealed the	treat mood disorder) to be				
	at 8:50am revealed: -The MA prepared 7 of Resident #7.	edication pass on 05/11/22 oral medications for administered to Resident				
	Observation of Residence available for administ 8:50am revealed ario					

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 47 of 83

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLI		FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
MANE OF PROVIDER OR SUPPLIER WICKSHIRE STEELE CREEK CHARLOTTE, NC 28278 SUMMARY STATEMENT OF DEFICIENCISS THE PROVIDER'S PLAN OF CORRECTION PREFIX TAG			HAL060166	B. WING		05	5/13/2022
MCKSHIRE STELLE CREEK 13600 S TRYON ST CHARLOTTE, NC 28278 28278	NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	. ZIP CODE	•	
(X4) ID (EACH DEPICIENCY MUST SE PRECIDED BY FULL RESOLUTION AND STATEMENT OF DEPICIENCIES PUBLIC RESOLUTION OF LORD CONTROL ON LORD CONTROL OF LORD CONTROL OF LORD CONTROL OF LORD CONTROL ON LORD CONTROL OF LORD CONTROL OF LORD CONTROL OF LORD CONTROL O	TO UNIC OT T	NOVIDEN ON OUT FIELD		, ,	, 211 0002		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 47 for administration. Review of Resident #7's May 2022 eMAR from 05/01/22 to 05/13/22 revealed: -There was an entry for aripiprazole 2 mg to be administered 4 of 13 opportunities due to medication was unavailable. Telephone interview with Resident #7's contracted pharmacy technician on 05/11/22 at 12:58pm revealed the last time aripiprazole was dispensed for Resident #7 methor their pharmacy was 03/09/22 for 30 tablets. Telephone interview with a Pharmacist for the facility's contracted pharmacy on 05/13/22 at 12:45pm revealed of the contracted pharmacy on 05/13/22 at 12:45pm revealed to end of the contracted pharmacy on 05/13/22 at 12:45pm revealed to end of the contracted pharmacy on 05/13/22 at 12:45pm revealed to end of the contracted pharmacy on 05/13/22 at 12:45pm revealed the last lime aripiprazole was dispensed for Resident #7's not receiving aripiprazole could lead to behavioral issues. d. Review of Resident #7's physician order dated 02/01/22 revealed there was an order for clonazepam 0.5 mg, (used to treat anxiety), to be administered twice daily. Observation of the medication pass on 05/11/22 at 8:50am revealed: -The MA prepared 7 oral medications for Resident #7Clonazepam was not administered to Resident	WICKSHI	RE STEELE CREEK					
for administration. Review of Resident #7's May 2022 eMAR from 05/01/22 to 05/13/22 revealed: -There was an entry for aripiprazole 2 mg to be administered daily at 8:00am. -Aripiprazole was not documented as administered 4 of 13 opportunities due to medication was unavailable. Telephone interview with Resident #7's contracted pharmacy technician on 05/11/22 at 12:58pm revealed the last time aripiprazole was dispensed for Resident #7 from their pharmacy was 03/09/22 for 30 tablets. Telephone interview with a Pharmacist for the facility's contracted pharmacy on 05/13/22 at 12:45pm revealed: -The pharmacy had no signed refill orders for Resident #7's aripiprazole. -The pharmacy was unaware Resident #7 had gone without aripiprazole. -Possible outcomes of not receiving aripiprazole could lead to behavioral issues. d. Review of Resident #7's physician order dated 02/201/22 revealed there was an order for clonazepam 0.5 mg, (used to treat anxiety), to be administered twice daily. Observation of the medication pass on 05/11/22 at 8:50am revealed: -The MA prepared 7 oral medications for Resident #7. -Clonazepam was not administered to Resident	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
Review of Resident #7's May 2022 eMAR from 05/01/22 to 05/13/22 revealed: -There was an entry for aripiprazole 2 mg to be administered daily at 8:00am. -Aripiprazole was not documented as administered 4 of 13 opportunities due to medication was unavailable. Telephone interview with Resident #7's contracted pharmacy technician on 05/11/22 at 12:58pm revealed the last time aripiprazole was dispensed for Resident #7 from their pharmacy was 03/09/22 for 30 tablets. Telephone interview with a Pharmacist for the facility's contracted pharmacy on 05/13/22 at 12:45pm revealed: -The pharmacy had no signed refill orders for Resident #7's aripiprazole. -The pharmacy was unaware Resident #7 had gone without aripiprazole. -Possible outcomes of not receiving aripiprazole could lead to behavioral issues. d. Review of Resident #7's physician order dated 02/01/22 revealed there was an order for clonazepam 0.5 mg, (used to treat anxiety), to be administered twice daily. Observation of the medication pass on 05/11/22 at 8:50am revealed: -The MA prepared 7 oral medications for Resident #7. -Clonazepam was not administered to Resident	D 358	Continued From page	e 47	D 358			
05/01/22 to 05/13/22 revealed: -There was an entry for aripiprazole 2 mg to be administered 4 aliy at 8:00amAripiprazole was not documented as administered 4 of 13 opportunities due to medication was unavailable. Telephone interview with Resident #7's contracted pharmacy technician on 05/11/22 at 12:58pm revealed the last time aripiprazole was dispensed for Resident #7 from their pharmacy was 03/09/22 for 30 tablets. Telephone interview with a Pharmacist for the facility's contracted pharmacy on 05/13/22 at 12:45pm revealed: -The pharmacy had no signed refill orders for Resident #7's aripiprazoleThe pharmacy was unaware Resident #7 had gone without aripiprazolePossible outcomes of not receiving aripiprazole could lead to behavioral issues. d. Review of Resident #7's physician order dated 02/01/22 revealed there was an order for clonazepam 0.5 mg, (used to treat anxiety), to be administered twice daily. Observation of the medication pass on 05/11/22 at 8:50am revealed: -The Mp repared 7 oral medications for Resident #7Clonazepam was not administered to Resident		for administration.					
02/01/22 revealed there was an order for clonazepam 0.5 mg, (used to treat anxiety), to be administered twice daily. Observation of the medication pass on 05/11/22 at 8:50am revealed: -The MA prepared 7 oral medications for Resident #7Clonazepam was not administered to Resident		o5/01/22 to 05/13/22 -There was an entry fadministered daily at -Aripiprazole was not administered 4 of 13 medication was unav Telephone interview of the dispensed for Reside was 03/09/22 for 30 the dispensed for Resident #7's aripipration of the pharmacy had in Resident #7's aripipration without aripipration of the dispense of th	revealed: for aripiprazole 2 mg to be 8:00am. documented as opportunities due to ailable. with Resident #7's technician on 05/11/22 at e last time aripiprazole was int #7 from their pharmacy ablets. with a Pharmacist for the harmacy on 05/13/22 at no signed refill orders for azole. unaware Resident #7 had zole. of not receiving aripiprazole oral issues.				
at 8:50am revealed: -The MA prepared 7 oral medications for Resident #7Clonazepam was not administered to Resident		clonazepam 0.5 mg,	(used to treat anxiety), to be				
Observation of Resident #7's medications available for administration on 05/11/22 at		at 8:50am revealed: -The MA prepared 7 of Resident #7Clonazepam was no #7. Observation of Resid	oral medications for t administered to Resident ent #7's medications				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 48 of 83

