Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE COMF	SURVEY
			A. BOILDING			2.0
		HAL060166	B. WING		I	R-C / 20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	FE. ZIP CODE		
			TRYON ST	,		
WICKSHIE	RE STEELE CREEK	CHARL	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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
{D 000}	Initial Comments		{D 000}			
	The Adult Care Licens Mecklenburg County Services conducted a November 14th throu	Department of Social				
D 125	10A NCAC 13F .0403 Medication Staff	s(a) Qualifications Of	D 125			
	aides, and their direct training, clinical skills written examination a 131D-4.5B. Persons a occupational licensure	staff who administer or referred to as medication supervisors shall complete validation, and pass the s set forth in G.S. authorized by state e laws to administer opt from this requirement.				
	This Rule is not met FOLLOW-UP TO TYPE					
	Non-compliance cont B Violation was not al	inues and the previous Type pated.				
	facility failed to ensure aides (MA) (Staff D, E	ation clinical skills validation				
	The findings are:					
	Review of Staff D's revealed: Staff D's hire date was	MA personnel record on as 08/19/23.				

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

TITLE (X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			' '	CONSTRUCTION	(X3) DATE S	
		A. BUILDING:				
		HAL060166	B. WING		R- 11/2	C 0/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
W// O/ CO ! !!!	DE OTEEL E ODEEK	13600 S T	RYON ST			
WICKSHIP	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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 125	Continued From page 1		D 125			
	-There was documentation of a virtual medication administration clinical skills validation dated 08/20/23. Review of a resident's October 2023 electronic medication administration record (eMAR) revealed there was documentation Staff D administered medications 150 times from 10/11/23 through 10/31/23. Review of a resident's November 2023 eMAR revealed there was documentation Staff D administered medications 84 times from 11/01/23 through 11/16/23.					
	Telephone interview v 2:15pm revealed:	vith Staff D on 11/16/23 at				
	staffing agencyShe had been workir	y the facility's contracted				
	since August 2023She began working i (SCU) on 11/15/23.	n the Special Care Unit				
	-Her MA duties includ medications.	-				
	-On 08/20/23, she wa medication administra by a contracted Regis	ation clinical skills orientation				
	administration clinical	d any additional medication skills validation in the				
	facilityShe did not notice th					
	not match the eMAR					
	-The MAs were support medications on the morders but she did no	edication cart to the eMAR				
	the medication cart, t	rect dose of medication on ne MA should have ogress notes and notified				

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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	
			720.2510		R-C
		HAL060166	B. WING		11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
WICKSHIE	RE STEELE CREEK		TRYON ST TTE, NC 28278		
	OUR MARK OT			PD0/405000 DLAV 05 0000507	011
(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 APPRO DEFICIENCY)	D BE COMPLETE
D 125	Continued From page 2		D 125		
	the pharmacy as well	as the resident's PCP.			
	Refer to telephone interview with a MA on 11/17/23 at 3:30pm.				
	Refer to interview with Manager (BOM) on 1	_			
	Refer to interview with the facility's Compliance Nurse on 11/20/23 at 3:33pm. Refer to interview with the Administrator on 11/20/23 at 4:40pm.				
		as 10/17/23. nentation of a medication			
	administration clinical skills validation. Review of a resident's October 2023 electronic medication administration record (eMAR) revealed there was documentation Staff E administered medications 8 times from 10/11/23 through 10/31/23.				
	revealed there was de	s November 2023 eMAR ocumentation Staff E tions 25 times from 11/01/23			
	revealed: -She was employed t contracted staffing ag-She had been working since October 2023She had not perform administration clinical	ency. ng at the facility as a MA			

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Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			SURVEY PLETED
		HAL060166	B. WING		l l	R-C / 20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E. ZIP CODE	, ,	
			TRYON ST	-,:		
WICKSHII	RE STEELE CREEK	CHARL	OTTE, NC 28278			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY 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 125	Continued From page	e 3	D 125			
	facility.					
	Refer to telephone in 11/17/23 at 3:30pm.	terview with a MA on				
	Refer to interview wit 10:46am.	h the BOM on 11/20/23 at				
	Refer to interview wit Nurse on 11/20/23 at	h the facility's Compliance 3:33pm.				
	Refer to interview wit 11/20/23 at 4:40pm.	h the Administrator on				
	revealed: -Staff F's hire date wa	nentation of a medication				
	Review of a resident' medication administrative revealed there was d	s October 2023 electronic ation record (eMAR)				
	revealed there was d	s November 2023 eMAR ocumentation Staff F tions 54 times from 11/01/23				
	2:00pm revealed: -She was employed to contracted staffing ag-She had been working since October 2023She had not perform administration clinica	gency. ng at the facility as a MA				

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Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
						R-C
		HAL060166	B. WING		11	/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	ΓE, ZIP CODE		
WICKSHII	RE STEELE CREEK		TRYON ST OTTE, NC 28278			
(VA) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CO	OPPECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 125	Continued From page	· 4	D 125			
	Refer to telephone int 11/17/23 at 3:30pm.	erview with a MA on				
	Refer to interview with 10:46am.	n the BOM on 11/20/23 at				
	Refer to interview with Nurse on 11/20/23 at	n the facility's Compliance 3:33pm.				
	Refer to interview with 11/20/23 at 4:40pm.	n the Administrator on				
	Telephone interview with a MA on 11/17/23 at 3:30pm revealed -From 09/11/23 to 11/14/23 the MAs completed					
	required training class					
	-The Administrator was scheduling agency sta and their required skil	aff for required trainings,				
	Interview with the BO revealed:	M on 11/20/23 at 10:46am				
	training records week -The facility utilized st	for auditing facility staff ly. affing agency staff since				
		sible for auditing the staff 's agency staff training				
	-She was responsible training needs to the	for communicating staff facility's compliance nurse. he facility's contracted				
	agency staff were req medication clinical sk					
	Interview with the faci	lity's Compliance Nurse on				

Division of Health Service Regulation

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL060166	B. WING		11/20/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
W#0K01	DE OTEEL E ODEEK	13600 S T	RYON ST		
WICKSHIE	RE STEELE CREEK	CHARLOT	TE, NC 28278		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 125	Continued From page 5		D 125		
	facility's contracted farance -A medication administration was to be prin-person, in the facili medication administration -The BOM was responsive staff requiring medical skills validation -She was not aware Staff requires -She was not aware	Iding medication I skills validation for the acility staff. Istration clinical skills berformed with each MA ty prior to the MA performing ation tasks. Insible for notifying her of edication administration in. Istaff D, Staff E, or Staff F did			
	not have a medication administration clinical skills validation. Interview with the Administrator on 11/20/23 at 4:40pm revealed: -The BOM was responsible for auditing facility staff training recordsThe BOM was responsible for notifying the facility's Compliance Nurse of any MA needing the medication administration clinical skills validation prior to performing medication				
	August 2023She was aware staffi required to have the s	taffing agency staff since ing agency staff were same training requirements			
	clinical skills validation facility with each MA pany medication admir -The BOM did not mater staffing agency stars. She was not aware startual medication adrivalidation on 08/20/23	untain staff training records aff. Staff D had been provided a ministration clinical skills 3 by facility staff. administration clinical skills			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE	SURVEY
			7.1. 56.25.116.			R-C
		HAL060166	B. WING			/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E, ZIP CODE		
WICKSHIE	RE STEELE CREEK		TRYON ST TTE, NC 28278			
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETE DATE
D 125	5 Continued From page 6		D 125			
	staff had a valid medi	ensured staffing agency MA ication administration clinical to performing medication				
	staff completed a meclinical skills validation medication administration being unable to have administer resident's failure was detrimentations.	change of 6 sampled MA dication administration on prior to performing ation tasks, resulting in staff the knowledge needed to medications. The facility's all to the health, safety, and dents, which constitutes a				
		a plan of protection in . 131D-34 on 11/16/23 for				
	CORRECTION DATE VIOLATION SHALL N 2024.	E FOR THE TYPE B NOT EXCEED JANUARY 4,				
{D 164}	10A NCAC 13F .0505 Diabetic Resident	5 Training On Care Of	{D 164}			
	Diabetic Residents An adult care home s the care of residents unlicensed staff prior insulin as follows: (1) Training shall be nurse, registered pha practitioner. (2) Training shall incl	chall assure that training on with diabetes is provided to to the administration of provided by a registered armacist or prescribing lude at least the following: diabetes and care involved f diabetes;				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY IPLETED	
		HAL060166	B. WING			R-C 1/20/2023
	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 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 164}	for insulin administrat (e) treatment and pre and hyperglycemia, in symptoms; (f) blood glucose mo precautions; (g) universal precaut (h) appropriate admi (i) sliding scale insuli	g and injection techniques ion; evention of hypoglycemia including signs and initoring; universal ions; inistration times; and in administration.	{D 164}			
	This Rule is not met FOLLOW-UP TO TYPE The Type B Violation Non-compliance cont	PE B VIOLATION was not abated. inues.				
	facility failed to ensur aides (MA) (Staff D, E	and record reviews the e 3 of 6 sampled medication E and F) completed training c residents prior to the lin.				
	revealed: -Staff D's hire date was -There was no docume diabetic care for resident's medication administrative revealed there was designed.	nentation of training on lents. s October 2023 electronic ation record (eMAR)				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		D 0
		HAL060166	B. WING		R-C 11/20/2023
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		
	CLIMMA DV CT			DDOVIDEDIC DI AN OF CODDECTION	u
(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
{D 164}	Continued From page 8		{D 164}		
	(FSBS) 15 times and times from 10/27/23 t	administered insulin 13 hrough 10/31/23.			
	revealed there was do				
	2:15pm revealed: -She was employed be staffing agencyShe had been working since August 2023Her MA duties include when needed and cheordered.	ovith Staff D on 11/16/23 at by the facility's contracted and at the facility as a MA sed administering insulin ecking residents' FSBS as orking at the facility, she had along related to care of			
	Refer to interview witl Manager (BOM) on 1	_			
	Refer to interview with Nurse on 11/20/23 at	n the facility's Compliance 3:33pm.			
	Refer to interview with 11/20/23 at 4:40pm.	n the Administrator on			
	revealed: -Staff E's hire date wa -There was no docum diabetic care for resid	nentation of training on lents. s November 2023 electronic ation record (eMAR)			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING		R-	
		HAL060166	B. WING		11/2	0/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	WICKSHIRE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 164}	Continued From page	9	{D 164}			
	checked resident's FSBS 2 times and administered insulin 2 times from 11/01/23 through 11/16/23.					
	revealed: -She was employed be staffing agencyShe had been working since October 2023Her MA duties include when needed and cheorderedSince she started wo not received any trained diabetic residents.	on 11/16/23 at 11:10am by the facility's contracted ag at the facility as a MA led administering insulin ecking residents' FSBS as brking at the facility, she had ling related to care of at the BOM on 11/20/23 at				
	Refer to interview with Nurse on 11/20/23 at	n the facility's Compliance 3:33pm.				
	Refer to interview with 11/20/23 at 4:40pm.	n the Administrator on				
	3. Review of Staff F's revealed: -Staff F's hire date wa-There was no docum diabetic care for resid	as 10/24/23. nentation of training on				
	Review of a resident's medication administrative revealed there was do checked resident's FS administered insulin 8 through 11/16/23.	ocumentation Staff F SBS 9 times and				

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Telephone interview with Staff F on 11/16/23 at

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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
					D 0
			P WING		R-C
		HAL060166	B. WING		11/20/2023
NAME OF D	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E ZIR CODE	
NAME OF T	NOVIDEN ON 3011 LIEN			E, ZII GODE	
WICKSHIE	RE STEELE CREEK	13600 S	TRYON ST		
	(2 0 1 2 2 2 2 1 K	CHARLO	OTTE, NC 28278		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE
				DEFICIENCY)	
(D 164)	0	- 40	(D 164)		
{D 164}	4} Continued From page 10		{D 164}		
	2:00pm revealed: -She was employed by the facility's contracted				
		by the facility 3 contracted			
	staffing agency.				
		ng at the facility as a MA			
	since October 2023.				
		ded administering insulin			
	when needed and ch	ecking residents' FSBS as			
	ordered.				
	-Since she started wo	orking at the facility, she had			
		ning related to care of			
	diabetic residents.				
	Refer to interview with	h the BOM on 11/20/23 at			
	10:46am.	IT the BOM on 11/20/23 at			
	10.40am.				
		h the facility's Compliance			
	Nurse on 11/20/23 at	3:33pm.			
	Refer to interview with	h the Administrator on			
	11/20/23 at 4:40pm.				
	-				
	Interview with the BO	0M on 11/20/23 at 10:46am			
	revealed:				
		e for auditing facility staff			
	training records week				
		,			
		taffing agency staff since			
	August 2023.				
		sible for auditing the facility's			
	contracted agency sta				
	-She did not maintain				
	contracted staff training				
	-She was responsible	e for communicating staff			
	training needs to the	facility's Compliance Nurse.			
		•			
	Interview with the fac	ility's Compliance Nurse on			
	11/20/23 at 3:33pm re				
	-She was responsible				
	_	uding training on the care of			
	diabetic residents.		1		1

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-The BOM was responsible for notifying her of

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	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL060166	B. WING		R-C 11/20/2023	
	ROVIDER OR SUPPLIER	13600 S TF	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 APPROPR DEFICIENCY)	BE COMPLE	
{D 164}	employee providing d -She was not aware S not have diabetic train diabetic care of reside Interview with the Adr 4:40pm revealed: -The BOM was respo facility's staff training -The BOM was respo facility's Compliance I needs prior to the star -The facility utilized a staff since August 202 -She was aware all ag have the same trainin staff.	cical training prior to the iabetic care of residents. Staff D, Staff E, or Staff F did ning prior to providing ents. Ininistrator on 11/20/23 at mail of the records and staff training ff working in the facility. It contracted staffing agency staff were required to g requirements as facility intain staff training records aff.	{D 164}			
	staff completed diaber residents with diabete unable to have the known residents with a diagram facility's failure was desafety, and well-being constitutes a Type B Variety provided a accordance with G.S. this violation.	etrimental to the health, of the residents, which /iolation. a plan of protection in 131D-34 on 11/16/23 for				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		R-C
		HAL060166	B. WING		11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
WICKSHIE	RE STEELE CREEK	13600 S TR			
			E, 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 271	Continued From page	: 12	D 271		
D 271	10A NCAC 13F .0901 Supervision	(c) Personal Care and	D 271		
	an accident or incider	d immediately in the case of it involving a resident to vention according to the			
	reviews, the facility fa	ns, interviews, and record iled to ensure immediate			
	with the facility's polic 5 sampled residents (observed by staff exh	, ,			
	The findings are:				
	Mobility Management revealed: -It is the policy of the are systematically ass	s Incident Reports- Falls and Policy dated 10/01/20 facility to ensure residents sessed to determine their opriate interventions to issues and determine			

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DIVISION	of Health Service Regu	liation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					50
			B WING		R-C
		HAL060166	B. WING		11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STRFFT AF	DRESS, CITY, STA	TE. ZIP CODE	
0. 11				, , , , , , , , , , , , , , , , , , , ,	
WICKSHIP	RE STEELE CREEK		RYON ST		
		CHARLO	TTE, NC 28278		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	
TAG	REGOLATORI ORT	EGO IDENTIL TING INI GRAMATIGN)	TAG	DEFICIENCY)	WATE
			+		
D 271	Continued From page	e 13	D 271		
	procedures to be imp	lamented to decrease fall			
		lemented to decrease fall			
	and/or minimize injuri				
	-Upon move in, with s	•			
		onths, annually and after			
	•	e nurse will assess the			
		their risk for falls or repeat			
	falls.				
	-A report will be subm				
		Services my mail, fax,			
	email, or in person wi	ithin 48 hours of the initial			
	discovery or knowled	ge of the accident or			
	incident.				
	-The Executive Direct	tor or Health Services			
	Director will assure th	ne notification of a resident's			
	responsible person or	r contact person, as			
		dent Register, of the any			
		requiring medical treatment			
		ency medical evaluation, with			
		oon as possible but no later			
		me of initial discover or			
		ry by staff and documented			
	in the resident's file.	., ., c.a a abbamonto			
		II, the community must show			
	documentation of an				
		fall and interventions that			
		ent or reduce the risk of			
	subsequent falls.	Cit of reduce the fish of			
	oubocquerit ialio.				
	Review of Resident +	#4's current FL2 dated			
	09/22/23 revealed:	, 10 Sulfont 1 L2 dated			
		Alzheimer's dementia.			
	-Resident #4 was cor				
		of care was Special Care			
		or care was opecial Care			
	Unit (SCU).				
	Davious of Decident #	Ma Dra adminais			
	Review of Resident #				
	Screening dated 07/2				
	-Resident #4 had a hi	istory of wandering			

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-Resident #4 required assistance with dressing,

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	` ′	CONSTRUCTION	(X3) DATE	SURVEY LETED
			A. BUILDING: _			
		HAL060166	B. WING		l l	20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHII	RE STEELE CREEK		RYON 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 ((EACH CORRECTIVE ACTI) CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 271	Continued From page	e 14	D 271			
	bathing, and toiletingResident #4 was abl verbal cues.	e to feed self but required				
	revealed: -Resident #4 had a hi -Resident #4 required	I supervision with bathing. ependent with ambulation				
	on revealed: -There was no docum seeing an outside pro -There was no docum Incident report.	4's record on 11/15/23 and nentation of Resident #4 ovider. nentation of an Accident or tation of fall/injury risk				
	11/11/23 revealed: -There was documen checked on from 7:00 -There was documen #4 complained her ar (MA's) were told/call the There was documen her family member to lunchThere was documen of the facility at 2:00p	tation at 10:00am Resident m hurt and medication aides family member. tation Resident #4 went with the doctor's office after tation Resident #4 was out m and 3:00pm. documentation hourly				
	member on 11/15/23 -Resident #4's family 11/12/23.					