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		HAL060166	B. WING		05/13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
MICKELLI	RE STEELE CREEK	13600 S TI	RYON ST		
WICKSHIP	RE STEELE CREEK	CHARLOT	TE, NC 28278		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 48	D 358		
	8:50am revealed clor for administration.	nazepam was not available			
	Review of Resident # 05/01/22 to 05/13/22	7's May 2022 eMAR from revealed:			
	-There was an entry f be administered twice 4:00pm. -Clonazepam was no	-			
	administered 9 of 25 medication was unav	• •			
	12:58pm revealed the	with Resident #7's technician on 05/11/22 at e last time clonazepam was ent #7 from their pharmacy			
	was 02/05/22 for 60 t				
	facility's contracted pl 12:45pm revealed:	with a Pharmacist for the harmacy on 05/13/22 at			
		no signed refill orders for			
	Resident #7's clonaze -The pharmacy was u gone without clonaze	unaware Resident #7 had			
		of not receiving clonazepam			
	02/01/22 revealed the	nt #7's physician order dated ere was an order for (used to treat depression), to			
	be administered daily	in the morning.			
	at 8:50am revealed:	edication pass on 05/11/22			
	-The MA prepared 7 of Resident #7.	oral medications for			
	#7.	น สนาแแรงเฮเฮน เบ เพียงในชาใ			

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 49 of 83

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				7. 50.E5.11.6.	
		HAL060166	B. WING		05/13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
WICKSHIRE STEELE CREEK		RYON ST TTE, NC 28278			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 49	D 358		
	Observation of Resident available for administ 8:50am revealed fluve for administration.				
	Review of Resident # 05/01/22 to 05/13/22	7's May 2022 eMAR from revealed:			
		or fluvoxamine 100 mg to daily at 9:00am. t documented as opportunities due to			
	12:58pm revealed the	technician on 05/11/22 at e last time fluvoxamine was nt #7 from their pharmacy			
	facility's contracted pl 12:45pm revealed: -The pharmacy had n Resident #7's fluvoxa -The pharmacy was u gone without fluvoxar -Possible outcomes of	ınaware Resident #7 had			
	f. Review of Resident 02/01/22 revealed the	#7's physician order dated ere was an order for mg (used to treat high			
	at 8:50am revealed: -The MA prepared 7 of Resident #7.	edication pass on 05/11/22 oral medications for administered to Resident #7.			

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 50 of 83

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL060166	B. WING		05/13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
MICKERIE	RE STEELE CREEK	13600 S T	RYON ST		
WICKSHII	NE STEELE GREEK	CHARLOT	TE, NC 28278		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 50	D 358		
	Observation of Resid available for administ 8:50am revealed met administration.				
	05/01/22 to 05/13/22 -There was an entry f administered daily at -Metoprolol was not co	or metoprolol 25 mg to be			
	12:58pm revealed the	technician on 05/11/22 at e last time metoprolol was nt #7 from their pharmacy			
	facility's contracted pl 12:45pm revealed: -The pharmacy had n Resident #7's metopr -The pharmacy was u gone without metopro -Possible outcomes of	ınaware Resident #7 had			
	02/01/22 revealed the D Capsule 50 mcg, (a administered in the m	edication pass on 05/11/22			
	-Vitamin D was not a	dministered to Resident #7.			

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 51 of 83

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		HAL060166	B. WING		05	5/13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STATE	, ZIP CODE		
WICKSHIE	RE STEELE CREEK		TRYON ST			
		CHARLO	TTE, NC 28278			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 51	D 358			
	Observation of Resid available for administ 8:50am revealed Vita administration.					
	05/01/22 to 05/13/22 -There was an entry f administered daily at -Vitamin D was not do	or Vitamin D 50 mcg, to be				
	12:58pm revealed the	technician on 05/11/22 at e last time Vitamin D was nt #7 from their pharmacy				
	facility's contracted pi 12:45pm revealed: -The pharmacy had n Resident #7's Vitamir -The pharmacy was u gone without Vitamin -Possible outcomes of	ınaware Resident #7 had				
	revealed: -When medications w documented it on the (eprogress notes)She did not know wh reviewing eprogress of -She requested refills	on the eMAR. a refill but did not know why				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 52 of 83

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		HAL060166	B. WING		05/13/20	022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
MICKSHIE	RE STEELE CREEK	13600 S TI	RYON ST			
WIOROIM	NE OTELLE ONLEN	CHARLOT	TE, NC 28278			
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE C	(X5) OMPLETE DATE
D 358	Continued From page	e 52	D 358			
	-She made the Resid or the Special Care C	ent Care Coordinator (RCC) coordinator (SCC) aware if ot on the cart before it ran				
	11:30am revealed: -She received training to eliminate medicatio left the medication was checked to make sure the eMAR and expect that nightIf the medication did night, she would mak aware the next morni available for administ she gave the medication medication in the morning medication resident did not have	s not on the cart, she e the refill was completed on ted the medication to be in not come in during the e the RCC or the SCC ng the medication was not ration. ations to Resident #7 during on pass and realized the many of her medications. aware of the issue after her				
	revealed: -The MA was respons medicationsShe was not aware Frefill orders at the phase of the medications as of the medications as of the medication was done training was done on the medication was done on t	esident #7 was not getting rdered. e until 2-3 weeks ago when				
	11:30am and 05/13/2 -He expected the prin	ministrator on 05/13/22 at 2 at 2:20pm revealed: nary care provider (PCP) to nedications were not				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 53 of 83

PRINTED: 06/03/2022 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		HAL060166	B. WING		05/13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	ΓΕ, ZIP CODE	
		13600 S T	RYON ST		
WICKSHII	RE STEELE CREEK		TE, NC 28278		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 358	Continued From page	= 53	D 358		
	administered to the re				
		ere were no signed refill			
	_	harmacy for Resident #7.			
	7 of her medications.	esident #7 was not receiving			
		re to be audited weekly by			
		ensure medications were			
	available for administ				
		nation. ne medication cart audits			
	were being completed				
		on 05/07/22 for medication			
	errors and medication				
	Attempted telephone #7s PCP on 05/13/22 unsuccessful.	interview with the Resident 2 at 12:14pm was			
	administered as orde sampled for record regreater than prescribe medication and was holeeding (Resident # another resident's me panic disorder and wareceiving the medicather head and 1 of 6 medication pass, who medications to lower medication to treat flumedication to treat de The facility's failure reand constitutes a Typ	o did not receive two blood pressure, a uid retention, and a epression (Resident #7). esulted in serious neglect e A1 Violation.			
		a plan of protection on ce with G.S. 131D-34 for			
	CORRECTION DATE	FOR THE TYPE A1			

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 54 of 83

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL060166	B. WING		05/13/2022
	ROVIDER OR SUPPLIER	13600 S	DDRESS, CITY, STATERYON ST	TE, ZIP CODE	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 367	(j) The resident's me record (MAR) shall be following: (1) resident's name; (2) name of the medical strength and dose administered; (4) instructions for addort reatment; (5) reason or justifical medications or treatmed documenting the result of the medications or treatmed ocumentation of medications or treatmed ocumentation of the medications or treatmed ocumented and main administration record. This Rule is not met Based on interviews facility failed to ensur records were comple residents sampled redecrease blood clotting. Review of Resident # revealed diagnoses in disease and hypertersidents and the record of the findings are:	4 Medication Administration idication administration e accurate and include the cation or treatment order; age or quantity of medication idinistering the medication idinistering the medication idinistering the medication idinistering the medication of ments as needed (PRN) and culting effect on the resident; administration; any omission of ments and the reason for the efusals; and, if the person administering in the person administration (MAR). The medication administration is and accurate for 1 of 7 in the person administration in the and accurate for 1 of 7 in the person administration in the and accurate for 1 of 7 in the person administration in the and accurate for 1 of 7 in the person administration in the and accurate for 1 of 7 in the person administration in the and accurate for 1 of 7 in the person administration in the person administrati	D 367		

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 55 of 83

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		LETED	
			B. WING			
		HAL060166	B. WING		05	/13/2022
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	TE, ZIP CODE		
WICKSHII	RE STEELE CREEK		TRYON ST			
			TTE, NC 28278			
(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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From page	e 55	D 367			
	summary dated 11/05 -Resident #1 was hos embolism (blood clot -Discharge medicatio (a medication to decr 10mg twice daily for s twice daily beginning Review of Resident # Provider's (PCP) orde an order for apixaban Review of Resident # 03/01/22 revealed: -There was an adden Resident #1's family s anticoagulant (a med clotting) medicationAn order for rivaroxa	5/21 revealed: spitalized with a pulmonary in the lung). Instinctions included apixaban 5mg lease blood clotting); take six days and then take 5mg 11/12/21. It is signed Primary Care lears dated 02/04/22 revealed in 5mg one tablet twice daily. It is PCP's visit note dated indum to the note stating would like an alternative ication to decrease blood				
	03/01/22 revealed: -The apixaban was d -Rivaroxaban 10mg of prescribed for Resident # Medication Administrative revealed: -There was an entry fit twice dailyThe apixaban entry for 03/02/22.	order for Resident #1 dated iscontinued. one tablet daily was ent #1. ent #1. ent #1. for apixaban 5mg one tablet was discontinued on for rivaroxaban 10mg one				
	03/03/22. -The rivaroxaban was	s documented as				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 56 of 83

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION		
CORRECTION	IDENTIFICATION NOWIDER.	A. BUILDING:		COMPLETED	
	HAL060166	B. WING		05/13/2022	
VIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
STEELE CREEK					
	CHARLO	TTE, NC 28278			
(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	JLD BE COMPLETE	
Continued From page	: 56	D 367			
idministered 11 instal 3/31/22. There were 18 instan locumented with code	nces from 03/03/22 to nces the rivaroxaban was e "09" indicating the				
evealed: There was an entry for ablet daily at 9:00am. The rivaroxaban entrola/12/22. The rivaroxaban was administered 4 times of the times of the coumented with a collocumented	or rivaroxaban 10mg one y had a discontinue date of documented as from 04/01/22 to 04/11/22. ees the rivaroxaban was ode "09" indicating the				
rom 03/03/22 to 04/1: There were 22 instant of administered becareceived or was on or On 03/23/22, the mediator at family member divaroxaban was too evanted to speak with an alternative medical The note on 03/23/22 potify the PCP on 03/2 acility. On 04/04/22 and 04/0 enstances when there why the medication wo On 04/08/22, the medicelephone interview work administration of the potential of the p	1/22 revealed: aces the rivaroxaban was ause it had not been der. dication aide (MA) spoke and was informed the expensive and the family Resident #1's PCP about tion. 2 indicated the MA would 24/22 when he visited the 05/22, there were two was no documented reason as not administered. dication was discontinued.				
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE continued From page dministered 11 instants) (13/31/22). There were 18 instant occumented with code inedication was not accurse's notes. Leview of Resident # (14/12/22). There was an entry for ablet daily at 9:00 am (14/12/22). The rivaroxaban entry for ablet daily at 9:00 am (14/12/22). The rivaroxaban was dministered 4 times of a fine were 7 instants occumented with a content of a fine with a fine with a fine with a family member over a fine on 03/23/22, the member of a fine on 03/23/22, the member of a fine with a fine	STREELE CREEK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 56 dministered 11 instances from 03/03/22 to 3/31/22. There were 18 instances the rivaroxaban was ocumented with code "09" indicating the nedication was not administered and to see the urse's notes. Leview of Resident #1's April 2022 eMAR evealed: There was an entry for rivaroxaban 10mg one ablet daily at 9:00am. The rivaroxaban entry had a discontinue date of 4/12/22. There were 7 instances the rivaroxaban was ocumented with a code "09" indicating the nedication was not administered and to see the urse's notes. Leview of Resident #1's nursing progress notes of administered with a code "09" indicating the nedication was not administered and to see the urse's notes. Leview of Resident #1's nursing progress notes of administered because it had not been exceived or was on order. Do 03/03/22, the medication aide (MA) spoke with a family member and was informed the varoxaban was too expensive and the family ranted to speak with Resident #1's PCP about alternative medication. The note on 03/23/22 indicated the MA would of offy the PCP on 03/24/22 when he visited the	### HAL060166 ### STREET ADDRESS, CITY, STA 13600 S TRYON ST CHARLOTTE, NC 28278 ### STEELE CREEK ### STEELE CREEK ### SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ### STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ### STATEMENT OR DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ### DO 3/331/22. ### There were 18 instances from 03/03/22 to 3/311/22. ### There were 18 instances the rivaroxaban was occumented with code "09" indicating the neclication was not administered and to see the urse's notes. ### We was an entry for rivaroxaban 10mg one ablet daily at 9:00am. The rivaroxaban was documented as dministered 4 times from 04/01/22 to 04/11/22. There were 7 instances the rivaroxaban was occumented with a code "09" indicating the neclication was not administered and to see the urse's notes. #### We will be used to be used to be urse's notes on 03/03/22 to 04/11/22 revealed: #### There were 22 instances the rivaroxaban was ot administered because it had not been excived or was on order. ### ON 03/23/22, the medication aide (MA) spoke rith a family member and was informed the varoxaban was too expensive and the family rearted to speak with Resident #1's PCP about an alternative medication. ######### The note on 03/23/22 indicated the MA would only the PCP on 03/24/22 when he visited the macility. ###################################	HAL060166 B. WING B. WING STEELE CREK 13600 \$5 TRYON \$T CHARLOTTE, NC 28278 SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY WIIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Intrinsiered 11 instances from 03/03/22 to 3/31/22. There were 18 instances the rivaroxaban was cocumented with code "09" indicating the eldication was not administered and to see the urse's notes. Leview of Resident #1's April 2022 eMAR evealed: There was an entry for rivaroxaban 10mg one bible daily at 9.00am. The rivaroxaban was documented as dministered 4 times from 04/01/22 to 04/11/22. There were 7 instances the rivaroxaban was occumented with a code "09" indicating the eldication was not administered and to see the urse's notes. Leview of Resident #1's nursing progress notes om 03/03/22 to 04/11/22 revealed: There were 7 instances the rivaroxaban was occumented with a code "09" indicating the eldication was not administered and to see the urse's notes. Leview of Resident #1's nursing progress notes om 03/03/22 to 04/11/22 revealed: There were 22 instances the rivaroxaban was or administered because it had not been sceived or was on order. Dn 03/23/22 the medication aide (MA) spoke fith a family member and was informed the varoxaban was to expensive and the family anated to speak with Resident #1's PCP about a laternative medication. The note on 03/23/22 indicated the MA would ofify the PCP on 03/24/22 when he visited the citility. Dn 04/08/22, the medication was not administered. Dn 04/08/22, the medication was of administered. Dn 04/08/22, the medication was discontinued.	