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Division of Health Service Regulation

STATEMEN [*]	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE	SURVEY LETED
			A. BUILDING: _) C
		HAL060166	B. WING			R-C 20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
WICKSHII	RE STEELE CREEK		TRYON ST			
	Г		TTE, NC 28278	T		
(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 271	Continued From page	e 15	D 271			
	excruciating painResident #4's family to an orthopedic urge was diagnosed with a -The family member of facilityThe family member of #4 having a fall or of a where Resident #4 su -The family member of knew how Resident # 11/11/23 revealed Re arm told MA's and to Review of Resident # 11/13/23 revealed the Coordinator (SCC) ha #4's family member of	member took Resident #4 nt care facility where she right fractured elbow. reported fracture to the was not notified of Resident any an accident or incident ustained an elbow fracture. stated no one at the facility 44 fractured her elbow. 4's 24-hour report dated sident #4 complained about call the family member. 4's progress note dated e Special Care Unit ad spoken with Resident who was to bring in doctor Resident #4's arm and sling				
	11/17/23 at 12:00pm -She worked first shif -She had noticed that hurting and reported i -She said that one of Resident #4's armShe did document R	t on 11/11/23. : Resident #4's arm was				
	revealed:	n 11/17/23 at 1:30pm ed MA for Resident #4 on esident #4's arm was				

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Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-C	
		HAL060166	B. WING		11/20/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
MICKETIE	RE STEELE CREEK	13600 S T	RYON ST			
WICKSHIP	NE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
D 271	Continued From page	2 16	D 271			
5211	-She said the other M 11/11/23 applied dick pains and problems whones) to Resident #4-She does not recall five being told Resident #4-She did not document arm painShe did not know if the documented Resident -She did not complete Resident #4She did not report it Resident #4's Primary right arm painShe did not call Resishe stated Resident # family member. Interview with a second 3:18pm revealed:	IA working in the SCU on ofenac (used to treat aches, with joints, muscles, and 4's right arm. Resident #4 having a fall or 4 had fallen. Int that Resident #4 had right the other MA had the other MA had the other MA had the askin assessment on to the following shift or to y Care Provider (PCP) of dent #4's family because the told her not to call her				
	other MA working in the Resident #4 had right and an order for dipain and other symptoms.	#4 very well, knew Resident iclofenac gel (used to treat oms of arthritis of the joints				
	joint pain) and applied armShe did not documer having right arm painShe did not know if F documented resident	Resident #4's assigned MA having right arm pain. interview with a third MA on				

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IDENTIFICATION NUMBER HALOSO166 B. WING R.C. 11/20/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 13800 3 TRYON \$T 13800 3 TRYON \$T 13800 3 TRYON \$T CHARLOTTE, NC 28278 WICKSHIRE STEELE CREEK 13800 3 TRYON \$T CHARLOTTE, NC 28278 CHARLOTTE, NC 28278 D. 271 Continued From page 17 Review of Resident #4's orthopedic visit note dated 11/1/2/23 revealed: -Resident #4 presented with right elbow painThe familly member was unsure of a specific failResident #4 had a right nondisplaced radial neck fractureResident #4 was placed in a posterior splint and given a sling. Interview with the SCC on 11/20/23 at 1/20pm revealed: -She was responsible for reviewing all 24-hour communication logs, including weekend logs, every morning. Monday through FridayThe MA was responsible for following up with the PCP regarding Resident #4's pain. Telephone interview with Resident #4's PCP on 11/1/7/23 at 4.02pm revealed: -She was unaware that Resident #4 had a fractured elbowThe facility did not notify her or her practice that Resident #4 had complained of arm pain nor her fractured ebowThe facility did not notify her or her practice that Resident #4 had complained of arm pain nor her fractured elbowThe facility did not notify her immediately of any resident accident or incidentInterview with the Administrator on 11/20/23 at 4.38pm revealed: -She was notified of Resident #4's fractured elbow on 11/1/223The MA or SCC should have notified Resident #4's PCP when pain was reported.		FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	JRVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 13600 S TRYON ST CHARLOTTE, NC. 28278 WICKSHIRE STEELE CREEK 13600 S TRYON ST CHARLOTTE, NC. 28278 CHARLOTTE, NC. 28278 ID PROVIDER'S PLAN OF CORRECTION PRECIDENCY WILL BE PRECEDED BY FILL PRECIDENCY OR ISE DENTIFYING INFORMATION) D 271 Continued From page 17 Review of Resident #4 so orthopedic visit note dated 111/12/23 revealed: -Resident #4 had a right nondisplaced radial neck fractureResident #4 was placed in a posterior splint and given a sling. Interview with the SCC on 11/20/23 at 1:20pm revealed: -She was responsible for reviewing all 24-hour communication logs, including weekend logs, every morning, Monday through Friday, -The MA was responsible for following up with the PCP regarding Resident #4 had a right ton displaced radial neck fracture. Telephone interview with Resident #4's PCP on 11/17/23 at 4:02pm revealed: -She was unaware that Resident #4 had a fractured elbow, -The facility did not notify her or her practice that Resident #4 had complained of arm pain nor her fractured elbow, -The facility of in on toffy her or her practice that Resident #4 had complained of arm pain nor her fractured elbow, -She expected the facility to notify her immediately of any revealed: -She was notified of Resident #4's fractured elbow on 111/12/23The MA or SCC should have notified Resident #4's PCP when pain was reported.	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STIFE, ZIP CODE SUMMARY STATEBENT OF DEPOSITIONS CHARLOTTE, NC 28278 SUMMARY STATEBENT OF DEPOSITIONS CHARLOTTE, NC 28278 SUMMARY STATEBENT OF DEPOSITIONS SUMMARY STATEBENT OF DEPOSITIONS EACH DEPOSITION WIST BE PRECEDED BY FULL RESCULATORY OR LS. DIENTIFYING INFORMATION) D 271 Continued From page 17 Review of Resident #4's orthopedic visit note dated 11/12/23 revealed: - Resident #4 presented with right elbow pain. - The family member was unsure of a specific fall. - Resident #4 had a right nondisplaced radial neck fracture. - Resident #4 was placed in a posterior splint and given a sling. Interview with the SCC on 11/20/23 at 1:20pm revealed: - She was responsible for reviewing all 24-hour communication logs, including weekend logs, every morning. Monday through Friday. - The MA was responsible for adding progress note documentation if there was documentation on Resident #4's 2-hour communication log. - The May are responsible for following up with the PCP regarding Resident #4's part of the progress note documentation in the resident #4's had a fractured elbow. - The facility did not notify her or her practice that Resident #4's Add Open revealed: - She was unaware that Resident #4's had a fractured elbow. - The facility did not notify her or her practice that Resident #4 had complained of arm pain nor her fractured elbow. - The facility did not notify her or her practice that Resident #4's fractured elbow on 111/12/23. - The MA or SCC should have notified Resident #4's Fractured elbow on 111/12/3. - The MA or SCC should have notified Resident #4's PCP when pain was reported.						p/	_
MOCKSHIRE STEELE CREEK SUMMARY STATEMENT OF DEPICIENCIES DEPICE NC 28278			HAL060166	B. WING		1	
(X4) DD SUMMARY STATEMENT OF DEFICIENCIES TAG SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY PULL PREFIX TAG PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DATE OF TH	NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
CHARLOTTE. NC 28278 CANADARY STATEMENT OF DEFICIENCIES ID PREPIX CACH CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CANDEST TAG CACH CORRECTIVE ACTION SHOULD BE CARDSTANGE CACH CACH CARDSTANGE CACH CACH CACH CACH CACH CACH CACH CA			13600 S	TRYON ST			
D 271 Continued From page 17 Review of Resident #4's orthopedic visit note dated 11/12/23 revealed: -Resident #4 presented with right elbow painThe family member was unsure of a specific fallResident #4 had a right nondisplaced radial neck fractureResident #4 was placed in a posterior splint and given a sling. Interview with the SCC on 11/20/23 at 1:20pm revealed: -She was responsible for reviewing all 24-hour communication logs, including weekend logs, every morning, Monday through FridayThe MA was responsible for adding progress note documentation if there was documentation on Resident #4's 24-hour communication log -The MA was responsible for following up with the PCP regarding Resident #4's PCP on 11/17/23 at 4:02pm revealed: -She was unaware that Resident #4's PCP on 11/17/23 at 4:02pm revealed: -She was unaware that Resident #4 had a fractured elbowThe facility did not notify her or her practice that Resident #4 had complained of arm pain nor her fractured elbowShe expected the facility to notify her immediately of any resident accident or incident. Interview with the Administrator on 11/20/23 at 4:38pm revealed: -She was notified of Resident #4's fractured elbow on 11/12/23The MA or SCC should have notified Resident #4's PCP when pain was reported.	WICKSHII	RE STEELE CREEK	CHARLO	OTTE, NC 28278			
Review of Resident #4's orthopedic visit note dated 11/12/23 revealed: -Resident #4 presented with right elbow pain. -The family member was unsure of a specific fall. -Resident #4 had a right nondisplaced radial neck fracture. -Resident #4 was placed in a posterior splint and given a sling. Interview with the SCC on 11/20/23 at 1:20pm revealed: -She was responsible for reviewing all 24-hour communication logs, including weekend logs, every morning, Monday through Friday. -The MA was responsible for adding progress note documentation of the rewas documentation on Resident #4's 24-hour communication log. -The MA was responsible for following up with the PCP regarding Resident #4's pain. Telephone interview with Resident #4's PCP on 11/17/23 at 4:02pm revealed: -She was unaware that Resident #4 had a fractured elbow. -The facility did not notify her or her practice that Resident #4 had complained of arm pain nor her fractured elbow. -She expected the facility to notify her immediately of any resident accident or incident. Interview with the Administrator on 11/20/23 at 4:38pm revealed: -She was notified of Resident #4's fractured elbow on 11/12/23. -The MA or SCC should have notified Resident #4's PCP when pain was reported.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	(X5) COMPLETE DATE
dated 11/12/23 revealed: -Resident #4 presented with right elbow painThe family member was unsure of a specific fallResident #4 had a right nondisplaced radial neck fractureResident #4 was placed in a posterior splint and given a sling. Interview with the SCC on 11/20/23 at 1:20pm revealed: -She was responsible for reviewing all 24-hour communication logs, including weekend logs, every morning, Monday through FridayThe MA was responsible for adding progress note documentation if there was documentation on Resident #4* 24-hour communication logThe MA was responsible for following up with the PCP regarding Resident #4's pain. Telephone interview with Resident #4's PCP on 11/17/23 at 4:02pm revealed: -She was unaware that Resident #4 had a fractured elbowThe facility did not notify her or her practice that Resident #4 had complained of arm pain nor her fractured elbowShe expected the facility to notify her immediately of any resident accident or incident. Interview with the Administrator on 11/20/23 at 4:38pm revealed: -She was notified of Resident #4's fractured elbow on 11/12/23The MA or SCC should have notified Resident #4's PCP when pain was reported.	D 271	Continued From page	e 17	D 271			
11/17/23 at 4:02pm revealed: -She was unaware that Resident #4 had a fractured elbowThe facility did not notify her or her practice that Resident #4 had complained of arm pain nor her fractured elbowShe expected the facility to notify her immediately of any resident accident or incident. Interview with the Administrator on 11/20/23 at 4:38pm revealed: -She was notified of Resident #4's fractured elbow on 11/12/23The MA or SCC should have notified Resident #4's PCP when pain was reported.		Review of Resident # dated 11/12/23 revea - Resident #4 present - The family member value - Resident #4 had a right fracture Resident #4 was plagiven a sling. Interview with the SC revealed: - She was responsible communication logs, every morning, Mond - The MA was respons note documentation if on Resident #4's 24-1 - The MA was respons PCP regarding Resident #4's 24-1 - The MA was response PCP regarding Resident #4's 24-1 - The MA was respons	ed's orthopedic visit note led: ed with right elbow pain. was unsure of a specific fall. ght nondisplaced radial neck ced in a posterior splint and C on 11/20/23 at 1:20pm e for reviewing all 24-hour including weekend logs, ay through Friday. sible for adding progress f there was documentation nour communication log. sible for following up with the ent #4's pain.				
4:38pm revealed: -She was notified of Resident #4's fractured elbow on 11/12/23The MA or SCC should have notified Resident #4's PCP when pain was reported.		11/17/23 at 4:02pm re-She was unaware th fractured elbowThe facility did not not Resident #4 had comfractured elbowShe expected the fac	evealed: at Resident #4 had a otify her or her practice that plained of arm pain nor her cility to notify her				
The facility failed to immediately respond and		4:38pm revealed: -She was notified of Felbow on 11/12/23The MA or SCC shot #4's PCP when pain was seen as the seen and the seen are seen as the seen are seen as the seen are seen as the seen as the seen are seen as t	Resident #4's fractured uld have notified Resident was reported.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
7.11.0 1 27.11 1	or dorate of the transfer of t	IDENTIFICATION NOTIFICAL	A. BUILDING: _		
		HAL060166	B. WING		R-C 11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
WICKSHII	RE STEELE CREEK	13600 S TE	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 COMPLETE
D 271	elbow and staff did not the injury of unknow or resident experiencing recognized by her far which resulted in the fractured right elbow. residents at substantiand constitutes a Typ The facility provided a November 15, 2023, 131D-34 for this violation CORRECTION DATE VIOLATION SHALL N 20, 2023.	inplaining of pain to her right of seek immediate care for prigin resulting in the prolonged pain that was nily member the next day, resident being treated for a This failure placed all al risk for physical harm e A2 Violation. A plan of protection on in accordance with G.S. tion. E FOR THE TYPE A2 IOT EXCEED DECEMBER	D 271		
{D 273}	to meet the routine ar of residents. This Rule is not met FOLLOW-UP TO TYPE Non-compliance cont severity resulting in severity resulting resulting in severity resulting in severity resulting in sev	P. Health Care assure referral and follow-up and acute health care needs as evidenced by: PE A2 VIOLATION inues with an increase in erious physical harm.	{D 273}		

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
7.1.15 . 27.11 .		IS ENTING OF THE	A. BUILDING: _			
		HAL060166	B. WING		R- 11/2	C 0/ 2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE STEELE CREEK	13600 S TR	YON ST TE, NC 28278			
	CLIMMADV CT.		1			0/5)
(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 273}	Continued From page	: 19	{D 273}			
	related to the care an and #5).	d treatment of fractures (#4				
	The findings are:					
	Follow-up training ros (MA) from 10/12/23 to	s Health Care Referral and ter for medication aides o 11/13/23 revealed there n of training completed.				
	09/22/23 revealed: -Diagnoses included / -Resident #4 was con -Resident #4's level o					
	Unit (SCU). Observation of Reside	ent #4 on 11/14/23 at				
		sitting in a chair in the day				
	off of her shoulder an down straightThe medication aide in the sling and tighte	in a sling that was hanging d her left arm was hanging (MA) put her left arm back ned it up so that her left arm ss her abdomen and resting				
	revealed: -There was no documrelated to Resident #4	entation of Resident #4				
	Telephone interview v member on 11/15/23 -Resident #4's family 11/12/23.					

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SU	
			A. BOILDING		 R-0	_
		HAL060166	B. WING			0/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE STEELE CREEK	13600 S	TRYON ST			
- Triontonii	CE OTELLE ORLLIN	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 20	{D 273}			
	"was holding her right excruciating pain"Resident #4's family to an orthopedic urge was diagnosed with a -Resident #4 was fitte -The family member of facilityThe family member of paperwork from the orangerwork from the oranger af family member of the family member of where Resident #4 collaboration for the family member is knew how Resident #4 returned resid	member took Resident #4 nt care facility where she n right fractured elbow. ed for a splint and sling. reported fracture to the did not give the facility any rthopedic provider. was not notified of Resident any an accident or incident buld have sustained an estated no one at the facility fully fractured her elbow. sook Resident #4 to an				
	dated 11/12/23 revea -Resident #4 presente -The family member v -Resident #4 had a rig fracture.	4's orthopedic visit note led: ed with right elbow pain. was unsure of a specific fall. ght nondisplaced radial neck ced in a posterior splint and				
	Review of Resident # dated 11/15/23 revea -Resident #4 was bro member due to swelli	ught in by her family ng of her hand. inued Resident #4's splint				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
			A. BUILDING:			D 0
		HAL060166	B. WING		l l	R-C I/ 20/2023
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 ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{D 273}	Continued From page	e 21	{D 273}			
	dated 11/13/23 reveal documentation of Residuscussions with the findischarge paperwork. Review of Resident # revealed the facility diphysician progress no provider on 11/15/23	sident #4's fall and family and to contact hospital from visit on 11/12/23. 4's record on 11/16/23 id obtain Resident #4's otes from the orthopedic at 4:52pm.				
	11/17/23 at 12:00pm -She assisted Reside 11/17/23She assisted Reside slingShe did not ask nor i	onal care aide (PCA) on revealed: ent #4 with dressing on ent #4 with putting on her receive any instructions and application of Resident				
	regarding the care an #4's elbow sling and s MA for instruction.	receive any instructions ad application of Resident should have asked the other				
	MA on 11/17/23 at 3:4	interview with a night shift 46pm was unsuccessful.				
	(SCC) on 11/20/23 at -She was aware on 1 not have any dischard orthopedic provider to #4's splint and slingShe did ask the fami discharge instructions -She did not attempt	1/13/23 that Resident #4 did ge instructions from the o address care of Resident				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE S		SURVEY PLETED	
7.11.2.1.2.11.1	5. GGT2011.GT.	.52	A. BUILDING:			
		HAL060166	B. WING		1	R-C / 20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E, 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 SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
	member had taken R -She did not notify Re provider (PCP) of Re -She did not contact I instructions to care for	esident #4's primary care				
	paperwork was obtain for the facility to follow	ned from outside providers				
	11/17/23 at 4:02pm re -She did not know Re elbow.	evealed: esident #4 had a fractured				
	_	otify her or her practice that plained of arm pain nor of cility to notify her				
	-The facility did not co instructions related to the splint or sling.	ontact her regarding fractured elbow and use of her related to the fracture,				
	then Resident #4 cou to not wearing a splin change with the fracture.	ld have increased pain due t or it could be because of a ure as in worsening of the				
	of worsening symptor increased swelling, in numbness/tingling in	the staff to watch for signs ms with a fracture such as creased pain and the arm and hand, all of quired an evaluation by a				
	4:38pm revealed: -She was notified of Felbow on 11/12/23She was not aware to	ministrator on 11/20/23 at Resident #4's fractured hat Resident #4 did have tion from the orthopedic				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	'	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	or dorace mon	IDENTIFICATION NOMBER.	A. BUILDING: _		
		HAL060166	B. WING		R-C 11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	ATE, ZIP CODE	
WICKSHII	RE STEELE CREEK	13600 S T	RYON ST TE, NC 28278		
	OUR MARK OT		1	T	701
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	LD BE COMPLETE
{D 273}	Continued From page	23	{D 273}		
{D 273}	provider addressing of and sling. -The SCC was responsible appropriate paperwork for the facility did not in paperwork to ensure expected the SCC to 2. Review of Resident 04/21/23 revealed: -Diagnoses included behavioral disturbance-Resident #5 was corresident #5's level of Review of Resident #7 report dated 11/10/23 resident #5 was sitting approximately 11:30p side of the chair to picting a	rare or Resident #4's splint Insible to ensure all Insible to ens	{D 273}		
	noticed his lips turning moments laterStaff called 911There was documen observed at time of in -Resident's family me	· · · · · · · · · · · · · · · · · · ·			
	notifying Resident #5' Observation of Resident 11:07am revealed Re				
	sock on his left lower				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
		HAL060166	B. WING			R-C 1/ 20/2023
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, 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 ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{D 273}	revealed: -There were no instruct Resident #5's splintThere was no dischard department visit note: -There was a copy of paperwork that listed medications, a picture not have any instructidocumented. Review of Resident #11/10/23 revealed: -Late entry document entered on 11/14/23 revealed: -Late entry documen	arge summary or emergency is. emergency department resident #5's current is of a left foot/ankle but did ons or physician orders 5's progress note dated is dated in the reached over the left is something up off the floor thair getting stuck between in the plue with vomiting a few is as a series of the many personal to the care of the care of the many personal to the care of the	{D 273}			

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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
					R-C
		HAL060166	B. WING		11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
MICKELII	13600 S T				
WICKSHIRE 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 CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
{D 273}	Continued From page	e 25	{D 273}		
,			` '		
	documentation Resid	ent #5 fell on 11/10/23.			
	revealed she did not i referral and follow-up	n 11/15/23 at 11:00am receive any training on related to resident's 10/01/23 through 11/14/23.			
	Interview with a MA on 11/15/23 at 2:05pm revealed:				
	-Sne was aware that fractured his left ankle	Resident #5 had fallen and			
		ਰ. placed splint on Resident			
	#5.	placed Splint on resident			
	-She was not aware of Resident #5's splint.	of any instructions for			
	T	interview with a night shift 46pm was unsuccessful.			
		vith Resident #5's PCP on nd on 11/20/23 at 12:40pm			
	-She did not know Re ankle prior to speakin-She expected the face	-			
	immediately.				
		en reported to her by the ve seen Resident #5 during			
	facility, she would have				
	-She was not contact				
	Resident #5's left ank				
	•	her related to the fracture,			
		ld have increased pain due			
	• .	t or it could be because of a ure as in worsening of the			
		the staff to watch for signs			
		ns with a fracture such as			
	increased swelling, in				
		the foot, all of which would			

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Division	of Health Service Regu	lation				
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
						•
			B. WING		R-	
		HAL060166	B. WING		11/2	0/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE		
			, ,	,		
WICKSHIF	RE STEELE CREEK		TRYON ST			
		CHARLO	TTE, NC 28278			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IAIE	DATE
{D 273}	Continued From page	e 26	{D 273}			
, ,			` ′			
		luation by a physician.				
	-On 11/17/23, Reside	nt #5's family member did				
	contact her regarding	fall with ankle fracture and				
	a Hospice referral.					
	Interview with the SC	C on 11/16/23 at 10:25am				
	and 11/20/23 at 1:20p	om revealed:				
	-She first started as the	ne SCC one month ago.				
		Resident #5 did not have any				
	discharge instructions					
	_	s care of his left ankle				
	fracture prior to 11/15					
	-	esident #5's PCP of his				
	fractured ankle.	Sident #0 3 1 Of Offilia				
		Resident #5's PCP to obtain				
	instructions to care fo					
	=	for obtaining and reviewing				
	the 24 hour and the 7	•				
		additional in-services related				
	-	hysician from 10/11/23				
	through 11/14/23.					
		lity to ensure all appropriate				
		ned from outside providers				
	for the facility to follow	v physician orders.				
		ility's Compliance Nurse on				
		and 11/20/23 at 3:34pm				
	revealed:					
		ed Nurse who began working				
	at the facility about a	month ago.				
	-She did not receive a	an in-service related to				
	notification of the phy	sician or follow up.				
	-The SCC/RCC was r	responsible for reviewing the				
		reports, prior to the morning				
	stand ups.					
		esponsible for notifying the				
		njuries sustained by a				
	resident.	,				
		esponsible for making sure				
		aken care of and assist if				
	ando renerrate were t	and i daid of and addide if	1			