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 57 of 83

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	1 ' '	(X3) DATE SURVEY COMPLETED	
		HAL060166	B. WING		05	5/13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
WICKSHI	RE STEELE CREEK		TRYON ST OTTE, NC 28278			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 367	and family members -They received an ord one tablet daily on 03 -The prescription was family had not come to Telephone interview of member on 05/12/22 -She picked up Reside the pharmacy and de -She had not picked of medication because in the second clotting -She thought the resident to get an order for was decrease blood clotting Interview with a MA of revealed: -If she was not able to she documented "09" notes, on the resident the reason in the nursury of the medication need would fax the reorder she notified the Resident's medication Interview with the RC revealed: -MAs were trained on and documentation by Wellness Director (HV)	Resident #1's prescriptions bicked them up. der for rivaroxaban 10mg /04/22. In not filled because the policy pick it up. With Resident #1's family at 11:52am revealed: ent #1's medications from livered them to the facility. Up the rivaroxaban to was too expensive. It was too expensive. It medication while waiting rfarin (a medication to one) in place. In 05/11/22 at 4:20pm In administer a medication of the pharmacy. It is eMAR and documented sets notes. It is employed to the pharmacy. It is employed to the pharmacy of the pharmacy. It is employed to the pharmacy of the pharma	D 367			

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 58 of 83

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		HAL060166	B. WING		05/13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE	
WIOKOLIII	DE OTEEL E ODEEK	13600 S T	RYON ST		
WICKSHII	RE STEELE CREEK	CHARLO	TTE, NC 28278		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETE
D 367	Continued From page	e 58	D 367		
	administration of medinto the resident's eM -The instances when indicated the rivaroxa transcription errors si dispensedShe did not think the be run each morning were not administered. Interview with the Adr 2:05pm revealed: -He expected the MA medication administrate the residents' eMARIf a medication was repeated the MA to pharmacy and notify the expected the MA to the respected the MA to the expected the MA to the respected the respected the MA to the respected the MA to the respected the MA to the respected the respected the MA to the respected the respected the MA to the respected the MA to the respected the respect	dications or any exceptions IAR. Resident #1's eMAR aban was administered were note the medication was not ere was a report that could to see what medications d to residents. ministrator on 05/13/22 at s to accurately document ation and any exceptions on the available to administer, o follow up with the			
D 451	10A NCAC 13F .1212 and Incidents	2(a) Reporting of Accidents	D 451		
	Incidents (a) An adult care hor department of social incident resulting in reaccident or incident resident requiring refervaluation, hospitalization other than first aid. This Rule is not met The facility failed to ecounty department of	esulting in injury to a erral for emergency medical ation, or medical treatment			

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 59 of 83

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			750.2510				
		HAL060166	B. WING		05/	13/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
WICKSHII	RE STEELE CREEK		TRYON ST				
			TTE, NC 28278				
(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	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE	
D 451	Continued From page	e 59	D 451				
	medical treatment oth	evaluation, hospitalization, or ner than first aide for 4 of 5 esident #1,#2,#5, & #6)					
	The findings are:						
	09/28/21 revealed dia artery disease, hyper osteoarthritis, lower e	t #1's current FL-2 dated agnoses included coronary tension, depression, extremity edema, chronic agia, and constipation.					
	revealed documentat being sent to the eme	1's facility progress notes ion related to Resident #1 ergency department (ED) on ding from an unknown					
		:1's record revealed no sident #1's referral for ED 22.					
	2:35pm revealed: -On 04/26/22, she wa aide (PCA) that Resid brief and on her bed. -On 04/26/22, she ca #1 sent to the ED for from her nose, mouth cause.	with Staff C on 05/03/22 at as notified by a personal care dent #1 had blood in her lled 911 and had Resident evaluation due to bleeding a, and brief with no known					
		no was responsible for nt report when a resident D for evaluation.					
	Refer to interview wit Coordinator (RCC) or	h the Resident Care n 05/12/22 at 9:15am.					
	Refer to interview wit	h the Special Care					

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 60 of 83

	or riealth Service Regu				Taza = .== =	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVE	
			A. BUILDING: _			
		HAL060166	B. WING		05/13/20)22
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
			TRYON ST	,		
WICKSHIE	RE STEELE CREEK		TTE, NC 28278			
0.40.15	CLIMMADV CT			DROVIDERIS DI ANI CE CORRECTIO	N	0.5
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) OMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI	RIATE	DATE
				DEFICIENCY)		
D 451	Continued From page	e 60	D 451			
	. •					
	Coordinator (SCC) or	n 05/13/22 at 1:30pm.				
	Pofor to intonvious with	h the Administrator on				
	05/13/22 at 3:30pm.	Title Administrator on				
	00/10/22 at 0.00pm.					
	2. Review of Residen	t #2's current FL-2 dated				
		agnoses included coronary				
	artery disease, hypertension, hyperlipidemia, history of cerebra-vascular accident, recurrent urinary tract infections, chronic pain, glaucoma, and frail elderly.					
		2's facility progress notes				
	revealed:					
		pm, staff documented erved in her bedroom on the				
	floor.	erved in her bedroom on the				
		esident #2 reported she had				
	fallen without any inju					
		pm, staff documented				
		[;] 2's physician to report a				
	medication error.					
		ation related to the type of				
		red to Resident #2 in error.				
	-Staff documented Re	. ,				
	•	should get sleepy and to				
	monitor Resident #2.	onal documentation related				
	to the incident.	onal documentation related				
	to the incident.					
	Review of Resident #	2's emergency department				
		dated 04/05/22 revealed:				
		itted after Resident #2 was				
	administered clonaze					
	medication she takes	, resident was drowsy and				
	fell, hitting the back of					
		ble and discharged back to				
	the facility.					
	Review of Resident #	2's record revealed no				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 61 of 83

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		HAL060166	B. WING		05	/13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
WICKSHII	RE STEELE CREEK		TRYON ST			
		CHARLO	TTE, NC 28278			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 451	Continued From page	e 61	D 451			
	incident report for Re evaluation on 04/04/2	sident #2's referral for ED 22.				
	Interview with Reside 12:00pm revealed sh 04/04/22 due to a me subsequent fall which	e was referred to the ED on dication error and				
	Telephone interview with Resident #2's responsible party on 05/11/22 at 10:30am revealed: -On 04/04/22 at 9:45pm he visited Resident #2 and was informed she had fallen that evening and was to be sent to the ED for evaluationResident #2 was evaluated at the ED on 04/04/22 with no physical injuries and discharged back to the facility.					
	aide (MA) on 05/10/2 -On the evening of 04 a medication adminis Resident #2 and notif physician, she checke Resident #2 on the flo					
	felt unsteady while star- On 04/04/22, Reside did not sustain any in requested staff assistar- On 04/04/22 at appro	nt #2 notified her that she juries from the fall and her to bed for the night.				
	#2 and requested she to the medication adn subsequent fallShe did not know wh	e be sent to the ED related				
	Refer to interview with	h the RCC on 05/12/22 at				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 62 of 83