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DIVISION	of Health Service Regu	lation	_			
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			B. WING		R-C	
		HAL060166	B. WING		11/20/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE		
NAME OF T	NOVIDEN ON OUT LIEN			12, 211 0002		
WICKSHIE	RE STEELE CREEK		RYON ST			
		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		
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE	
				DETICIENCY)		
{D 273}	Continued From page	27	{D 273}			
(= =: =)	Continuou i rom page	, 2,	(= =: 5)			
	the SCC/RCC needed					
	-She was not aware o	of any injuries that required a				
		sician therefore she could				
	not follow-up with any					
		9				
	Interview with the Adr	ministrator on 11/20/23 at				
	4:38pm revealed:	11111011011011011111111111111111111111				
	•	hat Resident #5 had any				
		or physician orders from				
	his visit to the emerge					
	11/10/23 addressing	care for his fractured				
	ankle/splint.					
		ponsibility to ensure all				
		k was obtained from outside				
	providers for the facili	ty to follow physician				
	instructions/orders.					
	-If the facility did not h	nave the appropriate				
	paperwork to ensure	care for the residents, she				
	expected the SCC to	contact the resident's PCP.				
	-The SCC/RCC was r	esponsible for reviewing the				
	24 hour and 72 hour i	reports prior to the morning				
	stand up meetings.					
		ssue meaning, checks were				
		CC/RCC to report to the				
	Compliance Nurse to	•				
	·	tional nurses hired to assist				
		e when needed to fill in for				
	•	n they had to complete				
		illing in for a MA or if they				
	were out of the facility					
		did not complete their				
		the Compliance Nurse, then				
	-	e could not assist with				
		her two nurses for help.				
	-The SCC, RCC, Con	npliance Nurse, and herself				
	reviewed and discuss	ed residents during the daily				
		nd expected issues to be				
	corrected by the next					
		,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		D.C.
		HAL060166	B. WING		R-C 11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
WICKSHII	RE STEELE CREEK	13600 S TR			
	I		E, 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 273}	Continued From page	28	{D 273}		
	The facility failed to ender 2 of 5 sampled respective regarding failure to footbain physician order the care and treatmer radial neck fracture du (#4) and failure to follobtain physician order the care and treatmer ankle fracture (#5). The neglect and injury white Violation.	nsure referral and follow-up sidents (Resident #4 and #5) flow up with the provider to rs and instructions related to nt of a right nondisplaced ue to an unwitnessed fall ow up with the provider to rs and instructions related to nt of a resident with a left nis failure resulted in serious ich constitutes a Type A1			
	20, 2023.	IOT EXCEED DECEMBER			
{D 358}	(a) An adult care hon preparation and admi prescription and nonby staff are in accorda (1) orders by a licens which are maintained	Medication Administration ne shall assure that the nistration of medications, prescription, and treatments ance with: sed prescribing practitioner in the resident's record; and on and the facility's policies as evidenced by: PE B VIOLATION	{D 358}		

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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
			D 14/11/0		R-C
		HAL060166	B. WING		11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
WICKSHII	RE STEELE CREEK	13600 S T	RYON ST		
	te oriente orient	CHARLO	TTE, NC 28278		<u> </u>
(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	29	{D 358}		
,	severity resulting in re				
	THIS IS A TYPE A2 V	IOLATION.			
	Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 4 residents (Resident #7 and #6) observed during the medication pass on 11/15/23 at 7:30am, for medications to lower blood pressure and to treat anemia (#7), and missed medications for blood pressure and edema (#6), and 2 of 5 sampled residents (Resident #2 and #5) related to missed medications for high cholesterol and cellulitis (#2), and a medication to treat hypothyroidism (#5).				
	The findings are:				
	policy revealed: -The Special Care Unthe Resident Care Coresponsible for printin Medication Audit Repstand up meetingThe Medication Audit medicationsThe SCC/RCC were the 24 hour and the 7 exceptions on medications progress notesThe SCC/RCC were with the pharmacy relimedications missingThe SCC/RCC were	g and reviewing the ort every morning before the t Report contained missed responsible for obtaining 2 hour report, for the			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLETED
		HAL060166	B. WING		R-C 11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, 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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFINE DEFICIENCY)	D BE COMPLETE
{D 358}	Continued From page	e 30	{D 358}		
	-The SCC/RCC were	responsible for discussing ns with the Administration in			
	11/09/23 revealed dia hypertension, atheros coronary artery disea bundle branch block (t #7's current FL2 dated agnoses included sclerotic heart disease, se without angina, a right (a condition that causes and anemia (lack of healthy			
	a. Review of Resident #7's current FL2 dated 11/09/23 revealed there was an order for amlodipine besylate 10 mg (used to treat high blood pressure) every day.				
	Review of Resident # 08/19/23 revealed an besylate 10mg every	•			
	at 7:32am revealed: -The medication aide Resident #7's mornin	ipine besylate 10mg was not			
	Medication Administrative revealedThere was an entry of amlodipine besylate of amlodipine documented as not an exception code "09" in notes" on 10/01/23, and	dated 08/19/23 for l0mg, one tablet daily. ipine besylate 10mg was dministered with the ndicating "other/see nurse			
		oine besylate was not			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		, ,	(X3) DATE SURVEY COMPLETED	
						R-C
		HAL060166	B. WING			/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STAT	E, ZIP CODE		
WICKSHIE	RE STEELE CREEK		TRYON ST			
	0.11.11.15./.07		TTE, NC 28278	PD0//PEDI0 D1 AV 05 00		
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
{D 358}	Continued From page	e 31	{D 358}			
	administered on 10/0 the medication not be	1/23 and 10/02/23 due to ing available.				
	Review of Resident # revealed.	7's November 2023 eMAR				
	-There was an entry of					
		l0mg, one tablet daily. ipine besylate 10mg was				
	documented as not a	dministered with the				
	exception code "09" indicating "other/see nurse notes" on 11/03/23, 11/06/23, 11/10/23 through					
	11/15/23.	3				
	Review of Resident #7's progress notes revealed: -Resident #7's amlodipine besylate was not administered on 11/03/23 due to needing the medicationResident #7's amlodipine besylate was not administered on 11/06/23, 11/10/23, through					
	Observation of Resid	nedication unavailable. ent #7's medications				
	available for administ 7:32am revealed ther					
	besylate available for					
	Review of Resident #	7's blood pressures (BP)				
	· · · · · · · · · · · · · · · · · · ·	was documented as 134/88				
	(normal BP was less -On 11/02/23, his BP	than 120/80). was documented as 142/84.				
	facility's contracted pl 10:15am revealed: -There was an order to 10mg, one tablet daily documented for Resid -On 08/18/23, there w	dent #7. vere 30 doses of amlodipine				
	besylate 10mg disper	•				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BOILDING		R-C	
HAL060166		B. WING		11/20/2023	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIRE STEELE CREEK		RYON ST			
	CHARLO	TTE, NC 28278			
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
{D 358} Continued From pag	e 32	{D 358}			
Resident #7On 09/22/23, there besylate 10mg dispersion of the cycle to obtain a new 10mg but the facility refill prescription of the every dayOn 10/20/23 the amodispensed to the facility of prescription of the arrevery dayOn 11/15/23, the facility of prescription of the arrevery dayOn 11/15/23, the facility of prescription of the arrevery dayOn 11/15/23, the facility of prescription of the arrevery dayOn 11/15/23, the facility of prescription of the arrevery dayOn 11/15/23, and the word and there was no refill leftThey did not receive physician's order writh 11/09/23The amlodipine besylate resident #7 require amlodipine besylateResident #7 require amlodipine besylate, to follow the PCP's of the prescription of the missing amlodity amlodipine besylate any amlodipine any amlodipine besylate any amlodipine any amlodi	were 28 doses of amlodipine ensed to the facility for acy technician attempted to w days prior to the end of the v refill of the amlodipine did not follow up with the he amlodipine besylate 10mg slodipine besylate was not fility on a 28-day cycle did not provide a refill mlodipine besylate 10mg scility requested a refill of ipine besylate 10mg but fit. Expected the refilled since and the refilled since was not refilled since and have been out of a 26 more doses of a from 10/20/23. The refired the refilled since and the refilled since are filled since and the refilled since and the refilled since and the refilled since are filled since and the refilled since	{D 330}			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMPLETE	
		HAL060166	B. WING		R-C 11/20/2	2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
MICKSHII	RE STEELE CREEK	13600 S TI	RYON ST			
WIOROIII	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE C	(X5) COMPLETE DATE
{D 358}	Continued From page	e 33	{D 358}			
("medication unavailab of the missing amlodi	ole" and notified the lead MA				
	-She was not notified receiving his amlodiping pharmacy required a -It was the responsibing about Resident #7 was that a refill prescription pharmacyResident #7's ongoing could be a result of notice -Amlodipine was used blood pressure by relative heart did not have decrease damage to -Resident #7 not receive besylate could cause	1/15/23 at 9:25am revealed: Resident #7 was not ine besylate or that the refill prescription. Ility of the facility to notify her as out of his amlodipine and on was required by the ang elevated blood pressures of receiving the amlodipine. It to decrease Resident #7's axing the blood vessels so to to work so hard and his heart.				
	11/15/23 at 11:07am and 11:07a	ed Nurse who began working month ago. Resident #7 did not have ster and was out of the				
	revealed: -On 11/12/23 she admorning medications, besylate was not on tadministration.	C on 11/16/23 at 10:25am ninistered Resident #7's and the amlodipine he medication cart for lodipine besylate missing in				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLE	
		HAL060166	B. WING		R-0	C 0/ 2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE		
	10115211 011 001 1 21211	13600 S T		, 332		
WICKSHIP	RE STEELE CREEK		TE, NC 28278			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	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 DATE
{D 358}	Continued From page	: 34	{D 358}			
	did not notify the phar	meeting around 9:30am but macy because she forgot ations that day and other				
	4:38pm revealed she #7's amlodipine was r	ninistrator on 11/20/23 at was not aware Resident missing and that it was not Iministered to Resident #7.				
		t #7's current FL2 dated re was an order for ferrous used to treat anemia)				
		7's previous order dated order for ferrous sulfate s.				
		7's previous order dated order for ferrous sulfate				
	at 7:32am revealed: -The MA was adminis morning medications.	s sulfate 325mg was not				
	revealedThere was an entry of sulfate 325mg, every -Resident #7's ferrous documented not admicode "09" indicating "10/13/23, 10/14/23, 1 and 10/14/23 and 10/	s sulfate 325mg was inistered with the exception other/see nurse notes" on 0/15/2310/18/23 at 9:00am				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOWIDER.	A. BUILDING: _		COMILETED
		HAL060166	B. WING		R-C 11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
WICKSHII	RE STEELE CREEK	13600 S T			
		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)	LD BE COMPLETE
{D 358}	Continued From page	e 35	{D 358}		
	sulfate 325mg one ta -Resident #7's ferrous documented not adm	blet daily.			
	Resident #7's ferrous administered on 10/1	1/23, 10/13/23, 0/17/23, 10/18/23, and			
	revealedThere was an entry of sulfate 325mg, one talent #7's ferrous documented as not all exception code "09" i	s sulfate 325mg was			
	Resident #7's ferrous administered on 11/0	7's progress notes revealed sulfate was not 6/23, 11/10/23, through nedication unavailable.			
	medication to medica 10/18/23 revealed Re	s contracted pharmacy tion cart audit dated esident #7's ferrous sulfate able for administration.			
	facility's contracted pl 10:15am revealed: -Resident #7 had an 325mg, one tablet da	vere 12 doses of ferrous			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING			R-C
		HAL060166	B. WING			20/2023
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 SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED TO DEFICIENCED TO TO DEFICIENCED TO TO TO THE PROVIDER OF THE PROVIDER	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{D 358}	Continued From page	36	{D 358}			
	Resident #7's ferrous was no refill left so the the 10/18/23 refill was Resident #7. -The cycle fill pharma notify the facility a few cycle to obtain a new 325mg but the facility refill prescription of the every day. -On 11/01/23 the ferrodispensed to the facility dispensed to the facil because the facility disprescription of the fer day. -They did not receive the FL2 dated 11/09/2 -The ferrous sulfate w 10/18/23 and would heresident #7 required	ity on a 28-day cycle id not provide a refill rous sulfate 325mg every Resident #7's order from 23. vas not refilled since lave been out on 11/01/23.				
	revealed: -On 11/06/23 during has first time she noticed any ferrous sulfate 32 documented the ferrounavailable" and notification in the same sulfate and noticed ferrous sulfate 325mg the ferrous sulfate as	us sulfate as "medication fied the lead MA of the e. ner medication pass was the Resident #7 did not have to administer, documented "medication unavailable" MA of the missing ferrous				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R-C
		HAL060166	B. WING		11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
WICKSHIE	RE STEELE CREEK	13600 S TF			
	OLUMBA DV OT		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 37	{D 358}		
{D 330}	Physician (PCP) on 1 -She was not notified of his ferrous sulfate a prescriptionResident #7 was and sulfate using iron to m which were used to complete the body to help prevent a higher risk of a hear of the body to help prevent a higher risk of a hear of the body to help prevent a higher risk of a hear of the body to help prevent a higher risk of a hear of the body to help prevent a higher risk of a hear of the body to help prevent a higher risk of a hear of the body to help prevent a sulfate to administration for over a linterview with the SC revealed: -On 11/12/23 she administration.	1/15/23 at 9:25am revealed: Resident #7 missed doses and required a refill emic and required ferrous make healthy blood cells arry oxygen through the a heart attack or stroke. us sulfate put Resident #7 at rt attack or stroke. fility Compliance Nurse on revealed: dd Nurse who began working month ago. Resident #7 did not have hinister and was out of the	{D 330}		
	not on the medication -She reported the ferr morning stand up me	cart for administration. rous sulfate missing in the eting around 9:30am but did cy because she forgot due			
		ns that day and other duties.			
	4:38pm revealed she #7's ferrous sulfate w	ministrator on 11/20/23 at was not aware Resident as missing and that it was ot administered to Resident			
	Refer to interview with 11:00am.	n a MA on 11/15/23 at			
	Refer to interview with Nurse on 11/15/23 at	n the facility's Compliance 11:07am.			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
74121 2741	or contraction	IDEITH IO/HIGH HOMBER	A. BUILDING: _		
		HAL060166	B. WING		R-C 11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE	
WICKSHIE	RE STEELE CREEK	13600 S TI CHARLOT	RYON ST TE, 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 38	{D 358}		
	Refer to interview with 10:25am.	h the SCC on 11/16/23 at			
	Refer to interview with Coordinator (RCC) or	h the Resident Care n 11/20/23 at 12:33pm.			
	Refer to interview with Nurse on 11/20/23 at	h the facility's Compliance 3:34pm			
	Refer to interview with 11/20/23 at 4:45pm.	h the Administrator on			
	11/09/23 revealed: -Diagnoses included impairment, and hype	t #6's current FL2 dated hypertension, mild cognitive erlipidemia. for hydrochlorothiazide			
		high blood pressure and			
	revealed there was a	6's FL2 dated 04/03/23 n order for 2.5mg one tablet by mouth			
	sheet dated 07/14/23	for hydrochlorothiazide mouth daily.			
	Review of Resident # revealed an admissio	6's Resident Register n date of 04/07/23.			
	at 7:30am revealed: -The medication aide #6's morning medicat	edication pass on 11/15/23 (MA) administered Resident cions. chlorothiazide 12.5mg was			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-	С
		HAL060166	B. WING		11/2	0/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	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 LSC 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}	Continued From page	e 39	{D 358}			
	not available to admir	nister.				
	revealed: -Resident #6's responded resident resi	a new order today from the (PCP) and will fax it to the ned.				
	revealedThere was an entry ff 12.5mg, dailyResident #6's hydrod documented as not a exception code "09" inotes" on 11/06/23, 1 and 11/16/23 at 8:00a-Resident #6's hydrod documented as admin	ndicating "other/see nurse 1/07/23, 11/10/23, 11/11/23				
	Review of Resident #	6's progress notes from				

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10/27/23 to 11/16/23 revealed:

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STATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE	SURVEY
			A. BUILDING: _		_	_
		HAL060166	B. WING		I	R-C / 20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
WICKSHII	RE STEELE CREEK	13600 S	TRYON ST			
WICKSHII	RE STEELE GREEK	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 ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
{D 358}	Continued From page	e 40	{D 358}			
	-Resident #6's hydrod not administered on 11/10/23, due to "awa-Resident #6's hydrod not administered on 10 "medication unava-There was no documedications documed 11/08/23, 11/09/23, a when there was no hyon the medication call Review of Resident # 11/06/23 to 11/14/23 was not administered medication not being	chlorothiazide 12.5mg was 11/06/23, 11/07/23, and aiting pharmacy". chlorothiazide 12.5mg was 11/11/23 and 11/16/23, due ilable". nentation related to nted as administered on nd 11/12/23 to 11/14/23 ydrochlorothiazide available t. 6's progress notes from revealed hydrochlorothiazide on 4 occasions due to the available.				
	Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/15/23 at 10:32am revealed: -They entered Resident #6's medications to be listed on the eMARThey never filled medications for Resident #6 because she used an outside pharmacy					
	Resident #6's preferred 11:02am revealed: -There was an active hydrochlorothiazide 1 for Resident #6Hydrochlorothiazide 01/16/23 for a quantif 02/02/23 for a quantif #6This medication was when she lived in an admission to the facil -There was one refill	2.5mg, take one tablet daily 12.5mg was dispensed on y of 90 tablets and again on y of 90 tablets for Resident dispensed to Resident #6 other state (prior to her				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			123.25.143		R-	c
		HAL060166	B. WING		1	0/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
WICKSHIRE STEELE CREEK 13600 S T			TRYON ST			
WIOROIM	NE OTELLE ONLLN	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 358}	Continued From page	2 41	{D 358}			
	hydrochlorothiazide and had not dispensed any hydrochlorothiazide for Resident #6 since 02/02/23.					
	11/16/23 at 11:10am a -When Resident #6 w she brought all medic to Resident #6's adm -She always tried to g brought refills before medicationsShe found out today hydrochlorothiazide w #6's preferred pharma -The facility did notify were needed, but she	ras admitted to the facility rations that were filled prior rission on 04/07/23. If yet 90-day supplies and Resident #6 ran out of (11/16/23) that the ras last filled by Resident				
	3:30pm revealed: -On 11/15/23, during Resident #6 did not h 12.5mg to administer -Resident #6 was out for one to two weeksResident #6 could be her spouse who was -The MA called Resid 11/16/23 to get refills pharmacyThe RP told her that medications to be fille -The MA faxed over the orders dated 07/14/23 -The RCC had the faxed side of the faxed or the faxed could be side of the faxed or	of her hydrochlorothiazide of her hydrochlorothiazide orrow the medication from also a resident in the facility. ent #6's RP on 11/15/23 and from the preferred the resident didn't have any ed. the 6 month signed physician to the preferred pharmacy. to confirmation. there were any faxes sent for				

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DIVISION C	of Health Service Regu	lation				
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
					R-	·C
		HAL060166	B. WING		1	20/2023
NAME OF D		CTDEET AL	DDECC CITY CTA	TE 7/D CODE		
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	I E, ZIP CODE		
WICKSHIF	RE STEELE CREEK		TRYON ST			
		CHARLO	TTE, NC 28278			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY 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	(X5) COMPLETE DATE
{D 358}	Continued From page	 e 42	{D 358}	,		
•			'			
	8:40am revealed:	ent #6's PCP on 11/16/23 at				
		ctronic prescription in June				
		thiazide with 11 refills to				
	Resident #6's preferre					
		ing hydrochlorothiazide to				
	treat high blood press					
		prothiazide could affect the				
	Resident's blood pres					
	-The resident lived ou					
	admission to the facili					
		ent #6 had used the facility's				
		initially and then switched				
	over to a preferred ph					
		that the hydrochlorothiazide				
	was not available unti	ne staff notified her of				
	missing medications.					
	IIIISSING MEGICALIONS.					
	Interview with the RC revealed:	CC on 11/20/23 at 12:33pm				
	-He had not had any	issues with receiving				
	Resident #6's medica	ations.				
	-Resident #6 was pos	ssibly out of her medication				
		o tell what medications were				
		t #6 upon admission, or from				
	Resident 6's preferred					
		ought in her medication from				
	her preferred pharma	<u> </u>				
		f hydrochlorothiazide was				
	dispensed between J	uly 2023 to present.				
	-He was not aware th					
	_	and not sure how long she				
	was out of the medica	ation				
	Intervious with the fee	ilitula Camplianaa Nuraa an				
		cility's Compliance Nurse on				
	11/20/23 at 3:35pm re -She was not aware of					
	-Sile was not aware t	i iliooiliy				

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hydrochlorothiazide for Resident #6 until

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Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-C	
		HAL060166	B. WING		11/20/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
WICKSHIRE 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 SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
{D 358}	Continued From page	e 43	{D 358}			
	11/15/23, when surve attention. -She expected medic Resident #6.	eyors brought it to her ations to be on the cart for				
	4:45pm revealed: -She was not aware of #6's medicationsShe was not aware to "09" code for Resider a medication was adroclearly unavailableShe expected the Moof any missed medical-she did not know if the ever contacted for Resider and she was not aware to the hydrochlorothiazide.	he backup pharmacy was				
	Nurse on 11/15/23 at	h the facility's Compliance 11:07am. h the SCC on 11/16/23 at				
	Refer to interview with 11/20/23 at 12:33pm.	h the Resident RCC on				
	Refer to interview with Nurse on 11/20/23 at	h the facility's Compliance 3:34pm				
	Refer to interview with 11/20/23 at 4:45pm.	h the Administrator on				
	3. Review of Residen	t #2's current FL2 dated				

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04/03/23 revealed diagnoses included chronic

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		R-C
		HAL060166	B. WING		11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
WICKSHIE	RE STEELE CREEK	13600 S TF			
			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 44	{D 358}		
	obstructive pulmonary and hypertension.	y disease, hyperlipidemia			
	04/03/23 revealed the	ation used to treat abnormal			
		2's Primary Care Provider's /07/23 revealed an order for ily.			
		edication cart on 11/15/23 at ident #2's atorvastatin 80mg administration.			
	Review of Resident #2's October 2023 electronic medication administration record (eMAR) revealed: -There was an entry dated 04/12/23 for atorvastatin 80mg, one tablet dailyResident #2's atorvastatin 80mg was				
	documented as admir 10/27/23 and 10/31/2	nistered daily between 3.			
		2's October 2023 progress was no documentation 2's atorvastatin 80mg.			
	Review of Resident # electronic medication (eMAR) revealed: -There was an entry of atorvastatin 80mg, on -Resident #2's atorva documented as admit 11/01/23 and 11/13/23	administration record dated 04/12/23 for ne tablet daily. statin 80mg was nistered daily between			
	Review of Resident # progress notes reveal				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING.		R-C
		HAL060166	B. WING		11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
WICKSHII	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
{D 358}	Continued From page	e 45	{D 358}		
	documentation related atorvastatin 80mg.				
	Interview with Reside 10:00am and 11:30ar	nt #2 on 11/14/23 between			
		umerous medications and			
		medications or what they			
	were used to treat.				
	-His daily medications and administered dail	s were stored by the facility			
	and administered dan	y by MAS.			
	Interview with a first s	shift MA on 11/17/23 at			
	3:30pm revealed:				
	-Resident #2 was pre daily.	scribed atorvastatin 80mg			
	•	admission to the facility,			
	•	entation of Resident #2's			
	atorvastatin 80mg bei Resident #2's RP.	ing brought to the facility by			
		a local pharmacy for his			
	medication refills.	as responsible to request			
	Resident #2's atorvas	·			
		as responsible to deliver			
		statin 80mg to the facility.			
		as not aware Resident #2's			
	_	s not on the medication cart. vastatin 80mg was not			
		ration, the facility was to			
	request a refill from th				
	pharmacy until Resid				
	#2's local pharmacy.	statin 80mg from Resident			
	#2 S local phannacy.				
	pharmacist on 11/15/2 -The pharmacy maint	with the facility's contracted 23 at 10:29am revealed: ained a profile for Resident			
	#2's medicationsResident #2 did not u	utilize the pharmacy for			
	medication refills.	and pharmady for			

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Division	of Health Service Regu	lation			_
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
					R-C
		HAL060166	B. WING		
		HALU6U166			11/20/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		13600 S	TRYON ST		
WICKSHIP	RE STEELE CREEK		TTE, NC 28278		
			1112, NO 20270	T	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(710)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
1710		,	,,,,,	DEFICIENCY)	
{D 358}	Continued From page	e 46	{D 358}		
	The facility had not re	equested a refill of Resident			
	#2's atorvastatin 80m	g.			
	T-1				
		vith the pharmacist at			
	T =	ed pharmacy on 11/15/23 at			
	2:48pm revealed:				
	-Resident #2 utilized				
	atorvastatin 80mg on				
		statin 80mg was last filled			
	on 01/16/23 for 90 do				
	-The facility or Reside	ent #2's RP were responsible			
	to request refills of Re	esident #2's atorvastatin			
	80mg.				
	-There were no additi	onal refill requests for			
	Resident #2's atorvas	statin 80mg.			
		is responsible for delivery of			
	Resident #2's medica				
	-Atorvastatin 80mg w	-			
	_	myocardial infarctions and			
	cerebrovascular accid				
	Corobrovacoalar acon	2011.0.			
	Telenhone interview v	vith Resident #2's RP on			
	11/16/23 at 3:17pm re				
		nitted to the facility on			
	04/07/23.	Titled to the facility off			
		admission on 04/07/23, she			
		ons Resident #2 had to the			
	facility but did not rec				
	_	s brought to the facility.			
		ere responsible to request			
	Resident #2's medica				
		onsible to notify her when			
		tion refills were called into			
	Resident #2's local ph				
	I	to deliver Resident #2's			
	medications to the fac				
		f Resident #2's atorvastatin			
	80mg being requeste	d since Resident #2's			
	admission to the facil	ity.			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU	
			A. BUILDING: _			
		HAL060166	B. WING		R-0	C 0/ 2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIRE STEELE CREEK 13600 S T			YON 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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 358}	Continued From page	e 47	{D 358}			
{D 358}	Telephone interview vi 11/16/23 at 8:45am re-Resident #2 was predaily to treat Resident-She expected the factor atorvastatin 80mg was prescribed. -She expected the fact #2's atorvastatin 80mt the facility's refill policy of the last dose. -She expected the fact #2's atorvastatin 80mt administration. -She was not aware F80mg daily was not atorvastatin 80mg was not administration. -She was not aware F80mg was not administration. Interview with the faction coordinator (RCC) or revealed: -MAs were responsible resident's medications doses. -The facility was respirately serious resident #2's RP was Resident #2's RP was Resident #2's medical-He was not aware Resident #2's medical-He was not aware Resident was unavailable with the faction 04/20/23 at 3:33pr	with Resident #2's PCP on evealed: scribed atorvastatin 80mg t #2's cholesterol. cility to ensure Resident #2's s administered as cility to request Resident g refills in accordance with ey, usually within one-week cility to notify her if Resident g was not available for Resident #2's atorvastatin vailable for administration. isk of a myocardial infarction ecident if his atorvastatin stered as order. dility's Resident Care in 11/20/23 at 12:33pm le to request refills of s within the last seven consible to request Resident lent #2's local pharmacy. Is responsible to deliver tions to the facility. esident #2's atorvastatin ailable for administration. dility's Registered Nurse (RN) in revealed she was not atorvastatin 80mg daily was	{D 358}			
	Interview with the faci 04/20/23 at 4:20pm re	ility Administration on evealed she was not aware				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOWIDEN.	A. BUILDING:		COMIT LETED
		HAL060166	B. WING		R-C 11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
MICKELII	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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE
{D 358}	Continued From page	e 48	{D 358}		
,,	Resident #2's atorvas available for administ	statin 80mg daily was not ration.			
	04/03/23 revealed the	ation used to treat and			
		2's Primary Care Provider's /07/23 revealed an order for vice daily.			
	9:40am revealed Res	edication cart on 11/15/23 at ident #2's doxycycline is filled on 11/03/23 for 60			
	medication administrative revealed: -There was an entry of doxycycline 100mg to 8:00pm for wound he -Doxycycline 100mg to with the exception connurse note" for two do	dated 04/25/23 for vice daily at 6:00am and aling. twice daily was documented de "09" indicating 'other/see oses on 10/27/23, for one r two doses on 10/29/23,			
	notes revealed: -There was an entry of documented "medical aware." -There was an entry of documented doxycyc-There was an entry of documented doxycyc	2's October 2023 progress on 10/27/23 at 5:51am which tion unavailable, RCC on 10/27/23 at 8:23pm which line 100mg was on order. on 10/28/23 at 6:33am which line 100mg was on order. on 10/28/23 at 5:58pm which line 100mg was not			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
HAL060166		B. WING		R-C 11/20/2023	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE. ZIP CODE	1 = 0 = 0
			RYON ST	,	
WICKSHI	RE STEELE CREEK		TTE, NC 28278		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{D 358}	Continued From page	e 49	{D 358}		
	availableThere was an entry of documented doxycyc supposed to supply." -There was an entry of documented "medicar aware, family aware." -There were no additi doxycycline 100mg to Review of Resident # revealed: -There was an entry of doxycycline 100mg to 8:00pmDoxycycline 100mg to with the exception control of the supplemental to the suppl	on 10/29/23 at 7:58pm which line 100mg "family is on 10/30/23 at 7:56pm which tion unavailable, RCC onal entries related to vice daily. 2's November 2023 eMAR dated 04/25/23 for vice daily at 6:00am and twice daily was documented de "09" indicating 'other/see oses on 11/01/23, 11/02/23,			
	Review of Resident #2's November 2023 progress notes revealed: -There was an entry on 11/01/23 at 7:59pm which documented doxycycline 100mg was not administered because the medication was not available. -There was an entry on 11/02/23 at 5:56am which documented "medication unavailable." -There was an entry on 11/02/23 at 8:43pm which documented doxycycline 100mg was "unavailable." -There was an entry on 11/03/23 at 6:09am which documented doxycycline 100mg was "unavailable." -There was an entry on 11/03/23 at 6:09am which documented doxycycline 100mg was "unavailable." -There was an entry on 11/03/23 at 6:09am which documented "medication unavailable, RCC and physician aware." -There was an entry on 11/04/23 at 5:49am which documented "medication unavailable, RCC and physician aware, waiting on family to delivery				

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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			R-C 11/20/2023	
	ROVIDER OR SUPPLIER	13600 S T	DDRESS, CITY, STA RYON ST TTE, NC 28278	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
{D 358}	10:00am and 11:30ar -He was prescribed a wounds to prevent inf -His daily medications and administered by I -In October 2023, the administer his antibio availableIn early November 2 refill his antibioticHe was administered Telephone interview v 11/16/23 at 4:35pm re -Resident #2 was pre twice dailyIn late October 2023 she documented in R related to Resident #2 medication not availa -In late October 2023 Resident #2's doxycy medication she docur available for administ -Resident #2's RP wa Resident #2's doxycy delivery Resident #2's facilityIn late October 2023 she had documented and the RCC related 100mg but may not h PCP or RCCShe was not respons Resident #2's doxycy	nt #2 on 11/14/23 between in revealed: in antibiotic to treat his leg fection. It is were stored by the facility MAs. MAs occasional did not tic because it was not in 223, he notified his RP to it is antibiotic on 11/14/23. With a second shift MA on evealed: is scribed doxycycline 100mg and early November 2023, esident #2's progress notes 2's doxycycline 100mg it is for administration. It is and early November 2023, cline 100mg was the only mented as not being ration. It is responsible to request cline 100mg for refill and to is doxycycline 100mg to the indicated with the isible for requesting a refill for indicated with the indi	{D 358}		

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was not available for administration.

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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			R-C 11/20/2023	
	ROVIDER OR SUPPLIER	13600 S T	DRESS, CITY, STA	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 APPROPE DEFICIENCY)	BE COMPLETE
{D 358}	Continued From page	÷ 51	{D 358}		
	3:30pm revealed: -Resident #2 was pre twice dailyResident #2 utilized medication refillsResident #2's RP was Resident #2's doxycy-Resident #2's doxycy-Resident #2's doxycy-In late October 2023 she was aware Residwas not on the medicwas waiting on Residelivery Resident #2's -In late October 2023 a second shift MA has Resident #2's doxycy available for administ-If Resident #2's doxycy available for administ request a refill from the pharmacy until Resident #2's doxycycline 100mgThe facility had not refills according to the pharmacy waiting the pharmacy maint #2's medicationsResident #2 did not usedication refillsResident #2's doxycycline.	as responsible to deliver cline 100mg to the facility. and early November 2023, ent #2's doxycycline 100mg ation cart and the facility ent #2's RP to fill and so doxycycline 100mg. and early November 2023, do notified her related to cline 100mg not being ration. It is recycline 100mg was not ration, the facility was to the facility's contracted ent #2's RP delivered.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED	
						c
		HAL060166	B. WING		1	0/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		13600 S T	RYON ST			
WICKSHIE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 358}	Continued From page	e 52	{D 358}			
	Telephone interview of Resident #2's preferred 2:48pm revealed: -Resident #2 utilized to doxycycline 100mg reduces for refill every request for refill every request for refill every reduces for refill every reduces for refill every reduces for refill every reduces for refill every reduced for 10/07/23 for reduced for Resident #2's doxycyclispensed to Resident #2's doxycyclispensed to Resident #2's doxycyclispensed to Resident #2's doxycyclispensed for Resident #2's RP was reduced to request refills of Resident #2's medical reduced reduc	with the pharmacist at ed pharmacy on 11/15/23 at the pharmacy for efills. ycline 100mg required a y 30 days. ycline 100mg twice daily was 60 doses. ycline 100mg twice daily was at #2's RP on 10/07/23. ycline 100mg twice daily was 60 doses. ycline 100mg twice daily was 60 doses. ycline 100mg twice daily was 61 doses. ycline 100mg twice daily was 62 doses. ycline 100mg twice daily was 63 doses. ycline 100mg twice daily was 63 doses. ycline 100mg twice daily was 65 doses.				
	11/16/23 at 3:17pm re	re responsible to request				
	-The facility was resp	non reniis. Onsible to notify her when tion refills were called into				
	Resident #2's local ph -She was responsible medications to the fac -In early November 20 her that his doxycyclin	narmacy. to deliver Resident #2's cility. 023, Resident #2 notified ne 100mg had not been				
		v days. quested a refill of Resident ng from Resident #2's local				

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R-C	
		HAL060166	B. WING		11/20	0/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, STA	TE, ZIP CODE		
MICKOLU	DE OTEEL E ODEEK	13600 S TF	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 358}	Continued From page	= 53	{D 358}			
	pharmacy and deliver					
	11/16/23 at 8:45am re- Resident #2 was pre- twice daily to treat Re- chronic cellulitis. -She expected the face	escribed doxycycline 100mg esident #2's bilateral leg cility to ensure Resident #2's				
	doxycycline 100mg twice daily was administered as prescribedShe expected the facility to request Resident #2's doxycycline 100mg refills in accordance with					
	of the last doseShe expected the factorial states and the same states are states as the same states are same same same same same same same sam	cy, usually within one-week cility to notify her if Resident mg was not available for Resident #2's doxycycline				
	-Resident #2's legs w evidence of infection. -Resident #2 'was at I	en 10/27/23 and 11/04/23. vere not currently exhibiting risk of the likelihood of				
	cellulitis' if his doxycy not administered as o					
	Interview with the faci Coordinator (RCC) or revealed: -MAs were responsib	n 11/20/23 at 12:33pm				
	resident's medication dosesThe facility was resp #2's refills from Resid pharmacyResident #2's RP was	onsible to request Resident dent #2's preferred as responsible to deliver				
	Resident #2's medica	ations from Resident #2's				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILBING.		R-C
		HAL060166	B. WING		11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, STA	TE, ZIP CODE	
MICKSHII	RE STEELE CREEK	13600 S	TRYON ST		
WICKSIII	NE STEELE ONLER	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETE
{D 358}	100mg twice daily wa administration in late November 2023. Interview with the fact 11/20/23 at 3:33pm re Resident #2's doxycy not available for admi 2023 and early Novembre Resident #2's doxycy not available for admi 2023 at 4:20pm re Resident #2's doxycy not available for admi 2023 and early Novembre Refer to interview with 11:00am. Refer to interview with Nurse on 11/15/23 at	esident #2's doxycycline is unavailable for October 2023 or early dility's Compliance Nurse on evealed she was not aware cline 100mg twice daily was instration in late October imber 2023. dility Administration on evealed she was not aware cline 100mg twice daily was instration in late October instruction in late October instruc	{D 358}		
	Refer to interview with 12:33pm.	n the RCC on 11/20/23 at			
	Refer to interview witl Nurse on 11/20/23 at	n the facility's Compliance 3:34pm			
	Refer to interview witl 11/20/23 at 4:45pm.	n the Administrator on			
	04/21/23 revealed:	t #5's current FL2 dated Vascular dementia with e, benign prostatic			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
7442 1 2744 01 0014	NEO TION	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:		
		HAL060166	D 14/11/0		R- 11/2	.C 2 0/2023
NAME OF PROVIDE	R OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
WICKSHIRE STE	EELE CREEK		TRYON ST TTE, NC 28278			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETE DATE
hyperages -Reses -Reses -Reses - The (user by many many many many many many many man	sident #5's level of the treat under an outh daily. ew of Resident #7/23 revealed an um 150mcg by mover of Resident #62/23 revealed an um 175mcg by mover of Resident #62/23 revealed an um 175mcg by mover of Resident #62/23 revealed an um 175mcg by mover of Resident #62/23 revealed an um 175mcg by mover of Resident #62/23 revealed an um 175mcg by mover of Resident #62/23 revealed an outhyroxine sodium othyroxine sodium othyroxine sodium documented as reption code of 02 of 12/23. Fident #5's levothy the daily was documented an entry for by mouth daily. Findent #5's levothy the daily was documented with the eating, other/see reword Resident #64/25's levothy dent #5's levo	othyroidism. stantly disorientated. f care was SCU. for levothyroxine sodium ctive thyroid gland) 137mcg 5's physician orders dated order for levothyroxine outh daily. 5's physician orders dated order for levothyroxine outh daily. 5's Cottober 2023 eMAR lated 10/12/23 for 175 mcg by mouth daily. in 175 mcg by mouth daily int administered with the indicating resident refusal	{D 358}			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. Boilbino.			R-C	
		HAL060166	B. WING		I	1/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
14/10/2011/		13600 S	TRYON ST			
WICKSHII	RE STEELE CREEK	CHARLO	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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
{D 358}	Continued From page	e 56	{D 358}			
		ration on 11/15/23 at vothyroxine sodium 137mcg a dispense date of 06/30/23				
	facility's contracted pl 10:18am revealed: -Levothyroxine sodiul was last filled and dis 06/30/23, for 28 dose -Resident #5 had and sodium 150mcg by m that was last filled and 09/27/23, for 28 dose -Resident #5 had and sodium 175mcg by m	order for levothyroxine south daily dated 07/06/23 d dispensed to the facility on es. order for levothyroxine south daily dated 10/11/23 d dispensed to the facility on				
	revealed: -She did not notice th levothyroxine sodium not match the eMAR -The MAs were to col medication cart to the notIf there was an incor the medication cart, t the progress notes, n	on the medication cart did				
	8:45am revealed: -She was not notified	that Resident #5 was ttose of levothyroxine				

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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
			B WING		R-C
		HAL060166	B. WING		11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
WICKSHI	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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
{D 358}	Continued From page	e 57	{D 358}		
	levothyroxine sodium lowNot receiving the cor sodium, Resident #5 sleeping more with po could lead to fallsShe expected the fac orders as prescribed. Interview with the faci 11/20/23 at 3:38pm re-She was a Registere at the facility about a -She did not know Re	cility to follow medications ility Compliance Nurse on evealed: d Nurse who began working month ago.			
	on 11/20/23 at 1:20pr -She did not know Re receiving the incorrect sodiumShe was responsible reports that identified missing from the med remember any issues medicationsShe did not complete since she started as t because of other duti- attentionShe was responsible medication cart audit the medication on the physician order but ha	esident #5 had been et dose of levothyroxine e for reviewing the 24 hour medications that were lication carts but did not s with Resident #5's e a medication cart audit the SCC 30 days ago es that required her e for completing a weekly that matched the eMAR with e medication cart and the ad not. lility to notify the pharmacy			

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DIVIDION	n Health Service Negu	lation			
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
					R-C
		HAL060166	B. WING	B. WING	
		TIALUUUTUU			11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
M(101/01/11	NE OTER! E ODER!	13600 S	TRYON 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	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE
				DEFICIENCY)	
{D 358}	Continued From page	e 58	{D 358}		
(,	Continuou i rom page				
		ministrator on 11/20/23 at			
	4:38pm revealed:				
	-She did not know Re				
	•	t dose of levothyroxine			
	sodium.				
	·	sible for comparing the			
		art to the eMAR before			
	administering a medic				
	•	en the incorrect dose of a			
		or MA were responsible for			
	calling the pharmacy				
	-The MAs or the SCC				
		ct doses of medications or if			
		available on a progress			
	note and on the 24 ho				
	· · · · · · · · · · · · · · · · · · ·	nsible for completing a			
	•	irt audit that matched the			
		art to the eMAR and the			
	physician order.				
		he medication cart audits			
	were not completed.				
		nsible for reviewing the 24			
	•	tified medications that were			
	missing from the med				
		e SCC had not completed			
	any medication cart a	iudits.			
	Defer to interview	h a MA an 11/15/22 at			
	11:00am.	h a MA on 11/15/23 at			
	i i .uuaiii.				
	Defer to intensions with	h the facility's Compliance			
	Nurse on 11/15/23 at				
	11/15/23 at	11.07am.			
	Refer to interview with	h the SCC on 11/16/23 at			
	10:25am.	11 the 300 off 11/10/23 at			
	IV.ZJaIII.				
	Refer to interview with	h the RCC on 11/20/23 at			
	12:33pm.	4.5 1.00 on 11/20/20 at			