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING			
		HAL060166	B. WING		05/13/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHII	RE STEELE CREEK		RYON ST TTE, NC 28278			
0.40.1=	CHMMADV CT	ATEMENT OF DEFICIENCIES		DDOMDEDIS DI ANI OF CORRECTIO	NN OUT	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
D 451	Continued From page	e 62	D 451			
	9:15am.					
	Refer to interview with the SCC on 05/13/22 at 1:30pm. Refer to interview with the Administrator on 05/13/22 between 2:00pm and 3:30pm.					
	10/20/21 revealed: -Diagnoses included anxiety, depression, I hypertension, Gilbert' liver, and Alzheimer's	nypothyroidism, s Syndrome, steatosis of Dementia. commended level of care				
	revealed: -On 04/10/22 at 8:53 Resident #5 was obsorbruise over her right 6 -On 04/11/22 at 2:24 Resident #5 was see -On 05/05/22 at 7:476 Resident #5 was obsorbruise	erved with a small knot and eye. om, staff documented on by her physician. am, staff documented or the floor in her go of hip pain and was sent to				
	04/11/22 revealed: -At 3:04pm, Resident 04/11/22 for a fall with	#5 was evaluated on a bruise on her forehead. charged back to the facility				
	05/05/22 revealed:	5's ED documentation dated nt #5 was referred for ED unwitnessed fall on				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 63 of 83

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED
		HAL060166	B. WING		05	5/13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
WICKSHII	RE STEELE CREEK		TRYON ST			
		CHARLO	OTTE, NC 28278			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 451	dated 05/05/22 reveal -At 7:27am, Resident that Resident #5 had -Resident #5 notified a fall and hit her head -Resident #5 was ser Review of Resident # incident report for Relevaluations on 04/11/2 Refer to interview wit 9:15am. Refer to interview wit 1:30pm. Refer to interview wit 05/13/22 between 2:0 4. Review of Resident 10/21/21 revealed: -Diagnoses included Disease, seizure discontinuous for the Special Con 04/27/22 at 12:52 Resident #6 was warmed	gnosed with a left ure. nitted to the hospital. 5's facility incident report led: #5's husband notified staff a fall in her bathroom. staff that she had sustained and her left hip was painful. In to ED for evaluation. 5's record revealed no sident #5's referral for ED (22, and 05/05/22). In the RCC on 05/12/22 at the Administrator on 100pm and 3:30pm. It #6's current FL-2 dated End-Stage Alzheimer's order, hypothyroidism. Sommended level of care	D 451	DEFICIENT		
	-On 04/28/22 at 6:34a Resident #6 returned	am, staff documented				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 64 of 83

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL060166	B. WING		05/13/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE STEELE CREEK		RYON ST			
	-	CHARLO	TTE, NC 28278			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE	
D 451	Continued From page 64		D 451			
	department (ED) at approximately 12:30am. Review of Resident #6's ED documentation dated 04/27/22 at 2:46pm revealed Resident #6 was evaluated for altered mental status. Review of Resident #6's physician's routine visit summary dated 04/28/22 revealed Resident #6 was seen for follow-up evaluation due to hospitalization on 04/27/22 for behavioral issues. Review of Resident #6's facility incident report dated 04/27/22 revealed: -On 04/27/22 at 12:52pm, staff documented Resident #6 was wandering into other residents' rooms and struck another resident in the faceResident #6 was sent to ED for evaluation.					
	Refer to interview with 9:15am.	h the RCC on 05/12/22 at				
	Refer to interview with 1:30pm.	h the SCC on 05/13/22 at				
	Refer to interview with 05/13/22 between 2:0	h the Administrator on 00pm and 3:30pm.				
	revealed: -The MAs were responsible incident report when a ED for evaluationShe and the SCC we incident reports and responsible incident reports and responsible was not sure with	C on 05/12/22 at 9:15am onsible for completing an a resident was sent to the ere responsible for reviewing notifying the Administrator. Then resident incident reports to the county Department of				
	-She was not sure wh	nich type of incidents, such n condition, required an				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 65 of 83

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL060166	B. WING		05/13/2022	
NAME OF PROVIDER	OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	
WICKSHIRE STEE	I E CREEK	13600 S TF	RYON ST			
Wickerink Cite		CHARLOT	TE, NC 28278			
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLE	
D 451 Contin	ued From page	e 65	D 451			
	-The Administrator was responsible for submitting incident reports to the county DSS.					
-MA's report evaluars -She a incider -She vas falls incider -The A incider Intervibetwer -MA's	were responsibe when a resider when a resider tion. Ind the RCC went reports and revas not sure when a change in the report to be a chaministrator want reports to the ew with the Adren 2:00pm and were responsibe.	as responsible for submitting				
ED for -The F incider -The ir forgot -He ex reports aideHe wa reports	evaluation. RCC or SCC went reports and recident reports to send them. Expected staff to se for any reside as responsible to the county as not aware in	ere responsible for reviewing notifying the Administrator. were not completed or he complete an incident nt requiring more than first for submission of incident				
Care U	Jnit CAC 13F .1306	Admission To The Special Admission To The Special	D 463			

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 66 of 83

PRINTED: 06/03/2022 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	` '		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
	HAL060166	B. WING		0.5	5/13/2022
NAME OF PROVIDER OR SUPPLIER		DDRESS, CITY, STAT	TE ZIP CODE	1 00	17172022
		FRYON ST	L, ZII GODE		
WICKSHIRE STEELE CREEK		TTE, NC 28278			
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES JUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
in the rules of this Subch of residents to the home that the following require admission to the special (1) A physician shall spresident's FL-2 that mee specific group of resider (2) There shall be a doc screening by the facility appropriateness of an in the special care unit. (3) Family members seresident to a special care disclosure information reand any additional writte policies and procedures this Subchapter that is not 131D-8. This disclosure the resident's record. This Rule is not met as Based on interviews and facility failed to ensure 2 (Residents #5 and #6) recare Unit (SCU) had a programment of the findings are: 1. Review of Resident #10/20/21 revealed: -Diagnoses included meanxiety, depression and -The recommended lever Review of Resident #5's was no pre-admission serial requirement.	Il requirements specified hapter for the admission e, the facility shall assure ements are met for I care unit: ecify a diagnosis on the ests the conditions of the ents to be served. cumented pre-admission to evaluate the endividual's placement in eking admission of a re unit shall be provided equired in G.S. 131D-8 en information addressing elisted in Rule .1305 of not included in G.S. e shall be documented in evidenced by: d record reviews, the endividual's placement in evidenced by: d record reviews, the endividual of the evidence of	D 463			