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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		R-C 11/20/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
MICKELII	RE STEELE CREEK	13600 S T	RYON ST		
WICKSHII	RE STEELE GREEK	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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTE
{D 358}	Continued From page	÷ 59	{D 358}		
, ,		h the facility's Compliance			
	Refer to interview with 11/20/23 at 4:45pm.	h the Administrator on			
	11/15/23 at 11:07am -She was a Registere at the facility about a -The SCC/RCC were weekly medication ca any missing medication to have an order or -The SCC/RCC were the 24 hour and 72 he audit report and and it the morning stand up concerns with medica as missing medication issues to herThe morning stand up FridayShe would then be re those issues were tak SCC/RCC needed he -She was not aware of since she started at the	and Nurse who began working month ago. The responsible for completing and audits that would reveal ons, and medications that do do not match the order. The responsible for reviewing our report, the medication medication cart audit prior to a sand report any issues or ations for the residents, such and medication order. The responsible for making sure were Monday through the seponsible for making sure were care of and assist if the elep. The facility since nothing was			
	and therefore she cou anything. -She was not aware t were not completed a if the SCC/RCC comp	morning stand up meetings uld not follow up with he medication cart audits and she did not check to see bleted the medication cart vas still learning her duties at			
	Interview with the SC revealed:	C on 11/16/23 at 10:25am			

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DIVISION	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
			_		_	_
					R-(
		HAL060166	B. WING		11/2	0/2023
	20,4252 02 011221152	070557.0	DD500 01TV 074	TE 710 000E		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	I E, ZIP CODE		
MICKSHIE	RE STEELE CREEK	13600 S T	RYON ST			
Wiokoiiii	CE OTELLE ONLEN	CHARLO1	TE, NC 28278			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ı	(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 APPROPR	RIATE	DATE
				DEFICIENCY)		
(D 250)	0	- 00	(D 350)			
{D 358}	Continued From page	9 60	{D 358}			
	-She first started as th	ne SCC 30 days ago				
		ility before the stand-up				
	meeting at 9:30am ev					
	•	Medication Audit report which				
		s that were left blank on the				
	eMAR.					
	-She was also respon	nsible for obtaining and				
	reviewing the 24 hour	and the 72 hour reports				
	which contained med	ications that were missing				
	off the medication car	t.				
	-She was also respon	sible for completing a				
		rt audit that matched the				
	•	ation on the medication cart				
	and the physician ord					
		audit would catch a missing				
	medication, or a medi	<u> </u>				
	administered as order					
		ility to notify the pharmacy				
	· •	here was an issue with				
	missing medications.					
		e a medication cart audit				
	since she started as t	he SCC 30 days ago				
	because of other dutie	es that required her				
	attention.					
	-On 10/11/23, she red	ceived an inservice by the				
	VP of Clinical Service	es on how to enter orders				
	into the eMAR system					
	-	additional inservices related				
	to medication adminis					
	through 11/14/23.	Stration 16/11/20				
	unough 11/11/20.					
	Interview with the Pag	sident Care Coordinator				
	(RCC) on 11/20/23 at					
		or the facility 3 weeks ago as				
	the RCC.					
		was not available on the				
	medication cart it was	the resident's responsibility				
	of the RCC and the M	IAs to reach out to the				
	pharmacy for a refill.					
		an outside pharmacy, it was				
		1 17	1			

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	A. BUILDING: _		(X3) DATE SURVEY COMPLETED	
	7. BOILBING			
HAL060166	B. WING		R-C 11/20/2023	
STREET ADDF	RESS, CITY, STAT	TE, ZIP CODE		
13600 S TR	YON ST			
CHARLOTT	E, NC 28278			
NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
	{D 358}			
idents' responsible the medication to the re to be completed MAs, but he had not its weekly and the recy performed a full a available, he would rest a new order if a If the pharmacy once is out of medications, received a dose or if recourrence, redication the progress readministration, redication was not redication was not redication was not recourrence, redication was not redication was not redication was not redication was not redication report, redication rep	{D 358}			
THE LIVE AT THE LESS OF SOME OF THE STATE OF	TOF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION) dents' responsible the medication to the e to be completed As, but he had not s weekly and the cy performed a full available, he would est a new order if a the pharmacy once s out of medications. refilled when there he bottle or bubble ed a dose or if ble, the MA would they were out of courrence. I family should be s note. ted on the progress ation, then it was administration. dication was not ween times d were not medication was not dishonest" by was administered in the cart. gger a missed nedication report, the box on the eMAR was	STREET ADDRESS, CITY, STA 13600 S TRYON ST CHARLOTTE, NC 28278 T OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION) General Research of the medication to the medication to the research of the pharmacy once out of medications. Teffilled when there are bottle or bubble and a dose or if ole, the MA would they were out of courrence. I family should be sonote. Ited on the progress ation, then it was administration. dication was not ween times divered medication was not medication was not dishonest" by was administered in the cart. I gger a missed medication report, the	STREET ADDRESS, CITY, STATE, ZIP CODE 13600 S TRYON ST CHARLOTTE, NC 28278 T OF DEFICIENCIES BEPRECEDED BY FULL VITEYING INFORMATION) TAG QUESTION (D 358) TO BE OF DEFICIENCIES BEPRECEDED BY FULL TAG (D 358) TO BE OF DEFICIENCY (D 358) TO BE OF DEFICIENCIES BEPRECEDED BY FULL TAG (D 358) TO BE OF DEFICIENCY (D 358) TO BE OF DEFICIENCY (D 358) TO BE DEFICIENCY (D 458) TO BE DEFICIENCY (D 458) TO BE DEFIC	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			7 .: BOILBING: _		_D	
		HAL060166	B. WING		R-C 11/20) /2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE STEELE CREEK	13600 S TI	RYON ST			
Wickerin	CE OTELLE ORLER	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	(X5) COMPLETE DATE
{D 358}	Continued From page	e 62	{D 358}			
` '	not the "09" codes whout of a medicationThe in-house MAs w medication cart audits -The agency MA staff but were also responsivere available on the	ere responsible to perform s. did not perform cart audits, sible to ensure medications cart.				
	Interview with the facility's Compliance Nurse on 11/20/23 at 3:34pm revealed: -She received an inservice from the Vice President of Clinical Services on 10/11/23 related to entering orders into the eMAR system, but did not know of any inservices related to medication administration for the MAsThe MAs were responsible for notification to the pharmacy related to any medications not available for administration or a medication with 7 doses left requiring a refill.					
	4:38pm revealed: -The MAs were responsive medication order issued documentation the issuesThe SCC/RCC was recart audits once a we Compliance Nurse whissuesThe last medication of the facility's contractedDuring the daily stan reports (progress note reports (holes in eMA time of administration reviewedThese 3 reports were	ensible for notification of emissing medications, and es to the SCC/RCC by sues on the 24 hour report. The responsible for performing ek and to notify the enen there were medication cart audit was performed by an end pharmacy on 10/18/23. d-up meetings, exception es), missed medication (R), variance reports (actual of medications) were elected discussed every day and to be corrected by the next				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R-C	
		HAL060166	B. WING		11/20/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
MICKEHIE	RE STEELE CREEK	13600 S T	RYON ST			
CHARLOT			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 APPROPE DEFICIENCY)	BE COMPLETE	
{D 358}	Continued From page	e 63	{D 358}			
(2 330)	-Most of the time the when they were revie -The SCC/RCC was redication cart audits related to the 3 report stand-up meetingsThe SCC/RCC should medications were filled residents no matter were not completedThis was a process in put in place for the SCC Compliance Nurse to -There were two addit the Compliance Nurse to addit the Compliance Nurse the SCC/RCC when the SCC/RCC	reports have been blank wed. responsible for the sonce a week on Thursdays is discussed during the Id have ensured and the same way for all which pharmacy was used. The medication cart audits ssue meaning, checks were CC/RCC to report to the assist with. Itional nurses hired to assist the when needed to fill in for they had to complete other on for a MA or if they were only reason. Idid not complete their the Compliance Nurse, then the could not assist with ther two nurses for help. Insure 4 of 7 residents' and #7) medications were thered which included on thigh blood pressure and tions for high cholesterol and medications for benign and hyperthyroidism (#5). medications as ordered at substantial risk for serious institutes a Type A2				
		a plan of protection on a accordance with G.S. tion.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			SURVEY PLETED	
		HAL060166	B. WING			R-C / 20/2023
	PROVIDER OR SUPPLIER	13600 S	ADDRESS, CITY, STATE TRYON ST OTTE, NC 28278	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT 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 T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{D 364	(g) The facility shall administered to resi or one hour after the time unless preclude. This Rule is not me FOLLOW-UP TO	24 Medication Administration I ensure that medications are dents within one hour before e prescribed or scheduled ed by emergency situations. It as evidenced by: YPE B VIOLATION Intinues and the previous Type abated. Is and record reviews, the are medications were one hour before or after the If of 5 sampled residents edications with multiple Is being administered too close and administration time	{D 364}			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
7012 1 2701	or dorate of the transfer of t	IDENTIFICATION NO.	A. BUILDING: _		D.C.	
		HAL060166	B. WING		R-C 11/20/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE		
WICKSHI	RE STEELE CREEK	13600 S T	RYON ST TTE, NC 28278			
	CUMMARY CT		1	DDOVIDEDIS DI ANI OF CODDECTIO	NN	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
{D 364}	Continued From page	e 65	{D 364}			
	a disease of the urina hyperlipidemia (the pi lipids in the blood), ar	rructive and reflux uropathy (ary or urogenital organs), resence of excess fat or and essential hypertension (a bertension that occurs in the ant cause).				
	Review of Resident # revealed an admissio					
		ers dated 06/14/23 revealed r metformin (used to treat				
	Review of Resident #3's October 2023 electronic medication administration record (eMAR) revealed there was an entry for metformin 500mg by mouth twice daily at 8:00am and at 4:00pm with documentation of administration at 4:00pm on 10/27/23.					
		ation Audit Report revealed istered outside of the one frame 1 out of 5				
	revealed there was a by mouth twice daily with documentation o	3's November 2023 eMAR n entry for metformin 500mg at 8:00am and at 4:00pm f administration at 8:00am and 11/13/23, at 4:00pm on and 11/11/23.				
	metformin was admin hour before/after time	ation Audit Report revealed istered outside of the one				

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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		R-C 11/20/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIRE 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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 364}	4} Continued From page 66		{D 364}			
	on 11/02/23 at 6:21pr	n.				
	Telephone interview of 11/20/23 at 12:30pm is used to treat Residen medication was admitted then the medication of effect and could poss Resident #3's blood is b. Review of Resident 06/14/23 revealed the apixaban (used to pre 2.5mg by mouth twice Review of Resident # revealed there was an by mouth twice daily of administration at 4: Review of Resident # Medication Administration.	with Resident #3's PCP on revealed metformin was t #3's blood sugar and if the nistered too close together, ould not cause the desired ibly have issues with augar. It #3's PCP orders dated ere was an order for event blood clots and stroke) e daily. 3's October 2023 eMAR in entry for apixaban 2.5mg 4:00pm with documentation 0.00pm on 10/27/23. 3's October 2023 edition Audit Report revealed estered outside of the one of frame 1 out of 5				
	revealed there was ar by mouth twice daily a documentation of adn	3's November 2023 eMAR n entry for apixaban 2.5mg at 8:00am and 4:00pm with ninistration at 8:00am on at 11/13/23, at 4:00pm on at 11/11/23.				
	apixaban was adminishour before/after time	ation Audit Report revealed stered outside of the one frame 6 out of 16 latest administration being				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			71. 501251110.		R-C
		HAL060166	B. WING		11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
WICKSHIE	RE STEELE CREEK	13600 S TI	RYON ST		
- Wickerin	CE OTELLE ONLLIN	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 364}	Continued From page	e 67	{D 364}		
{D 364}	Telephone interview of 11/20/23 at 12:30pm as a blood thinner and administered too closs medication could not keeping the blood thin c. Review of Residem 06/14/23 revealed the aspart solution pen-in blood sugars spikes) subcutaneously (SQ) meals and at bedtime. Review of Resident # revealed: -There was an entry fine pen-injector 100 units scale before meals at and at bedtime at 8:0 administration on 11/01/11/23, 11/12/23, ar on 11/11/23 at 11:30ar-On 11/02/23 at 7:30ar-	with Resident #3's PCP on revealed apixaban was used d if the medication was e together, then the cause the desired effect of nned. It #3's PCP orders dated ere was an order for insulin injector (used to help lower 100 units/1ml, inject per sliding scale before etc. 3's November 2023 eMAR For insulin aspart solution injects SQ per sliding to 7:30am, 11:30am, 5:30pm injects of 22/23, 11/05/23, 11/06/23, and 11/13/23 at 7:30am, and	{D 364}		
	-On 11/05/23 at 7:30a 11:30am was docume	am the FSBS was 113 and at ented as 105. am the FSBS was 139 and			
	at 11:30am was docu -On 11/11/23 at 7:30a 11:30am was 138, an -On 11/12/23 at 7:30a at 11:30am was 108. -On 11/13/23 at 7:30a at 11:30am was 133.	mented as 121. Im the FSBS was 127, Id at 5:30pm was 134. Im the FSBS was 134 and Im the FSBS was 129 and			
		3's November 2023 ation Audit Report revealed ministered outside of the			

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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		R-C 11/20/20	023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE STEELE CREEK	13600 S TF				
	I	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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE C	(X5) OMPLETE DATE
{D 364}	Continued From page	e 68	{D 364}			
(5 304)	one hour before/after opportunities with the on 11/11/23 at 1:57pm Telephone interview with 11/20/23 at 12:30pm -The insulin aspart waith waith was administered too closs medication could not blood sugars.	time frame 7 out of 16 latest administration being n. with Resident #3's PCP on revealed: as used to treat Resident d if the medication was e together, then the decrease Resident #3's	[5 304]			
	-The insulin aspart should be administered according to the blood sugar results obtained 30 minutes before meals and at bedtime. -The insulin aspart does not lower the blood sugar until about 1 to 1.5 hours after receiving the insulin. -If Resident #3 received the insulin after the blood sugar was obtained and then ate food then the blood sugar would stay high longer and could cause symptoms of high blood sugar such as tiredness and blurred vision.					
	06/14/23 revealed the	t #3's PCP orders dated ere was an order for at pyelonephritis) 400mg by				
	revealed there was an by mouth daily at 8:00	3's November 2023 eMAR n entry for acyclovir 400mg Dam with documentation of lam on 11/02/23, 11/12/23				
	acyclovir was adminis hour before/after time	ation Audit Report revealed stered outside of the one frame 3 out of 16 latest administration being				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE Co		, , ,	E SURVEY PLETED	
			7 56.25e <u>—</u>			R-C
		HAL060166	B. WING			/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	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 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 364}	Continued From page	e 69	{D 364}			
	11/20/23 at 12:30pm to treat pyelonephritis same time each day, not cause the desired e. Review of Residen 06/14/23 revealed the (used to treat benign by mouth daily. Review of Resident # revealed there was a mouth daily at 8:00ar	with Resident #3's PCP on revealed acyclovir was used s, and when not given at the then the medication could d effect to treat infection. It #3's PCP orders dated ere was an order for Flomax prostatic hyperplasia) 0.4mg E3's November 2023 eMAR in entry for Flomax 0.4mg by in with documentation of the part of the process of the proce				
	Flomax was administ before/after time fram	3's November 2023 ation Audit Report revealed ered outside of the one hour ne 3 out of 16 opportunities stration being on 11/12/23 at				
	11/20/23 at 12:30pm to treat benign prosta not given at the same	with Resident #3's PCP on revealed Flomax was used tic hyperplasia, and when time each day, then the cause the desired effect of				
	06/14/23 revealed the	t #3's PCP orders dated ere was an order for o treat diabetes) 25mg by				
	revealed there was a	3's November 2023 eMAR n entry for empagliflozin 8:00am with documentation				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			SURVEY PLETED	
			A. BOILDING.			₹- C
		HAL060166	B. WING			/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
			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 ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
{D 364}	Continued From page	e 70	{D 364}			
	of administration at 8 and 11/13/23.	:00am on 11/02/23, 11/12/23				
	empagliflozin was ad one hour before/after	ation Audit Report revealed ministered outside of the time frame 3 out of 16 latest administration being				
	11/20/23 at 12:30pm used to treat diabetes	-				
	Telephone interview with a first shift medication aide (MA) on 11/17/23 at 3:30pm revealed no one in management asked her why Resident #3's medications were late according to the Medication Administration Audit Report.					
	(RCC) on 11/20/23 at	sident Care Coordinator 12:33pm revealed he was 3 had received medications /27/23 to 11/13/23.				
		interview with Resident #3's P) on 11/20/23 at 3:42pm				
	4:45pm revealed: -During the daily stan management reviewe Administration Audit I actual time medicatio -We review and discu	d-up meetings, staff and ed the Medication Reports which show the ns were administered. ss this report every day and orrected by the next day.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			SURVEY PLETED	
			A. BUILDING:	A. BUILDING:		
		HAL060166	B. WING		I	R-C / 20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MICKOLI	DE OTES! E ODES!	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 ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
{D 364}	Continued From page	e 71	{D 364}			
	#3's medications.	of any issues with Resident A and RCC to notify the PCP ns.				
	Refer to interview with 12:19pm.	h a MA on 11/17/23 at				
	Refer to interview with Nurse on 11/15/23 at	h the facility's Compliance 11:07am.				
	Refer to interview with 10:25am	h the SCC on 11/16/23 at				
	Refer to interview with 10:25am.	h the RCC on 11/16/23 at				
	Refer to interview with 11/20/23 at 4:38pm.	h the Administrator on				
	09/22/23 revealed dia	t #4's current FL2 dated agnoses included , degenerative disc disease,				
	there was an order fo	t #4's Primary Care ers dated 09/22/23 revealed r amlodipine besylate (used essure) 5mg by mouth daily.				
	medication administra revealed there was a besylate 5mg by mou documentation of adr 10/27/23, 10/28/23, 1	n entry for amlodipine th daily at 7:00am with ninistration at 7:00am on 0/29/23 and 10/31/23.				
		4's October 2023 ation Audit Report revealed vas administered outside of				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 56.256.		R-C
		HAL060166	B. WING		11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
WICKSHIP	RE STEELE CREEK		RYON ST ITE, NC 28278		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	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)	D BE COMPLETE
{D 364}	Continued From page	e 72	{D 364}		
		fter time frame 4 out of 5 latest administration being n.			
	revealed there was an besylate 5mg by mou documentation of adm	4's November 2023 eMAR n entry for amlodipine th daily at 7:00am with ninistration at 7:00am on 11/06/23 - 11/11/23, and			
	Review of Resident #4's November 2023 Medication Administration Audit Report revealed amlodipine besylate was administered outside of the one hour before/after time frame 12 out of 16 opportunities with the latest administration being on 11/15/23 9:01am.				
	Telephone interview with Resident #4's PCP on 11/20/23 at 12:30pm revealed the amlodipine besylate was used to treat Resident #4's blood pressure and if the medication was administered too close together, then the medication could cause the blood pressure to drop more than intended.				
	09/22/23 revealed the	t #4's PCP orders dated ere was an order for vitamin e diseases) 25mcg by			
	revealed there was a	4's November 2023 eMAR n entry for vitamin D3, y with documentation of lam on 11/11/23 and			
		4's November 2023 ation Audit Report revealed nistered outside of the one			

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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		R-C 11/20/2023
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	11/20/2020
WICKSHI	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
{D 364}	on 11/14/23 at 9:43ar Telephone interview of 11/20/23 at 12:30pm used to treat Residen administered too closs not be a constant level blood to work effective. C. Review of Residen 09/22/23 revealed: the memantine HCL (use 10mg by mouth twice Review of Resident # revealed there was at 10 mg by mouth twice of administration at 8:11/14/23. Review of Resident # Medication Administration at 8:11/14/23. Review of Resident # Medication Administration at 9:11/14/23. Telephone interview of 11/20/23 at 12:30pm HCL was used to treat loss due to dementia close together then the level of the medication effectively.	eframe 2 out of 16 latest administration being n. with Resident #4's PCP on revealed the vitamin D was t #4's bone loss and if e together then there would el of the medication in the ely. t #4's PCP orders dated ere was an order for d to treat memory loss) daily. 4's November 2023 eMAR n entry for memantine HCL e daily with a documentation 00am on 11/11/23 and 4's November 2023 ation Audit Report revealed administered outside of the time frame 2 out of 16 latest administration being n. with Resident #4's PCP on revealed the memantine t Resident #4's memory and if administered too here would not be a constant in in the blood to work	{D 364}		
		t #4's PCP orders dated ere was an order for fish oil t disease and stroke)			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R-C
		HAL060166	B. WING		11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		13600 S TF	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 SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
{D 364}	Continued From page	e 74	{D 364}		
	1000mg by mouth da				
	Review of Resident #	4's November 2023 eMAR n entry for fish oil 1000mg by cumentation of lam on 11/11/23 and			
	Medication Administra fish oil was administe before/after time fram	ation Audit Report revealed red outside of the one hour the 2 out of 16 opportunities stration being on 11/11/23 at			
	11/20/23 at 12:30pm used to treat Residen prevent stroke and if together then there w	with Resident #4's PCP on revealed the fish oil was it #4's heart disease and administered too close ould not be a constant level he blood to work effectively.			
	09/22/23 revealed the	to treat allergy symptoms)			
	revealed there was an sodium 10mg by mou	ninistration at 8:00am on			
	montelukast sodium v the one hour before/a	ation Audit Report revealed was administered outside of ifter time frame 2 out of 16 latest administration being			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY	(X3) DATE SURVEY COMPLETED	
ANDILAN	or doring of the state of the s	IDENTIFICATION NOWIDER.	A. BUILDING: _	A. BUILDING:		
		HAL060166	B. WING		R-C 11/20/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHII	RE STEELE CREEK	13600 S T CHARLOT	RYON ST TE, NC 28278			
0(1) 15	SLIMMADV ST.	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECT	TION	-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLE	
{D 364}	Continued From page	e 75	{D 364}			
	Telephone interview v 11/20/23 at 12:30pm sodium was used to t and if administered to	with Resident #4's PCP on revealed the montelukast reat Resident #4's allergies to close together then there ant level of the medication in				
	09/22/23 revealed the	#4's PCP orders dated ere was an order for losartan eat hypertension) 25mg by				
	revealed there was an potassium 25mg by n	nouth daily at 8:00am with ninistration at 8:00am on				
	losartan potassium w the one hour before/a	ation Audit Report revealed as administered outside of after time frame 2 out of 16 latest administration being				
	11/20/23 at 12:30pm potassium was used pressure and if the m too close together, the	with Resident #4's PCP on revealed the losartan to treat Resident #4's blood edication was administered en the medication could sure to drop more than				
	Refer to interview with 12:19pm.	h a MA on 11/17/23 at				
	Refer to interview witl Nurse on 11/15/23 at	h the facility's Compliance 11:07am.				
	Refer to interview witl	h the SCC on 11/16/23 at				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL060166	B. WING		R-C 11/20/2023
					11/20/2023
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STAT	FE, ZIP CODE	
WICKSHII	RE STEELE CREEK	13600 S T	RYON ST TTE, NC 28278		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTI	ON (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
{D 364}	Continued From page	2 76	{D 364}		
	10:25am				
	Refer to interview with 10:25am.	n the RCC on 11/16/23 at			
	Refer to interview with 11/20/23 at 4:38pm.	n the Administrator on			
	04/21/23 revealed dia	t #5's current FL2 dated agnoses included vascular oral disturbance, benign and hypothyroidism.			
	(PCP) orders dated 0 an order for levothyro	t #5's Primary Care Provider 9/07/23 revealed there was xine sodium (used to treat d gland) 150mcg by mouth			
	Review of Resident # 10/11/23 revealed an sodium (used to treat hyperplasia) 175mcg	order for levothyroxine benign prostatic			
	revealed there was an sodium 150mcg by m	5's October 2023 eMAR nentry for levothyroxine outh daily at 7:00am with ninistration at 7:00am on and 10/31/23.			
	levothyroxine sodium the one hour before/a occurrences out of 5 of	ation Audit Report revealed was administered outside of			
	revealed there was ar	5's November 2023 eMAR n entry for levothyroxine outh daily at 7:00am with			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
						R-C
		HAL060166	B. WING			/20/2023
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 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 364}	Continued From page	e 77	{D 364}			
		ninistration at 7:00am on 11/05/23 - 11/07/23, 11/09/23				
	levothyroxine sodium the one hour before/a	ation Audit Report revealed was administered outside of after time frame 13 out of 16 latest administration being				
	11/20/23 at 12:30pm sodium was used to t hypothyroidism and if together then there w	with Resident #5's PCP on revealed the levothyroxine reat Resident #5's administered too close rould not be a constant level the blood to work effectively.				
	09/07/23 revealed the quetiapine fumarate (t #5's PCP orders dated ere was an order for used to treat depressive and ng by mouth twice daily.				
	revealed there was a fumarate 25mg by mo	outh twice daily at 9:00am umentation of administration				
	quetiapine fumarate the one hour before/a	ation Audit Report revealed was administered outside of				
	revealed there was a fumarate 25mg by mo	5's November 2023 eMAR n entry for quetiapine outh twice daily at 9:00am umentation of administration				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL060166	B. WING		R-C 11/20/2023
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 ONLLN	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 CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
{D 364}	Continued From page	÷ 78	{D 364}		
	at 9:00am on 11/13/2	3.			
	quetiapine fumarate v	ation Audit Report revealed was administered outside of fter time frame 1 out of 16			
	PCP on 11/20/23 at 1 fumarate was used to depressive disorders	vith Resident #5's previous 2:30pm revealed quetiapine treat Resident #5's major and if administered too here would not be a constant in the blood to work			
	09/07/23 revealed the	sed to treat mental/mood			
	revealed there was an sodium 125mg by mo and 6:00pm with docu	5's November 2023 eMAR n entry for divalproex outh twice daily at 8:00am umentation of administration 3, 11/10/23 - 11/13/23 and			
	divalproex sodium wa the one hour before/a opportunities with the	5's November 2023 ation Audit Report revealed as administered outside of fter time frame 6 out of 16 latest administration being as at 8:00am on 11/13/23 at			
	PCP on 11/20/23 at 1 was used to treat Res	with Resident #5's previous 2:30pm revealed divalproex sident #5's mood disorders o close together then there			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
,		.52.00.00.00.00.00.00.00.00.00.00.00.00.00	A. BUILDING:		
		HAL060166	B. WING		R-C 11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
WICKSHIP	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 COMPLETE
{D 364}	the blood to work effectively. the blood to work effectively. Review of Resident (1976) and (1976) are vealed the triamcinolone acetoni itching, redness, rash apply to both legs dail (1976) Review of Resident (1976) and (1976) and (1976) and (1976) and (1976) and (1976) are vealed there was an acetonide cream (1976) and (1976) and (1976) and (1976) and (1976) and (1976) are vealed the one hold (1976) and (1976) and (1976) and (1976) are vealed the medication of Resident (1976) are vealed the memantine (used to the mouth twice daily. Review of Resident (1976) are vealed the memantine (used to the mouth twice daily.	ant level of the medication in actively. It #5's PCP orders dated are was an order for de cream (used to treat , dryness, and scaling) 0.1% by 5's November 2023 eMAR of entry for triamcinolone apply to both legs daily at a thation of administration at 11/10/23 - 11/13/23 and 5's November 2023 eation Audit Report revealed de was administered for before/after time frame 6 so with the latest for 11/13/23 at 10:35am. With Resident #5's previous 2:30pm revealed de was used to treat sues and if administered too here would not be a constant on the skin to work It #5's PCP orders dated are was an order for reat memory loss) 5mg by 5's November 2023 eMAR	{D 364}		
	by mouth twice daily a	n entry for memantine 5mg at 8:00am and 6:00 with ninistration on 5mg by			

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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	B. WING		/2022
NAME OF D					11/20/	2023
	ROVIDER OR SUPPLIER	13600 S T	DRESS, CITY, STA RYON ST	TE, ZIP CODE		
WICKSHIF	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 364}	Continued From page	e 80	{D 364}			
	memantine was admi hour before/after time opportunities with the	nd 11/15/23. 5's November 2023 ation Audit Report revealed nistered outside of the one				
	Telephone interview with Resident #5's PCP on 11/20/23 at 12:30pm revealed the memantine HCL was used to treat Resident #5's memory loss due to dementia and if administered too close together then there would not be a constant level of the medication in the blood to work effectively.					
	f. Review of Resident #5's PCP orders dated 09/07/23 revealed there was an order for clotrimazole betamethasone (used to treat fungal infections and rash) 1-0.05% apply topically to face twice daily.					
	Review of Resident #5's November 2023 eMAR revealed there was an entry for clotrimazole betamethasone 1-0.05% apply topically to face twice daily at 8:00am and 6:00pm with documentation of administration at 8:00am on 11/07/23, 11/10/23 - 11/13/23 and 11/15/23.					
	clotrimazole betameth outside of the one ho out of 16 opportunitie	ation Audit Report revealed nasone was administered ur before/after time frame 6 s with the latest for the dose scheduled at				

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL060166	B. WING		R-C 11/20/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIF	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 COMPLETE	
{D 364}	11/20/23 at 12:30pm betamethasone was a fungal infection and if administered too clos medication could not the infection could not the infection could not the infection could not g. Review of Resident 09/07/23 revealed the potassium (used to tramouth daily. Review of Resident # revealed there was an potassium 25mg by m documentation of adm 11/07/23, 11/10/23 - 1 Review of Resident # Medication Administrational losartan potassium withe one hour before/a opportunities with the one 11/13/23 at 10:34aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa	with Resident #5's PCP on revealed the clotrimazole used to treat Resident #5's the medication was e together, then the cause the desired effect and to be controlled. It #5's PCP orders dated ere was an order for losartan eat hypertension) 25mg by 5's November 2023 eMAR in entry for losartan mouth daily at 8:00am with ministration at 8:00am on 1/1/3/23 and 11/15/23. 5's November 2023 extinct Audit Report revealed as administered outside of fiter time frame 6 out of 16 latest administration being am. with Resident #5's PCP on revealed the losartan to treat Resident #5's blood edication was administered en the medication could sure to drop more than In a MA on 11/17/23 at	{D 364}			
	Nurse on 11/15/23 at	11:0/am.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		· · · ·	(X3) DATE SURVEY COMPLETED	
		HAL060166			I	R-C / /20/2023
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	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 364}	Continued From page	e 82	{D 364}			
	Refer to interview wit 10:25am	h the SCC on 11/16/23 at				
	Refer to interview wit 10:25am.	h the RCC on 11/16/23 at				
	Refer to interview wit 11/20/23 at 4:38pm.	h the Administrator on				
	revealed diagnoses in Alzheimer's Dementia	a, coronary artery disease, er with metastasis, chronic				
	revealed an order for	nt #1's FL2 dated 02/13/23 refresh tears solution (a dry eyes) 1.4-0.6%, instill one r times a day.				
	(eMAR) revealedThere was an entry for 1.4-0.6%, instill one of for 8:00am, 12:00pm, -The entry was docur	for refresh tears solution drop in both eyes scheduled 4:00pm, and 8:00pm. mented as administered at 00pm and 8:00pm from				
	the refresh tears solu outside of the one ho 2 occurrences out of latest administration I 10:15am for the 8:00	ation Audit Report revealed tion was administered ur before/after time frame on 60 opportunities with the being on 11/11/23 at				
		on 11/20/23 at 12:30pm				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
74101 2741	or contraction	IDENTIFICATION NO.	A. BUILDING: _		
		HAL060166	B. WING		R-C 11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
WICKSHIE	RE STEELE CREEK	13600 S T CHARLO	RYON ST ITE, NC 28278		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	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 364}	Continued From page	e 83	{D 364}		
	Resident #1's dry eye administered too clos medication could not	es solution was used to treat es and if the medication was e together, then the cause the desired effect and y causing irritation to the			
	revealed an order for	t #1's FL2 dated 02/13/23 acetaminophen extended (a medication used for pain), s a day.			
	(eMAR) revealedThere was an entry f 650mg, one tablet thr -The acetaminophen	administration record for acetaminophen ER fee times a day. was documented as fam, 2:00pm and 8:00pm			
	the acetaminophen E of the one hour before occurrences out of 45	1's November 2023 ation Audit Report revealed R was administered outside e/after time frame on 2 opportunities with the latest on 11/11/23 at 10:15am for			
	11/20/23 at 12:30pm was used to treat Res medication was admithen the medication obecause there neede the medication in his	with Resident #1's PCP on revealed acetaminophen ER sident #1's pain and if the nistered too close together, could not control his pain d to be a constant level of blood to control his pain.			
	revealed an order for				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
			A. BOILDING.			
		HAL060166	B. WING		l l	R-C / 20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	, ZIP CODE		
MICKSHII	RE STEELE CREEK	13600 S T	RYON ST			
WICKSHII	RE STEELE GREEK	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 364}	Continued From page	e 84	{D 364}			
	both knees topically fo	our times a day.				
	apply one gram to bo a dayThe diclofenac was o at 8:00am, 12:00pm, 11/01/23 to 11/15/23. Review of Resident # Medication Administra the diclofenac sodium of the one hour before occurrences out of 60	administration record for diclofenac sodium 1% th knees topically four times documented as administered 4:00pm and 8:00pm from				
	11/20/23 at 12:30pm was used to treat Resmedication was admit then the medication obecause there needed	with Resident #1's PCP on revealed diclofenac sodium sident #1's pain and if the nistered too close together, ould not control his pain d to be a constant level of body to control the pain.				
	revealed an order for	t #1's FL2 dated 02/13/23 oxcarbazepine (a eizures) 150mg two times a				
	two times a dayThe entry was docum					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMPLETED
		HAL060166	B. WING		R-C 11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
WICKSHIE	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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{D 364}	Continued From page	e 85	{D 364}		
	the oxcarbazepine so outside of the one hot 2 occurrences out of 3 latest administration be 10:15am for the 8:00a	ation Audit Report revealed dium was administered ur before/after time frame on 30 opportunities with the being on 11/11/23 at			
	11/20/23 at 12:30pm sodium was used to to and if the medication together, then the merisk of a seizure due to	revealed oxcarbazepine reat Resident #1's seizures was administered too close dication could increase the to not having a constant o control the seizures.			
	Refer to interview with 12:19pm.	h a MA on 11/17/23 at			
	Refer to interview with Nurse on 11/15/23 at	h the facility's Compliance 11:07am.			
	Refer to interview with 10:25am	h the SCC on 11/16/23 at			
	Refer to interview with 10:25am.	h the RCC on 11/16/23 at			
	Refer to interview with 11/20/23 at 4:38pm.	h the Administrator on			
	revealed: -All medications were hour before to one ho timeOn 11/11/23, she add	n 11/17/23 at 12:19pm to be administered one our after the administration ministered the 8:00am our late in the SCU because			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		PLETED	
						R-C	
		HAL060166	B. WING		11/	/20/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, STA	TE, ZIP CODE			
		13600 S	TRYON ST				
WICKSHII	RE STEELE CREEK	CHARLO	TTE, NC 28278				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE	
{D 364}	Continued From page	e 86	{D 364}				
	che was administerin	g medications on the AL					
		gan over on the AL around					
	7:00am.	gan over on the AL around					
		y residents to administer					
	medications to that w						
	-She did not receive a	anv new training on					
		ation times since she hired					
	about 5 months ago.						
	ŭ						
	Interview with the fac	ility Compliance Nurse on					
	11/15/23 at 11:07am						
	-She was a Registere	ed Nurse who began working					
	at the facility about a						
		responsible for completing					
		nistration Audit Report and					
	reviewing it every mo						
	-The Medication Audi						
	medication administra						
	-The SCC/RCC could						
		ation times and then could					
		ith the MAs responsible for					
	before and one hour	tions outside the one hour					
	before and one nour	ailei.					
	Interview with the SC	C on 11/16/23 at 10:25am					
	revealed:						
	-She first started as the	he SCC 30 days ago.					
		ility before the stand-up					
	meeting at 9:30am ev						
	T	Medication Administration					
	Audit Report which co	ontained medication					
	administration times.						
	-She was responsible						
	Medication Administra						
	_	responsible for administering					
		f the one hour before and					
	one hour after rule.						
		he Medication Administration					
		ne started as the SCC, 30					
	days ago because of	other duties that required	1				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
	HALOGOAGE		B WING		R-C
		HAL060166			11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
WICKSHIE	RE STEELE CREEK		TRYON ST		
		CHARLO	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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{D 364}	Continued From page	e 87	{D 364}		
	her attention.				
	nor automion.				
		C on 11/16/23 at 10:25am			
	revealed:	a DCC 30 days aga			
	-He first started as the	e RCC, 30 days ago. lity before the stand-up			
	meeting at 9:30am ev				
	_	Medication Administration			
	Audit Report which co				
	administration times.				
		for reviewing the Medication			
		eport and meeting with the Iministering medications			
		ur before and one hour after			
	rule.	ar before and one floar after			
	-He did not review the	e Medication Administration			
	Audit Reports since h	e started as the RCC, 30			
		other duties that required			
	his attention.				
	Interview with the Adr 4:38pm revealed:	ministrator on 11/20/23 at			
	-The MAs were respo	onsible to administer			
		one hour before to one hour			
		nedication administration			
	time.	lity of the SCC/PCC to			
	· ·	lity of the SCC/RCC to Administration Audit report			
		to the MAs responsible for			
		tions outside that time			
	frame.				
		on some occasions a MA			
		dministering medications in			
		J at the same time, which			
		ons late for some residents			
	on a different unit.	ssue meaning, checks were			
		CC/RCC to report to the			
	Compliance Nurse to	· · · · · · · · · · · · · · · · · · ·			
		tional nurses hired to assist			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. Bolebino.		R-C	
	HAL060166 B			11/20/2023	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIRE STEELE CREEK	13600 S T	RYON ST			
	CHARLO	TTE, NC 28278			
PREFIX (EACH DEFICIENCY	NTEMENT OF DEFICIENCIES 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 364} Continued From page	88	{D 364}			
the Compliance Nurse the SCC/RCC when the duties such as filling in out of the facility for an -When the SCC/RCC checks and report to the Compliance Nurse issues and use the other -There was no new transport to the Compliance Nurse issues and use the other -There was no new transport to the Compliance Nurse issues and use the other -There was no new transport of the compliance of getting staff in their	e when needed to fill in for hey had to complete other in for a MA or if they were my reason. did not complete their he Compliance Nurse, then e could not assist with mer two nurses for help. aining on medication ifter October 2023 because new roles. ———————————————————————————————————	{D 364}			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7.11.2.1.2.11.1	or connection	BENTI TO THOU NOMBER.	A. BUILDING: _			
		HAL060166	B. WING		R- 11/2	-C 20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHI	RE STEELE CREEK		TRYON ST TTE, NC 28278			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRICENCY)	ULD BE	(X5) COMPLETE DATE
D 367	Continued From page	e 89	D 367			
D 367	10A NCAC 13F .1004 Administration	4(j) Medication	D 367			
	(j) The resident's merecord (MAR) shall be following: (1) resident's name; (2) name of the medical strength and dosa administered; (4) instructions for addort treatment; (5) reason or justifical medications or treatmedocumenting the result of documentation of medications or treatmomission, including reason, including record. This Rule is not met Based on observation reviews, the facility farmedication administration record. This Rule is not met Based on observation reviews, the facility farmedication administration administration record. This Rule is not met Based on observation reviews, the facility farmedication administration administration record. This Rule is not met Based on observation reviews, the facility farmedication administration administration administration record. This Rule is not met Based on observation reviews, the facility farmedication administration administration record. This Rule is not met Based on observation reviews, the facility farmedication administration record. This Rule is not met Based on observation reviews, the facility farmedication administration record. This Rule is not met Based on observation reviews, the facility farmedication administration record.	any omission of nents and the reason for the efusals; and, if the person administering atment. If initials are used, a to those initials is to be intained with the medication (MAR). as evidenced by: as, interviews, and recordailed to ensure the ation records were accurate Resident #7, #6, and #2) documentation of a blood and a medication used to edications for blood pressure medications for high				

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	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: _	A. BUILDING:		LETED	
		HAL060166	B. WING			R-C /20/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STAT	E, ZIP CODE			
MICKSHII	RE STEELE CREEK	13600 S	TRYON ST				
WICKSIIII	NE STEELE GREEK	CHARLO	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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 367	Continued From page	e 90	D 367				
	Policy dated 10/01/20 the administration record administered the med	orevealed the recording on the medication shall be by the staff who					
	11/09/23 revealed dia hypertension, atheros coronary artery disea bundle branch block	at #7's current FL2 dated agnoses included sclerotic heart disease, se without angina, a right (a condition that causes and anemia (lack of healthy					
	11/09/23 revealed the	used to treat high blood					
	Medication Administrative revealedThere was an entry to 10mg, one tablet dail -Resident #7's amlod	for amlodipine besylate					
	revealedThere was an entry f 10mg, one tablet dail -Resident #7's amlod documented as admi	ipine besylate 10mg was nistered 11/01/23, 11/02/23, 1/07/23, and 11/08/23. ent #7's medications					
	7:32am revealed ther	e was no amlodipine					