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 67 of 83

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:			E SURVEY PLETED
		HAL060166	B. WING			5/13/2022
	ROVIDER OR SUPPLIER	13600 S	ADDRESS, CITY, STATE, TRYON ST OTTE, NC 28278	ZIP CODE		
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 463	Continued From page	e 67	D 463			
	Refer to interview with Coordinator (SCC) or	h the Special Care n 05/13/22 at 10:15am.				
	Refer to interview with Specialist on 05/12/2	h the Regional Clinical 2 at 3:15pm.				
	Refer to interview with 05/13/22 at 11:18am	h the Administrator on				
	Review of Resident #6's current FL2 dated 10/21/21 revealed: -Diagnoses included end-stage Alzheimer Disease and seizure disorder. -The resident was constantly disoriented with wandering behaviors.					
	with bathing, feeding	personal care assistance				
	was no pre-admission	6's record revealed there n screening for the resident priateness of the resident's J.				
	Refer to interview with Coordinator (SCC) or	h the Special Care n 05/13/22 at 10:15am.				
	Refer to interview with Specialist on 05/12/2	h the Regional Clinical 2 at 3:15pm.				
	Refer to interview with 05/13/22 at 11:18am	h the Administrator on				
	(SCC) on 05/13/22 at -She started her position	ecial Care Coordinator : 10:15am revealed: tion in February 2022 and complete all of her training				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 68 of 83

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 13600 S TRYON ST CHARLOTTE, NC 28278 (X4) ID PREFIX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 463 Continued From page 68 -She was not sure who was responsible for completing the SCU prescreening at this timeShe started auditing resident records about 1		STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
WICKSHIRE STEELE CREEK 13600 S TRYON ST CHARLOTTE, NC 28278 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 463 Continued From page 68 -She was not sure who was responsible for completing the SCU prescreening at this time.			HAL060166	B. WING		05/13/2022	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) D 463 Continued From page 68 -She was not sure who was responsible for completing the SCU prescreening at this time.	NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 463 Continued From page 68 -She was not sure who was responsible for completing the SCU prescreening at this time.	WICKSHIE	RE STEELE CREEK					
-She was not sure who was responsible for completing the SCU prescreening at this time.	PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLET	Œ
week ago but had not gotten to Resident #5's or Resident #6's record. -She was not aware that they were missing the SCU prescreening evaluation. Interview with the Regional Clinical Specialist on 05/12/22 at 3:15pm revealed: -The SCU prescreening forms could not be found for the 2 sampled residentsThe prescreening should have been completed by the SCC on admissionThe contracted electronic database for the facility provided a report that reveals what documents were missing from the resident recordsThe SCC was trained on how to access that report today (05/12/22). Interview with the Administrator on 05/13/22 at 11:18am revealed: -The facility recently started a contract with an electronic database system and had to scan in all paper documentsThe SCU prescreening evaluations could not be located in the electronic database for Resident #5 or Resident #6The previous SCC had a physical file folder with the resident's SCU prescreening evaluations but the folder could not be locatedThe SCC was responsible for ensuring that all residents in the SCU had a prescreening evaluations but the folder could not be locatedThe PCC was responsible for ensuring that all residents in the SCU had a prescreening evaluations but the folder could in the president's recordsThe He Glo not audit the resident's recordsThe did not audit the resident's records.	D 463	-She was not sure who completing the SCU processes and sware to SCU prescreening events and the second and the	no was responsible for prescreening at this time. resident records about 1 a gotten to Resident #5's or that they were missing the aluation. Igional Clinical Specialist on evealed: Ing forms could not be found idents. Ingold they been completed sion. In the resident Ingold from the residents Ingold from the resident Ingold from the resi	D 463	DELI MIENCI)		

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 69 of 83

PRINTED: 06/03/2022 FORM APPROVED

Division of Health Service Regulation

DIVISION	n nealth Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
		HAL060166	B. WING		05/1	3/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE		
TO AVIL OF TH	TO VIDER ON OUT FIELD			, 2.11 0002		
WICKSHIP	RE STEELE CREEK		RYON ST			
		CHARLO	TTE, NC 28278			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
IAO		,	IAG	DEFICIENCY)		
D 464	Oti	- 00	D 464			
	Continued From page					
D 464		Special Care Unit Res.	D 464			
	Profile & Care Plan					
	404 1104 0 405 4005					
		' Special Care Unit Resident				
	Profile & Care Plan	discussion to the Dulas AOE				
		uirements in Rules 13F				
		of this Subchapter, the				
	facility shall assure th	•				
	` ,	admission to the special				
	care unit and quarterly thereafter, the facility shall					
	•	dent profile containing				
		describes the resident's				
		self-help abilities, level of				
		cial management needs,				
		disabilities, and degree of				
	cognitive impairment.					
		plan as required in Rule				
		chapter shall be developed				
		he resident profile and				
		that involves environmental,				
		e strategies to help the				
		ntain the maximum level of				
	• .	and compensate for lost				
	abilities.					
	This Dula is not meet	as syldeneed by:				
	This Rule is not met	•				
		ns, interviews, and record				
		illed to ensure a Special				
		ident Profile and Care Plan				
	-	30 days of admission for 2				
	oi z sampied resident	ts (Residents #5 and #6).				
	The findings are:					
	1. Review of Residen	t #5's current FL2 dated				
	10/20/21 revealed:					
	-Diagnoses included	memory impairment.				
	-	nd Alzheimer's dementia.				
		evel of care was the SCII				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 70 of 83

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	(X3) DATE SURVEY COMPLETED	
		HAL060166	B. WING		05/13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
WICKSHI	RE STEELE CREEK		TRYON ST TTE, NC 28278		
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTE
D 464	Continued From page	70	D 464		
		5's record revealed there SCU Resident Profile and within 30 days of			
	Refer to interview with SCU personal care aide on 05/13/22 at 12:30pm.				
	Refer to interview with 05/13/22 at 12:40pm.	n SCU medication aide on			
	Refer to interview with the Special Care Coordinator (SCC) on 05/13/22 at 10:15am. Refer to interview with the Regional Clinical Specialist on 05/12/22 at 3:15pm.				
		n the Administrator on nd 05/13/22 at 11:18am			
	2. Review of Residen 10/21/21 revealed:	t #6's current FL2 dated			
	wandering behaviorsThe resident needed with bathing, feeding -The resident's recom	disorder. nstantly disoriented with personal care assistance			
		6's record revealed there SCU Resident Profile and within 30 days of			
	05/11/22 at 10:00am find a care plan for Re	gional Clinical Specialist on revealed he was not able to esident #6 so her Primary signed a new care plan for			

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 71 of 83

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	SURVEY LETED
7.1.12 . 2.1.1	5. GG.W.EG.WG.	152111110711101111011152111	A. BUILDING: _			
		HAL060166	B. WING		05/	13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
WICKSHII	RE STEELE CREEK		TRYON ST			
			TTE, NC 28278			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 464	Continued From page	e 71	D 464			
	her this morning, (05/11/22).					
	Refer to interview with SCU personal care aide on 05/13/22 at 12:30pm. Refer to interview with SCU medication aide on 05/13/22 at 12:40pm.					
	Refer to interview wit Coordinator (SCC) or	h the Special Care n 05/13/22 at 10:15am.				
	Refer to interview with the Regional Clinical Specialist on 05/12/22 at 3:15pm. Refer to interview with the Administrator on 05/12/22 at 4:30pm and 05/13/22 at 11:18am.					
	aide (MA) regarding r -He did not know of a refer to for resident ca	revealed: I report from the medication resident care needs. rny document the staff would				
	revealed: -She did not know wh refer to for resident careful standup in mornings to discuss a Resident's behaviors progress notes. Interview with the Spe (SCC) on 05/13/22 at She started her position. The Regional Clinical training her on how to	meetings were held in the any resident needs. s are documented in the staff ecial Care Unit Coordinator				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 72 of 83