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	i Health Service Regu				T	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		ĒΥ
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	' <u> </u>
					R-C	
		HAL060166	B. WING		11/20/20	122
		TIALUGUTOU			11/20/20	123
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		13600 S T	RYON ST			
WICKSHIE	RE STEELE CREEK	CHARLO'	TTE, NC 28278			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	N	(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		OMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
D 367	Continued From page	<u> 91</u>	D 367			
	. •		- ***			
	besylate available.					
		vith a representative with the				
	•	harmacy on 11/15/23 at				
	10:15am revealed:	for amladinina basylata				
	10mg, one tablet daily	for amlodipine besylate				
	documented for Resid					
		vere 30 doses of amlodipine				
	besylate 10mg disper	•				
	Resident #7.	loca to the identity for				
		vere 28 doses of amlodipine				
	besylate 10mg disper	· · · · · · · · · · · · · · · · · · ·				
	Resident #7.	loca to the racinty for				
		late was not dispensed				
	•	ould have been out of				
	amlodipine besylate o					
	-Resident #7 required					
		on 10/20/23 to 11/15/23, to				
	follow the PCP's orde					
	Interview with a medic	cation aide (MA) on 11/17/23				
	at 12:33pm revealed:					
	-She administered an					
		/23, 11/07/23 and 11/08/23.				
		e previous MA documented				
	•	iting for the pharmacy to				
	dispense the amlodip					
		ed the amlodipine besylate				
	as administered by a	ccident.				
	E David (D. 17	1 H71				
		t #7's current FL2 dated				
		ere was an order for ferrous				
		used to treat anemia)				
	325mg every day.					
	Povious of Posidors #	7'o primary cara providerla				
		7's primary care provider's				
		10/12/23 revealed an order				
	for ferrous sulfate 325	ning every 12 nours.	1			

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DIVISION	n Health Service Negu	ialion			_
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL060166	B. WING		11/20/2023
NAME OF D	DOVIDED OD CUDDUED	CTDEETAG	ADDECC CITY CTA	TE 7/D 00DE	•
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	I E, ZIP CODE	
WICKSHIP	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	(-1-)
PREFIX TAG	,	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
D 367	Continued From page	. 02	D 367		
D 001	. •] 5 00.		
		edication pass on 11/15/23			
		Resident #7's ferrous sulfate			
	325mg was not availa	able to administer.			
	Review of Resident #	7's October 2023 eMAR			
	revealed.	7 5 5515551 2525 51717 11 1			
	-There was an entry of	dated 10/12/23 for ferrous			
	sulfate 325mg, every				
	-Resident #7's ferrous				
	documented as admir	nistered at 9:00am on			
	10/03/23 to 10/05/23,	10/07/23 to 10/10/23,			
		0/17/23 and at 9:00pm at			
		and 10/15/23 to 10/16/23.			
	_	dated 10/19/23 for ferrous			
	sulfate 325mg one tal				
	-Resident #7's ferrous	•			
	10/31/23.	nistered on 10/20/23 to			
	10/31/23.				
	Review of Resident #	7's November 2023 eMAR			
	revealed.				
	-There was an entry of	dated 10/19/23 for ferrous			
	sulfate 325mg, one ta	ablet daily.			
	-Resident #7's ferrous	s sulfate 325mg was			
		dministered on 11/01/23 to			
	11/05/23, and 11/07/2	23 to 11/09/23.			
	Observation of Reside	ont #7's modications			
	available for administ				
		e was no ferrous sulfate			
	available.	5 Hao no forfodo dallato			
	Telephone interview v	vith a representative with the			
		harmacy on 11/15/23 at			
	10:15am revealed:	-			
		order for ferrous sulfate			
	325mg, one tablet da	-			
		vere 12 doses of ferrous			
	sulfate 325mg dispen	sed to the facility for			

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Resident #7.

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Division of Health Service Regulation					(X3) DATE SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL060166	B. WING		11/20/2023
NAME OF T	DO//IDED OD 6/ 122/ 122		DDDE00 0:T/ 0=::	TE 710 000E	,
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	
WICKSHIE	RE STEELE CREEK		TRYON ST		
		CHARLO	OTTE, NC 28278		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION SHOUL	(- /
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE DATE
				DEFICIENCY)	
D 367	Continued From page	e 93	D 367		
	-On 11/15/23, the fac	ility requested a refill of			
		sulfate but there was no			
	refill left so the remain	ning 26 doses from the			
		spensed to the facility for			
	Resident #7.				
	-The ferrous sulfate v				
		have been out on 11/01/23.			
	·	d 15 more doses of ferrous			
		o 11/15/23, to follow the			
	PCP's order.				
	Interview with a medi	cation aide (MA) on 11/17/23			
	at 12:33pm revealed:				
	•	rrous sulfate to Resident #7			
	on 11/04/23, 11/07/23				
	-She did not know the	e previous MA documented			
	the ferrous sulfate as	awaiting for the pharmacy			
	to dispense the ferrou				
		ked the ferrous sulfate as			
	administered by accid	dent.			
	Refer to interview wit	h the Resident Care			
		n the Resident Care n 11/20/23 at 12:33pm.			
		11 11/20/20 αι 12.00μπ.			
	Refer to interview wit	h the Administrator on			
	11/20/23 at 4:38pm.	- · · · · · · · · · · · · · · · · · · ·			
	2. Review of Residen	it #6's current FL2 dated			
	11/09/23 revealed:				
		hypertension, mild cognitive			
	impairment, and hype				
		for hydrochlorothiazide			
		t high blood pressure and			
	swelling) one tablet b	y mouth daily.			
	Review of Resident #	6's FL2 dated 04/03/23			
	revealed there was a				
		2.5mg one tablet by mouth			
	daily.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			SURVEY PLETED	
			A. BUILDING.			2.0
		HAL060166	B. WING			R-C / 20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE	•	
NAME OF T	NOVIDEN ON 3011 EIEN		TRYON ST	, ZII GODE		
WICKSHI	RE STEELE CREEK		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 T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From page	94	D 367			
	sheet dated 07/14/23 -There was an order of 12.5mg one tablet by -The original order da	for hydrochlorothiazide mouth daily. ite was 04/07/23. 6's Resident Register				
	at 7:30am revealed: -The medication aide #6's morning medicat	chlorothiazide 12.5mg was				
	Observation of Resid available for administ 7:30am revealed ther hydrochlorothiazide 1 administration.	ration on 11/15/23 at				
	revealed: -Resident #6's respor medications to the fac- local pharmacy.					
	medication administrative revealedThere was an entry for 12.5mg dailyResident #6's hydrodeness.	6's October 2023 electronic ation record (eMAR) for hydrochlorothiazide chlorothiazide 12.5mg was nistered from 10/01/23 to				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN			A. BUILDING: _		OOMI LETED	
					R-C	
		HAL060166	B. WING		11/20/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MICKELIII	DE OTEEL E ODEEK	13600 S TF	RYON ST			
WICKSHIRE 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 367	Continued From page	95	D 367			
	revealedThere was an entry f 12.5mg dailyResident #6's hydrod documented as not a exception code "09" i notes" on 11/06/23, 1 and 11/16/23 at 8:00a -Resident #6's hydrod documented as admir	ndicating "other/see nurse 1/07/23, 11/10/23, 11/11/23				
	Telephone interview with a MA on 11/17/23 at 3:30pm revealed: -On 11/15/23, during the medication pass, Resident #6 did not have any hydrochlorothiazide 12.5mg available to administerResident #6 was out of her hydrochlorothiazide for one to two weeksResident #6 could borrow the medication from her spouse who was also a resident in the facility.					
her spouse who was also a resident in the facility. Review of Resident #6's progress notes from 10/27/23 to 11/16/23 revealed: -Resident #6's hydrochlorothiazide 12.5mg was not administered on 11/06/23, 11/07/23, and 11/10/23, due to "awaiting pharmacy"Resident #6's hydrochlorothiazide 12.5mg was not administered on 11/11/23 and 11/16/23, due to "medication unavailable"Resident #6's hydrochlorothiazide 12.5mg was not administered on 11/15/23 due to needing a prescription from the physician's assistant (PA)There was no documentation related to medications documented as administered on 11/08/23, 11/09/23, and 11/12/23 to 11/15/23 when there was no hydrochlorothiazide available						

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HAL060166 B. WING	R-C 11/20/2023
NAME OF PROVIDER OR SUPPLIER WICKSHIRE STEELE CREEK STREET ADDRESS, CITY, STATE, ZIP CODE 13600 S TRYON ST CHARLOTTE, NC 28278	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367 Continued From page 96 on the medication cart. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/15/23 at 10:32am revealed: -They only entered her medications to be listed on the eMARThey had never filled medications for Resident #6 because she used an outside pharmacy Telephone interview with the pharmacist at Resident #6's preferred pharmacy on 11/15/23 at 11:02am revealed: -There was an active order for hydrochlorothiazide 12.5mg, take one tablet daily for Resident #6'Hydrochlorothiazide 12.5mg was dispensed on 01/16/23 for a quantity of 90 tablets and again on 02/02/23 for a quantity of 90 tablets for Resident #6This medication was dispensed to Resident #6 when she lived in another state (prior to her admission to the facility)There was one refill left for hydrochlorothiazideThe pharmacy had not received any orders for hydrochlorothiazide and had not dispensed any hydrochlorothiazide and had not dispensed any hydrochlorothiazide and had not dispensed any hydrochlorothiazide for Resident #6 since 02/02/23. Review of the facility's Compliance Nurse's medication cart audit dated 11/16/23 to 11/17/23 revealed the hydrochlorothiazide 12.5mg quantity 90 was on the cart as of 11/17/23. Telephone interview with Resident #6's RP on 11/16/23 at 11:10am and 2:28pm revealed: -When Resident #6 was admitted to the facility she brought all medications that were filled prior to Resident #6's admission on 04/07/23.	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING:		
		HAL060166	B. WING		R-C 11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		13600 S TR	YON ST		
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
	hydrochlorothiazide of November 2023She always tried to go brought refills before medicationsShe found out today hydrochlorothiazide was supposed to medications today from the RP was instructed today (11/16/23) to see 12.5mg daily could be she was not aware, was the last time hydrochlorothiazide was the last time hydrochlorothiazide was not aware, was the last time hydrochlorothiazide was not aware.	vas last filled on 02/04/23. o pick up resident #6's om a local pharmacy. ed to call the pharmacy ee if hydrochlorothiazide ee filled. until today (11/16/23) this rochlorothiazide was filled. sident Care Coordinator			
	since the middle of Ju-There was no way to received for Resident the local pharmacy. -Resident #6's RP broal local pharmacy. -He could not verify if dispensed between many-He was not aware the hydrochlorothiazide awas out of the medical linterview with the fact 11/20/23 at 3:35pm resulting was a summary. -When the MA enterest they were responsible their PCP on the first when an outside pharmacy.	issues with receiving ations. sibly out of her medication ally 2023. In tell what medications were all 46 upon admission, or from a pught in her medication from a hydrochlorothiazide was anid-July and 11/16/23. In the was out of and not sure how long she ation at the was one weeled: In the open admission of the emal of the open and or the open and open and or the open and ope			

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AND DI AN OF CORRECTION INDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-C
		HAL060166	B. WING		11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE	
WICKSHII	RE STEELE CREEK		TRYON ST TTE, NC 28278		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTI	ON (X5)
PREFIX TAG	`	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 367	Continued From page	98	D 367		
	packSome of the MAs have transcribe orders into	point click care in the past. rs need to be approved and			
	4:45 PM revealed: -She was not aware the "09" code for Resident a medication was admiclearly unavailableShe expected the MA of any missed medication was not aware the maccurateShe did not know if the ever contacted for Resident aware the second sec	hat Resident 6's eMAR was ne backup pharmacy was			
	Refer to interview with Coordinator (RCC) or Refer to interview with 11/20/23 at 4:38pm.	11/20/23 at 12:33pm.			
	04/03/23 revealed: -Diagnoses included a chronic obstructive purhypertension, hyperliptediabetes mellitus, neurosteoarthritis, chronic prostatic hyperplasia, -An order for atorvast	oidemia, hypothyroidism, iropathy, depression, kidney disease, benign			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE Co		, , ,	E SURVEY PLETED
	HAL060166 B. W.		B. WING			R-C I/ 20/2023
NAME OF P	ROVIDER OR SUPPLIER	•	.DDRESS, CITY, STATE	, ZIP CODE	,	172072020
MICKOLI			TRYON ST			
WICKSHII	RE 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 AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From pag	e 99	D 367			
		#2's Resident Register 2 was admitted to the facility				
		#2's Primary Care Provider's 0/07/23 revealed an order for blet daily at bedtime.				
	revealed: -There was an entry	blet daily scheduled for vas documented as				
		_				
	revealed: -There was an entry	blet daily scheduled for vas documented as				
	was unavailable for a	aled there was no indicated atorvastatin 80mg administration. dedication cart on 11/15/23 at sident #2's atorvastatin 80mg				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY IPLETED	
		HAL060166	B. WING			R-C 1/20/2023
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE		
WICKSHIE	RE STEELE CREEK		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 ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From page	e 100	D 367			
	2:48pm revealed: -Resident #2 utilized atorvastatin 80mg on -The atorvastatin 80n 01/16/23 and would h 80mg on 04/16/23There were no additi Resident #2's atorvas -Resident #2's respon	the pharmacy on 11/15/23 at the pharmacy to dispense e tablet daily refills. In was not dispensed since have been out of atorvastatin onal refill requests for				
	11/16/23 at 4:35pm re-She documented addressed atorvastatin 80mg on 11/05/23, and 11/11/2-She did not recall if F80mg was on the med 2023. She may have marke administered in error dispensed on 01/16/2	ministration of Resident #2's 11/03/23, 11/04/23, 13. Resident #2's atorvastatin dication cart in November ed the atorvastatin 80mg as if the medication was last				
	, ,	n 11/20/23 at 12:33pm.				
	Refer to interview with 11/20/23 at 4:38pm.	h the Administrator on				
	(RCC) on 11/20/23 at -When a medication v	sident Care Coordinator 12:33pm revealed: was not available on the the responsibility of the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING: _	A. BUILDING:		
		HAL060166	B. WING		I	R-C 20/2023
NAME OF PROVIDER OR SUPP	PLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIRE STEELE CRE	FK	13600 S T	RYON ST			
WICKSTIIKE STEELE CKE	-LIX	CHARLOT	TE, NC 28278			
PREFIX (EACH D	DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 367 Continued Fr	om page	e 101	D 367			
RCC and the for a refill. -If the resider the responsib the medication of once a weekHe assigned been doing the The MAs did facility's controlled the pharm prescription when a medication of considered new the most with no considered new the most with no considered new the most with no considered administered documented administered availableThe MAs we checking that when it was result to the "09" considered new the considered new the most medication of the "09" considered new the most medication of the most medication of the most medication of the most medication of the agency	MAs to nt used a polity of the point to the point audit them to nem. I the carr racted pl 10/18/23 no medit macy and vas need dication valid de mean and the as admin , becaus re just "I t a medic not availa de does in the mis nowed w ponly audit codes wh cation. e MAs w art audits o respons	an outside pharmacy, it was the RP to pick up and deliver facility. Its were to be completed to the MAs, but he had not a the audits weekly and the farmacy performed a full as. Cation available, he would derequest a new order if a ded. Was listed on the progress information, then it was ble for administration. It a medication was not in between times instered were not the the medication was not being dishonest" by cation was administered able on the cart. In the trigger a missed assed medication report, the shen a box on the eMAR was atted the blanks on the eMAR, which meant someone was the fidid not perform cart audits, sible to ensure medications	D 367			

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STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BOILDII			R-C
		HAL060166	B. WING		11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
WICKSHIE	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 SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 367	Continued From page	e 102	D 367		
	medications that were and then documenting administered. -If the medication was or the medication was the eMAR, then the Mark medication or document administered. -The SCC/RCC were medication cart audits missing medications, and medications that medication cart. -Following the cart aunotify the Compliance medication issues. -When the SCC/RCC checks and report to the Compliance Nurse.	responsible for weekly s where they would find medication order issues			
D 438	38 10A NCAC 13F .1205 Health Care Personnel Registry		D 438		
	Registry The facility shall com	5 Health Care Personnel ply with G.S. 131E-256 and NCAC 13O .0101 and			
	This Rule is not met TYPE B VIOLATION	as evidenced by:			
	reviews, the facility fa	ns, interviews and record illed to complete a Health stry (HCPR) report within 24			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL060166	B. WING			R-C / 20/2023
	ROVIDER OR SUPPLIER	13600 S	DDRESS, CITY, STATE	E, ZIP CODE		
***************************************	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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 438	hours of knowledge of sampled residents (R of unknown origin that her right arm. The findings are: Review of Resident # 09/22/23 revealed: -Diagnoses included a-Resident #4 was corresident #4 was am-Resident #4's level of Unit (SCU). Review of Resident # Screening dated 07/2-Resident #4 had a hibehaviorsResident #4 required bathing, and toileting.	f resident injuries for 1 of 5 esident #4) who had injuries t resulted in a fracture for 4's current FL2 dated Alzheimer's dementia. istantly disoriented. bulatory. f care was Special Care 4's Pre-admission 7/22 revealed: story of wandering I assistance with dressing,	D 438			
	revealed: -Resident #4 had a hi -Resident #4 required -Resident #4 was ind and use of upper extr Telephone interview was member on 11/15/23 -Resident #4's family 11/12/23She stated Resident arm and seemed to b -She took Resident #	I supervision with bathing. ependent with ambulation emities. vith Resident #4's family at 11:52am revealed:				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
701012701	or connection	IDENTIFICATION NOMBER	A. BUILDING:		JOHN ELTED
			B. WING		R-C
		HAL060166	D. WING		11/20/2023
NAME OF P	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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 438	Continued From page	e 104	D 438		
D 438	-The family member of facilityThe family member of 44 having a fall or of a where Resident #4 sultant and the family member of knew how Resident #4 lnterview with a person 11/17/23 at 12:00pm -She worked first shift -She had noticed that hurting and reported it aides (MA)She said that one of on Resident #4's arm -She did document Repain on the hourly che Review of Resident #1/11/23 revealed the 10:00am Resident #4 and for the medication Resident #4's family revealed: -She was the assigned 11/11/23She did know that RehurtingShe did not recall Rebeing told Resident #4-She did not document arm pain.	was not notified of Resident any an accident or incident ustained an elbow fracture. Stated no one at the facility 44 fractured her elbow. In all care assistant (PCA) on revealed: It on 11/11/23. It Resident #4's arm was it to the two medication the MA's had put a cream It ecks and 24-hour report. It is hourly checks dated are was documentation at the complained her arm hurt in aides (MA's) to call member. In 11/17/23 at 1:30pm It is did MA for Resident #4 on the esident #4's arm was the sident #4's arm was the sident #4 having a fall or 4 had fallen. In that Resident #4 had right	D 438		
	-She did not complete Resident #4.	t #2 having right arm pain. e a skin assessment on the oncoming shift or to			

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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: _	A. BUILDING:		LEIED
					F	R-C
		HAL060166	B. WING		11/	20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
MICKELL	DE STEEL E CDEEK	13600 S T	TRYON ST			
WICKSHIP	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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 438	Continued From page	105	D 438			
	Resident #4's PCP at painShe did not call Resi	oout Resident #4's right arm dent #4's family because #4 told her not to call her				
	Attempted telephone on 11/17/23 at 3:46pr	interview with another MA n was unsuccessful.				
	dated 11/12/23 revea -Resident #4 presente -The family member v -Resident #4 had a rig fracture.	4's orthopedic visit note led: ed with right elbow pain. was unsure of a specific fall. ght nondisplaced radial neck ced in a posterior splint and				
	revealed that the facil	report to the Department of				
	(SCC) on 11/20/23 at -She worked as a MA #4's family member to orthopedic providerShe did not documer member took her out but should haveShe did not know Re elbow until the followi -She reported the inci 11/13/23She did not documer fractured elbow but sl -She documented on	non 11/12/23 when Resident book her to the urgent care int that Resident #4 family of the facility on 11/12/23 esident #4 had a fractured ing day. Ident to the Administrator on that Resident #4 had a				

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DIVISION	n Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					_	
			D MINIC		R-	
		HAL060166	B. WING		11/2	0/2023
NAME OF PE	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STA	TE ZIP CODE		
			RYON ST	,		
WICKSHIP	RE STEELE CREEK					
		CHARLO	TTE, NC 28278			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORT OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	NAIE	D/(IL
				,		
D 438	Continued From page	e 106	D 438			
	(D : 1 1 1 1	1. 12				
	of Resident #4's arm	•				
	-	with staff to make sure				
	-	y Care Provider (PCP) was				
	notified of her right ell	bow fracture.				
	-She did not followup	with staff to make sure				
	there was an incident	and accident report				
	completed for Reside	nt #4.				
	-She stated the MA sl	hould have notified Resident				
	#4's PCP of her right	elbow fracture and				
	completed an inciden					
		e an accident and incident				
	report for Resident #4					
		e incident to the Healthcare				
	-	HCPR) because this was the				
		Nurse responsibility to report				
	to the HCRP within 24					
	•	e Department of Social				
	Services.					
	•	for reviewing all 24-hour				
	_	including the weekend logs				
	that she reviewed eve	ery morning, Monday				
	through Friday.					
		sible for adding progress				
	note documentation if	f there was documentation				
		nour communication log.				
	-The MA was respons	sible for following up with the				
	PCP regarding Reside	ent #4's pain.				
	Telephone interview v	vith Resident #4's PCP on				
	11/17/23 at 4:02pm re					
	-She was unaware th					
	fractured elbow.					
		otify her or her practice that				
	-	plained of arm pain nor her				
	fractured elbow.	planted of arm pain flor flor				
	-She expected the fac	cility to notify her				
	mineuratery or any re	sident accident or incident.				
	interview with the Adr	ministrator on 11/20/23 at				

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4:38pm revealed:

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		COMI LETED	
		HAL060166	B. WING		R-C 11/20/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE STEELE CREEK	13600 S TI	RYON ST			
WICKSIIII	CE STEELE ONLER	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 438	Continued From page	e 107	D 438			
	of Resident #4's fract did not return to the farther and resident injury's of HCPR but if absent from responsible for report an investigation that to 24-hours of the incide days.	acility when she was notified ured elbow on 11/12/23 and acility until today (11/20/23). as responsible for reporting of unknown origin to the om the facility, the SCC was ing to the HCPR and begin was to be started within ent and completed within five				
	The facility failed to ensure an injury of unknown origin was reported to the HCPR for Resident #4 who sustained a fracture of her arm. This failure was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection on November 15, 2023 in accordance with G.S. 131D-34 for this violation.					
	CORRECTION DATE VIOLATION SHALL N 2023.	FOR THE TYPE B NOT EXCEED JANUARY 4,				
{D 451}	and Incidents 10A NCAC 13F .1212 Incidents (a) An adult care hor department of social sincident resulting in reaccident or incident reresident requiring references	_	{D 451}			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL060166	B. WING		R-C 11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE	•
WICKSHII	RE STEELE CREEK	13600 S T	RYON ST		
Wickerin	NE OTELLE ONLER	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 CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
{D 451}	This Rule is not met a Based on interviews a facility failed to notify of Social Services (DS of 5 sampled resident sustained an injury of resulted in a fracture of the finding are: Review of the facility's and Mobility Manager revealed: -Upon move in, with secondition, every 6 modevery fall episode, the resident to determine fallsThe Executive Direct Director will assure the responsible person or indicated on the Resident ror referral for emergenotification to be as set than 24 hours from tirk knowledge of the injuring the resident's fileShould a resident fall documentation of an account of the sident fall documentation of account of the sident fall documentation of account of the sident fall documentation of t	as evidenced by: and record reviews, the the local county Department SS) for incidents involving 1 s (Resident #4) who unknown origin that of her right arm. Incident Reports - Falls ment Policy dated 10/01/20 significant change in nths, annually and after e nurse will assess the their risk for falls or repeat or or Health Services e notification of a resident's contact person, as dent Register, of the any requiring medical treatment ncy medical evaluation, with con as possible but no later me of initial discover or ry by staff and documented	{D 451}	DEFICIENC!)	
	subsequent falls. Review of Resident # 09/22/23 revealed: -Diagnoses included / -Resident #4 was con	ent or reduce the risk of 44's current FL2 dated Alzheimer's dementia. stantly disoriented. f care was Special Care			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLETED
		HAL060166	B. WING		R-C 11/20/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	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 SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETE
{D 451}	Continued From page	e 109	{D 451}		
	bathing, and toiletingResident #4 was ableverbal cues. Review of Resident # revealed: -Resident #4 had a hibehaviorsResident #4 required resident #4 was indicated use of upper extremely report on 11/17/23 resubmit an Accident and total resident #4 report on 11/17/23 resubmit an Accident and total resident #4 report on 11/17/23 resubmit an Accident and resident #4 report on 11/17/23 resubmit an Accident and resident #4 report on 11/17/23 resubmit an Accident and resident #4 report on 11/17/23 resubmit an Accident and resident #4 report on 11/17/23 resubmit an Accident and resident #4 report on 11/17/23 resubmit an Accident and resident #4 report on 11/17/23 resubmit an Accident and resident #4 report on 11/17/23 resubmit an Accident and resident #4 report on 11/17/23 resubmit an Accident and resident #4 report on 11/17/23 resubmit an Accident and resident #4 report on 11/17/23 resubmit an Accident and resident #4 report on 11/17/23 resubmit an Accident and resident #4 report on 11/17/23 resubmit an Accident and resident #4 report on 11/17/23 resubmit an Accident and resident #4 report on 11/17/23 resubmit an Accident and resident #4 report on 11/17/23 resubmit and resident #4 report on	17/22 revealed: Istory of wandering It assistance with dressing, It is to feed self but required It is Care Plan dated 2/20/23 Istory of wandering It supervision with bathing. It is to be a supervision with a supervision w			
	Review of Resident # dated 11/12/23 revea -Resident #4 presente -The family member v-Resident #4 had a right fractureResident #4 was plangiven a sling. Interview with the Space (SCC) on 11/20/23 at -She worked as a MA #4's family member to orthopedic providerShe did not document	ed with right elbow pain. was unsure of a specific fall. ght nondisplaced radial neck ced in a posterior splint and ecial Care Coordinator			

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STATEMENT OF DEFICIENCIES ((X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR\	VEV
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	COMPLETED	
		A. DOILDING			
	HAL060166	B. WING		R-C 11/20/2	2023
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
	13600 S TF		•		
WICKSHIRE STEELE CREEK		TE, NC 28278			
(V4) ID SUMMARY STAT	EMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX (EACH DEFICIENCY I	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE 0	COMPLETE DATE
{D 451} Continued From page	110	{D 451}			
but should haveShe did not know Resielbow until the following. She reported the incid 11/13/23She documented on 1 Resident #4's family me. She did not document note that the resident he. She stated the MA show #4's PCP of her right elecompleted an incident afracture was reportedIt was her responsibilit sure Resident #4's PCI elbow fracture but she. It was her responsibilit make sure there was a report completed for Resident #4's PCI elbow fracture but she. She did not complete a report for Resident #4's PCI elbow fracture was a report completed for Resident #4's PCI elbow fracture was a report for Resident #4's PCI elbow fracture was a report for Resident #4's PCI elbow fracture was a report for Resident #4's PCI elbow fractured elbow elbow elbow elbow elbow elbow elbow elbowThe facility did not notice for the facility did not notice elbow elbow elbow elbow elbow elbowThe facility did not notice elbow elbow elbow elbow elbow elbow.	ident #4 had a fractured g day (11/13/23). ent to the Administrator on 1/13/23 she spoke with ember. in Resident #4's progress has a fractured elbow. Ould have notified Resident elbow fracture and and accident report when the ty to followup with to make P was notified of her right did not. The ty to followup with staff to note incident and accident esident #4 but she did not. In an accident and incident entil 11/16/23. Department of Social for reviewing all 24-hour following the weekend logs by morning, Monday The Resident #4's Primary in 11/17/23 at 4:02pm The Resident #4 had a sify her or her practice that lained of arm pain nor her				

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Interview with the Administrator on 11/20/23 at

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED		
					R-C	
		HAL060166	B. WING		11/20/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE STEELE CREEK	13600 S TF	RYON ST			
Wiokoiiii	CE OTELLE ORLER	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 APPROPF DEFICIENCY)	BE COMPLETE	
{D 451}	Continued From page	e 111	{D 451}			
{D 459}	elbow on 11/12/23She was not aware t an accident and incid 11/16/23The SCC was respond accident and incident responsible for notifying ServicesShe was not aware to Department of Social -She expected the SC and Incident reports a of Social Services.	reports and was ing the Department of Social he SCC did not notify the Services. CC to complete all Accident and to notify the Department	{D 459}			
(1) 400)	and Incident reports and to notify the Department of Social Services. 10A NCAC 13F .1302 Special Care Unit Disclosure 10A NCAC 13F .1302 Special Care Unit Disclosure (a) Only those facilities with units that meet the requirements of this Section may advertise, market or otherwise promote themselves as providing special care units for persons with Alzheimer's Disease or related disorders. (b) The facility shall disclose information about the special care unit according to G.S. 131D-8 and which addresses policies and procedures listed in Rule .1305 of this Section This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to disclose the form of care and treatment provided for residents in the Special Care Unit (SCU) for 3 of 3 residents (Residents		[5 400]			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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HAL060166		B. WING		11/20/2023		
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STA	TE, ZIP CODE		
WICKSHIF	RE STEELE CREEK		TRYON ST			
	CLIMMADY CT		OTTE, NC 28278	PROVIDENCE PLANTOS CORRECTION		
(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 459}	Continued From page	e 112	{D 459}			
	The findings are:					
	1.Review of Resident 02/13/23 revealed:	#1's current FL2 dated				
	-Diagnoses included Dementia.	ate onset Alzheimer's				
	-Resident #1's level o Unit (SCU).	f care was Special Care				
	Review of Resident # revealed an admission	1's Resident Register n date of 12/10/20.				
		1's record on 11/14/23 ot a signed SCU disclosure				
	Refer to interview with Manager (BOM) on 1					
	Refer to interview with Coordinator (SCC) or					
	Refer to interview with 11/20/23 at 4:38.	n the Administrator on				
	09/22/23 revealed:	t #4's current FL2 dated Alzheimer's dementia. f care was SCU.				
	Review of Resident # revealed an admissio	4's Resident Register n date of 07/26/21.				
		4's record on 11/15/23 ot a signed SCU disclosure				
	Telephone interview v	vith Resident #4's family				

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member on 11/15/23 at 11:52am revealed she did

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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		HAL060166	B. WING		R-C 11/20/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE STEELE CREEK	13600 S TI	RYON ST TE, NC 28278			
	CHMMADY CT		T .	DDOWDEDIS DI AN OF CODDECTIO	N	
(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 459}	Continued From page	e 113	{D 459}			
	given to her but did no	mission paperwork that was ot recall if the disclosure the admission paperwork.				
	Refer to interview with 10:48am.	n the BOM on 11/20/23 at				
	Refer to interview with 1:20pm.	n the SCC on 11/20/23 at				
	Refer to interview with 11/20/23 at 4:38.	n the Administrator on				
	04/21/23 revealed:					
	Review of Resident # revealed an admissio	-				
		5's record on 11/14/23 ot a signed SCU disclosure				
	member on 11/16/23 remember signing ad	vith Resident #5's family at 3:47pm revealed she did mission paperwork but was fically signed a resident				
	Refer to interview with 10:48am.	n the BOM on 11/20/23 at				
	Refer to interview with 1:20pm.	n the SCC on 11/20/23 at				
	Refer to interview with 11/20/23 at 4:38.	n the Administrator on				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE S COMPLI	
			7 50.25 10.		R-	С
		HAL060166	B. WING		11/2	0/2023
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIR	RE STEELE CREEK		RYON 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 SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 459}	Continued From page	: 114	{D 459}			
	revealed: -She was responsible on the SCU Disclosur admission processShe complied the adincluded the SCU Disthe admission packet resident's recordThere were not any robtain the SCU Disclosure with the SCU Disclosure with the SCU revealed: -She was hired about not any new admission-She had not complete	new admissions for her to osure Statements. C on 11/20/23 at 1:20pm 30 days ago and there were				
{D 468}	Interview with the Administrator on 11/20/23 at 4:38 revealed: -The SCC was responsible for auditing the resident's record in the SCU to make sure the Disclosure Statements were there and signedShe was not aware the audit was not completedThe BOM was responsible for ensuring the SCU disclosure was reviewed and signed upon admission to the SCU.		{D 468}			
	Orientation And Train	_				
		re that special care unit staff llowing orientation and				

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	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
		HAL060166	B. WING		R- 11/2	C 0/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
MICKSHII	RE STEELE CREEK	13600 S	TRYON ST			
WIOROIII	NE OTELLE ONLLN	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 468}	Continued From page	2 115	{D 468}			
	training: (1) Prior to establish administrator shall do 20 hours of training siple served for each spoperated. The administration of the start identifies content, text schedules regarding to the training and content to the tra	ing a special care unit, the cument receipt of at least pecific to the population to be decial care unit to be istrator shall have in place a ff assigned to the unit that its, sources, evaluations and training achievement. Heek of employment, each of perform duties in the late complete six hours of the late and supervision of the late and the six hours of the late and the previous Type bated. Let a so for the late and heeds for the late and needs for the late and needs for the late and needs for the late and care unit (SCU) within				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CONNECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMI LETED	
		HAL060166	B. WING		R-C 11/20/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, 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 APPROPRIED TO THE APPROPRIED TO THE APPROPRIED CONTROL OF THE APPROPRIED CONTROL OF THE APPROPRIED CONTROL OF THE APPROPRIED CONTROL OF T	BE COMPLETE	
{D 468}	Continued From page	e 116	{D 468}			
	01/01/23 revealed the	s current license dated e facility was licensed as an a SCU with a capacity of 48				
	_	s current census tracking log nsus on 11/14/23 was 40				
	1. Review of Staff D's medication aide (MA) personnel record revealed: -Staff D's hire date was 08/19/23There was no documentation of a 6-hour orientation on the nature and needs of the SCU residents for Staff D.					
	11/12/23 revealed Sta 10/29/23, 10/30/23, 1	chedule for 10/27/23 through aff D worked in the SCU on 0/31/23, 11/01/23, 11/02/23, 1/06/23, 11/07/23, and				
	2:15pm revealed: -She was employed the she had been working MA since August 202: -Since she started wo not received any train	orking at the facility, she had				
	Refer to interview with Coordinator (RCC) or Refer to interview with Manager (BOM) on 1	n 11/20/23 at 12:33pm. In the Business Office				
	Refer to interview with Nurse on 11/20/23 at	h the facility's Compliance 3:33pm.				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
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		LIAL OCOACC	B. WING		R-		
		HAL060166	1 5		11/2	0/2023	
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE			
		13600 S T					
WICKSHIF	RE STEELE CREEK		TE, NC 28278				
			TE, NC 20270	T			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE	
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IAG		,	1/40	DEFICIENCY)			
{D 468}	Continued From page	e 117	{D 468}				
	Defer to intensions with	h the Administrator on					
		n the Administrator on					
	11/20/23 at 4:40pm.						
	O Davious of Otoff Cla	MA paraappal reserve					
	2. Review of Staff E's	MA personnel record					
	revealed:	40/47/00					
	-Staff E's hire date wa						
	-There was no docum						
		ure and needs of the SCU					
	residents for Staff E.						
		ee schedule for 10/27/23					
	through 11/12/23 reve	ealed Staff E worked in the					
	SCU on 11/01/23, 11/	03/23, 11/04/23, 11/05/23,					
	11/08/23, and 11/09/2	23.					
	Interview with Staff E	on 11/16/23 at 11:10am					
	revealed:						
	-She was employed the	hrough the facility's					
	contracted staffing ag						
		ng at the facility as a MA					
	since October 2023.	,					
		y scheduled to work in the					
	SCU.	,					
		s scheduled to work in the					
	SCU.						
		orking at the facility, she had					
	not received any train						
	_	needs of the SCU residents.					
	-She had to ask the fa						
		ts in the SCU, because she					
	did not know the resid	ienis.					
	Defends intensions 10	h the DOC on 44/00/00 -t					
		h the RCC on 11/20/23 at					
	12:33pm.						
		h the BOM on 11/20/23 at					
	10:46am.						
			1				

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Refer to interview with the facility's Compliance

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
	HAL060166		B. WING		R-C 11/20/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE STEELE CREEK	13600 S TR				
		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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
{D 468}	Continued From page	e 118	{D 468}			
	Nurse on 11/20/23 at	3:33pm.				
	Refer to interview with 11/20/23 at 4:40pm.	n the Administrator on				
	3. Review of Staff F's revealed: -Staff F's hire date wa-There was no docum orientation on the nat residents for Staff F.	as 10/24/23.				
	Review of the employee schedule for 10/27/23 through 11/12/23 revealed Staff F worked in the SCU on 10/31/23, 11/03/23, 11/10/23, and 11/12/23.					
	2:00pm revealed: -She was employed be staffing agencyShe had been working since October 2023She was frequently stage.	<u> </u>				
	staffing agency ownerevealed: -The facility had contragency to provide statement of the facility was responded as a statement of the facility was responded by the facility was responded	vith the facility's contracted r on 11/16/23 at 11:40am racted with the staffing ff for the facility's SCU. onsible for providing any the staffing agency staff d to work in the facility. facility a complimentary station for each staffing				

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STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		HAL060166	B. WING		11/20/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MICKELII	RE STEELE CREEK	13600 S T	RYON ST			
WICKSHII	CE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
{D 468}	Continued From page	e 119	{D 468}			
	agency staff prior to e SCU. -The facility never recorientation opportunit -Between August 202 numerous staffing agescheduled to work in expressed concern for residents. Interview with the RC revealed: -He was responsible to the SCUHe was not responsi requirements for stafficompliance Nurse we agency staffThe Administrator was	each staff's first shift in the guested the staffing agency y. 3 and November 2023, ency staff which were the facility's SCU had or a lack of orientation to the C on 11/20/23 at 12:33pm to schedule staff to work in ble for any training for agency and the facility's ere responsible for training as responsible to keep				
	-The Administrator was responsible to keep agency staff personnel records. Interview with the BOM on 11/20/23 at 10:46am revealed: -She was not aware staff scheduled to work in the SCU required a minimum of 6 hours of facility specific orientation, on the nature and needs for the residents of the SCU, within the first week of employmentThe Administrator made her aware of the 6 hour SCU training requirements within the past weekThe facility's Compliance Nurse was responsible for all staff training requirementsShe kept training sign-in sheets in a binder for facility staff trainingIndividual staff training certificates were the responsibility of the trainer and should be kept in personnel recordsShe was responsible for auditing facility staff training records weekly.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED							
			A. BUILDING:									
			B. WING	B WING		R-C						
		HAL060166	B. WING		11/20	/2023						
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
WICKSHIRE STEELE CREEK 13600 S TRYON ST												
WICKSHII	NE STEELE GREEK	CHARLO	TTE, NC 28278									
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)						
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IAG			IAG	DEFICIENCY)								
(D 460)	0	100	{D 468}									
{D 468}	Continued From page	÷ 120	{D 400}									
		taffing agency staff since										
	August 2023.											
	-She did not maintain	or audit agency staff										
	training records.											
	Intervious with the fee	ilitula Camplianaa Nuraa an										
	11/20/23 at 3:33pm re	ility's Compliance Nurse on										
	-She was responsible to provide training for staffThe BOM was responsible for notifying her of any staff requiring training.											
	-She was not aware of the 6 hours of orientation on the nature and needs of the residents of the SCU for staff scheduled to work in the SCU. -She had not provided any training to staff related											
	to the 6 hours of orientation to SCU residents.											
	Interview with the Administrator on 11/20/23 at											
	4:40pm revealed: -The BOM was responsible to audit facility staff training recordsThe BOM was responsible for notifying the											
		Nurse of any training needs.										
		nintain staff training records										
	for staffing agency sta											
		taffing agency staff since										
	August 2023.	5 5 7										
	-Staff D was frequent	ly scheduled to work in the										
	SCU.											
	-She was not familiar	with Staff E or Staff F's										
	schedules.											
	-She was aware staff											
	•	nimum of 6 hours of SCU										
		first week of employment.										
	-	looked auditing of staffing										
	agency staff training i											
minimum of 6 hours of orientation on the nature and needs for the residents of the SCU within the first week of employment.												

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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		R-C 11/20/2023						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
WICKSHIRE STEELE CREEK 13600 S TRYON ST CHARLOTTE, 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	(X5) COMPLETE DATE					
{D 468}	The facility failed to e completed 6 hours of nature and needs for within the first week of staff being unable to be needed to care for rediagnoses of Alzheim dementia with behavistaff had not received orientation and care ror there was a lack of regarding the SCU refacility staff to help vis because agency staff. The facility's failure was a safety, and well-being constitutes a Type Ur. The facility provided a accordance with G.S. this violation.	nsure 3 of 6 sampled staff orientation training on the the residents of a SCU of employment, resulting in have the basic knowledge sidents in the SCU with a er's dementia and vascular oral disturbances. Agency I any SCU training related to needs of the SCU residents, forientation provided sidents, agency staff asked sually verify residents, as detrimental to the health, ag of the residents, which habated B Violation.	{D 468}								

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