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HAL060166	B. WING		0:	5/13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MICKSHII	RE STEELE CREEK	13600 S	TRYON ST			
WICKSHII	NE STEELE CREEK	CHARLO	OTTE, NC 28278			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 464	Continued From page		D 464			
	as needed to comple was fully trainedShe started auditing week ago and was not and Resident #6 did planShe was not sure wherefer to direct the resubsence of a completion absence of a completion of the source of the sourc	ted care plan. ained on how to complete a at this time. s are currently documented				
	05/12/22 at 3:15pm r -The HWD was responsive responsible for the HWD position water responsible for the HWD position water responsive responsible for the HWD position water responsive res	consible for completing the bigned in February 2022. Int Care Coordinator (RCC) completing care plans until its filled. In a completing care plans until its filled. In a complete completed its filled in a completed its filled in a completed its filled in a completed its filled.				
	4:30pm and 05/13/22 -The HWD, SCC an I completing resident's -He was not aware th #6 did not have comp -He thought the trave care plans before she	nat Resident #5 and Resident				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 73 of 83

PRINTED: 06/03/2022 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL060166	B. WING		05/13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
WICKOLIII	DE OTEEL E ODEEK	13600 S T	RYON ST		
WICKSHI	RE STEELE CREEK	CHARLOT	TE, NC 28278		
(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 APPROPE DEFICIENCY)	BE COMPLETE
D 464	Continued From page	e 73	D 464		
D0.40	required a resident prupdated quarterly. -The SCC or HWD we completing the SCU rit quarterly. -The previous HWD auploading all of the fathe electronic database February 2022. -The SCU resident proof or Resident #5 and February 45.	and the previous SCC were acility's paper evaluations to se before they left in rofiles could not be located Resident #6.	Dovo		
D912	G.S. 131D-21(2) Dec	laration of Residents' Rights	D912		
	G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.				
	reviews, the facility fa received care and ser and in compliance wit laws and rules and re	ns, interviews and record illed to ensure residents rvices which were adequate, th relevant federal and state			
	The findings are:				
	facility failed to ensure A and C) who adminis completed the clinical sampled staff (Staff A	and record reviews the e 2 of 3 sampled staff (Staff stered medications had I skills checklist and 1 of 3) had completed the hing prior to administering			

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 74 of 83

PRINTED: 06/03/2022 FORM APPROVED

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL060166	B. WING		05/13/2022
	ROVIDER OR SUPPLIER		ODRESS, CITY, STA	TE, ZIP CODE	
WIOROIM	CE OTELLE ONLEN	CHARLO	TTE, NC 28278		
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D912	Continued From page	: 74	D912		
		o Tag D935 10A NCAC 13F edication Aide Training and Violation)].			
D914	G.S. 131D-21(4) Decl	aration of Residents' Rights	D914		
	Every resident shall h	ation of Residents' Rights ave the following rights: al and physical abuse, ion.			
	reviews, the facility fa	observations and record iled to ensure all residents it related to medication			
	The findings are:				
	reviews, the facility farmedications as ordered observed during the merrors with two medicals a medication to treat of treat fluid retention, a medication to treat and for 2 of 6 resident record review including to decrease blood clotheat panic disorders at [Refer to Tag D358 10] Medication Administrations as ordered to the control of	ed for 1 of 6 residents (#7) medication pass including ations to treat hypertension, depression, a medication to medication to treat mood, a xiety and a supplement; ts (#1 and #2) sampled for ag errors with a medication to thing (#1), and medication to and decrease anxiety (#2). OA NCAC 13F .1004(a) ation (Type A1 Violation)].			
		s and record reviews, the e referral and follow-up to			

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 75 of 83

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL060166	B. WING		05	5/13/2022
	ROVIDER OR SUPPLIER	13600 S	DDRESS, CITY, STATE TRYON ST DTTE, NC 28278	E, ZIP CODE		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D914	2 of 7 sampled reside not receiving a blood bleeding (#1) and mis to treat fluid retention medication to treat ar supplement (#7). [Re	acute health care needs for ents (#1, and #7) related to thinning medication and esed doses of a medication , a medication for mood, a	D914			
D935	Training and Competer G.S. § 131D-4.5B (b) Medication Aides; Transcription Evaluation Requirement (b) Beginning Octobe home is prohibited from any unsupervised methat individual has present to a few promedication aide during an adult care home of the following: (1) A five-hour training Department that incluing all of the following: a. The key principles administration. b. The federal Center Prevention guidelines applicable, safe inject procedures for monitor bleeding occurs or the exists. (2) A clinical skills evan NCAC 13F .0503 and (3) Within 60 days from	Adult Care Home sining and Competency ents. r 1, 2013, an adult care or allowing staff to perform dication aide duties unless eviously worked as a g the previous 24 months in r successfully completed all g program developed by the des training and instruction of medication s for Disease Control and on infection control and, if the potential for bleeding aluation consistent with 10A 10A NCAC 13G .0503. In the date of hire, the completed the following:	D935			

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 76 of 83

PRINTED: 06/03/2022 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	DF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:	A. BUILDING:		LETED
		HAL060166	B. WING		05.	13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
WICKSHIE	RE STEELE CREEK	13600 S T	RYON ST			
Wickerin	NE OTELLE ONLEN	CHARLO	TTE, NC 28278			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D935	training and instruction. The key principles administration. The federal Center Prevention guidelines applicable, safe inject procedures for monitobleeding occurs or the exists. An examination of Head accordance with substitute and Color of He	partment that includes on in all of the following: of medication rs of Disease Control and so on infection control and, if tion practices and oring or testing in which ee potential for bleeding eveloped and administered alth Service Regulation in section (c) of this section. as evidenced by: and record reviews the see 2 of 3 sampled staff (Staff stered medications had I skills checklist and 1 of 3 at had completed the hing prior to administering personnel record revealed: 02/21/22. edication aide (MA). mentation she completed the	D935			
	Review of a resident' medication administra	s March 2022 electronic ation record (eMAR)				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 77 of 83

AND DIAN OF CODDECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL060166	B. WING		05/1	3/2022
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 00/1	0,2022
WICKSHIE	RE STEELE CREEK	13600 S TR CHARLOT	YON ST TE, NC 28278			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D935	Review of a resident's Staff A administered resident's Staff A did not administed 2022. Telephone interview was:48am revealed: -She was hired by the February 2022 as a pand MAShe had not taken the Aide examShe had not received medication administration administration administration training Business Office Mana-On 04/04/22, she addithe facility, no addition assist her. Refer to interview with Coordinator (RCC) or Refer to interview with Manager (BOM) on 0.00 Refer to telephone into the staff of the	nistered medications on and 03/27/22. S April 2022 eMAR revealed medications on 04/04/22. S May 2022 eMAR revealed ster medications in May with Staff A on 05/11/22 at efacility at the end of ersonal care aide (PCA) The North Carolina Medication and the agent (BOM). The India Mark were available to the Resident Care in 05/12/22 at 9:14am. The Resident Care Unit in 05/13/22 at 11:18am. The Business Office	D935	DEL ROILING I)		
	Nurse (RN) on 05/12/					

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 78 of 83

AND DIAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL060166	B. WING		05/	13/2022
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	ITE, ZIP CODE	1 3	
WICKSHIE	RE STEELE CREEK	13600 S T CHARLOT	RYON ST TE, NC 28278			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D935	Continued From page	÷ 78	D935			
	11:40am.					
	Refer to interview with at 2:10pm.	n Administrator on 05/13/22				
	-Staff C was hired on -She worked as a per medication aide (MA) -There was documen 15-hour MA training of -There was no documedication clinical sk validation. -There was no documenthe written MA exam. Review of a resident's medication administrative revealed Staff C adm 03/01/22, 03/02/22, 0 03/10/22, 03/14/22, 0	sonal care aide (PCA) and a tation she completed the in 06/24/21. Intentation she completed the fills checklist competency in the strain that she passed is March 2022 electronic ation record (eMAR) inistered medications on 3/05/22, 03/06/22, 03/09/22, 3/15/22, 03/16/22, 03/19/22, 3/24/22, 03/25/22, 03/28/22,				
	Staff C administered (04/03/22, 04/07/22, 04/16/22, 04/16/22, 04/16/22, 04/16/22, 04/16/22, 04/16/22, 04/16/22, 04/16/22, 04/16/22, 04/16/22, 04/16/22, 04/16/22, 04/16/22, 04/16/22, 04/16/22, 04/16/22, 04/16/22, 04/16/22	s April 2022 eMAR revealed medications on 04/02/22, 4/11/22, 04/12/22, 04/13/22, 4/17/22, 04/20/22, 04/21/22, 4/26/22, 04/27/22 and				
		s May 2022 eMAR revealed medications on 05/01/22.				
	2:35pm revealed: -She was hired by the promoted to MA in Fe	e facility as a PCA and was bruary 2022. e received medication				

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 79 of 83

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			7 50.25			
		HAL060166	B. WING		05/13/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE STEELE CREEK	13600 S T				
		CHARLOT	TE, NC 28278			
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	Ξ
D935	Continued From page	e 79	D935			
	Manager (BOM) and Coordinator (SCC) willicensed healthcare pushed id not know what training the former SC. She was scheduled in Medication Aide examulation and the schedule in February 2022, sharesidents' medication. Refer to interview with Coordinator (RCC) or Refer to interview with 11:18am.	nat medication administration CC had prior to training her. to take the North Carolina in on 05/08/22. the started to administer is independently. In the Resident Care				
	•	terview with the previous 2 at 11:27am and 11:40am.				
	Refer to interview with 05/13/22 at 2:10pm.	h the Administrator on				
	revealed: -The facility's previou 15-hour MA training a skills checklist compe -The Administrator an setting up the training RNAfter the County initi 04/12/22, she was ma MAs in the facility we -Those MAs were tak	and the medication clinical stency validation for MAs. and BOM were responsible for a through the previous HWD sated the complaint on ade aware that some of the				

Division of Health Service Regulation

they become fully trained.

STATE FORM 6899 RH7E11 If continuation sheet 80 of 83

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
HAL060166	B. WING		05/13/2022	
STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
13600 S	TRYON ST			
CHARLO	TTE, NC 28278		1	
Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
e 80	D935			
-The RCC did not audit staff records and was unsure how the untrained staff were identifiedThe BOM was responsible for ensuring that staff training was up to date.				
RN was responsible for raining. nsible for ensuring that staff				
A for the facility and BOM position in December RN left the facility in since that time the facility access to an RN that could on clinical skills checklist in for MAs. The medication clinical skills a validation was required alminister medication to Staff C did not have the ills checklist competency prior to administering ants alone because the he Administrator was aware ully trained prior to tions. The formal interest and the prior to tions.				
	HAL060166 STREET AI 13600 STREET AI CHARLO ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) E 80 dit staff records and was ined staff were identified. Insible for ensuring that staff	HAL060166 B. WING STREET ADDRESS, CITY, STAT 13600 S TRYON ST CHARLOTTE, NC 28278 ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) B. 80 D935 D35 D35 D35 D36 D37 D37 D37 D37 D37 D37 D37	IDENTIFICATION NUMBER: HALO60166 BYTREET ADDRESS, CITY, STATE, ZIP CODE 13600 S TRYON ST CHARLOTTE, NC 28278 ATEMENT OF DEFICIENCIES ATEMENT OF DEFICIENCIES TAG TAG PREFIX ACROSS-REFERENCED OF INFAPPROPE DEFICIENCY) DEFICIENCY 10 PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD. CROSS-REFERENCED OT INFAPPROPE DEFICIENCY) DEFICIENCY TAG TAG TAG TAG TAG TAG TAG TA	

Division of Health Service Regulation

necessary clinical trainings were in the staff

STATE FORM 6899 RH7E11 If continuation sheet 81 of 83

PRINTED: 06/03/2022 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7 50.25 10.		
		HAL060166	B. WING		05/13/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
WICKSHIE	RE STEELE CREEK	13600 S T			
		CHARLO	TE, NC 28278		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D935	Continued From page	e 81	D935		
	record and completed -She was responsible were complete, but st records.	d on time. for ensuring staff records ne did not audit the staff			
	on 05/12/22 at 11:27a-She worked at the farebruary 2020 until the She remained availate leaving, for as needed and the end of April 20 contacted her to provide the contacted her to provide the same of the same	sked to provide 5/10/15-hour cember 2021 but did provide ills checklist competency As in mid-April 2022. The medication clinical skills a validation to Staff A or Staff e of the required Medication Validation Form in April 2022			
	Interview with the Adr 2:10pm revealed: -The BOM, RCC and scheduling new empl previous HWD RN. -He and the BOM we up with deadlines for -The BOM should have the dates of required -The RCC and SCC s spreadsheet and wou checking it then sche	MAs' medication skills. ministrator on 05/13/22 at SCC were responsible for oyee training with the re responsible for keeping annual and other training. We a spreadsheet to track training for staff members should have access to the			

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 82 of 83

PRINTED: 06/03/2022 FORM APPROVED

Division of Health Service Regulation

AND BLAN OF CORRECTION INDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL060166	B. WING		05/13/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD 13600 S TI	DRESS, CITY, STA	TE, ZIP CODE	
WICKSHIE	RE STEELE CREEK		TE, NC 28278		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D935	-He was aware that se administering medical validated by the prevision. The facility was work training up to date. Refer to Tag D0358 1 Medication Administrated Programmer of Date o	disheet to track staff training. Jome MAs were tions before they were Journal on getting the MAs OA NCAC 13F .1004(a) Joan of the resident (Type SD Assure 3 of 3 sampled staff Joadministered medications Joan of the resident of the residents who Joan of the resident and Joan of the resident and Joan of the resident and Joan of protection in Joan of protection in Joan of the resident on May 11, 2022	D935		

Division of Health Service Regulation

STATE FORM 6899 RH7E11 If continuation sheet 83 of 83