AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL047015	B. WING		12/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE	
WICKSHI	RE CREEKS CROSSING	8398 FA	YETTEVILLE R	DAD	
	-	RAEFO	RD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLET
(D 000)	Initial Comments		{D 000}		
	County Department	nsure Section and the Hoke of Social Services conducted ecember 20-21, 2023.			
{D 358}	10A NCAC 13F .100 Administration	4(a) Medication	{D 358}		
	(a) An adult care ho preparation and adm prescription and non-by staff are in accord (1) orders by a licen which are maintained (2) rules in this Sect and procedures.  This Rule is not met TYPE B VIOLATION  Based on observation reviews, the facility fawere administered as (#6) observed during including errors with health/mood disorder and social anxiety disdeficiency (#6) and for (#3, #6) who did not rem antiblotic medical infection (#3) and whomedications used to fanxiety disorders and (#6).  The findings are:	sed prescribing practitioner in the resident's record; and ion and the facility's policies as evidenced by:  Ins., interviews, and record alled to ensure medications is ordered for 1 of 4 residents the medication pass medications to treat mental irs., to treat major depressive sorders and vitamin or 2 of 6 sampled residents receive a prophylactic long atton given to prevent bone or did not receive treat depression and social is sleep disorder as ordered is medication administration.		The community completed a thou audit of each carliving and Memory and memory as missing were to the RCC/MCC/C who gave instruct obtaining the medications and we to obtain the medications and we to obtain the medications and we to obtain the medications and orders to obtain Every effort was obtain any and all in progress notes we	dentified reported reported resignee 12/22 ions on cation in the RCC/MCC/DCsign D. PCP and missing worked 12/22 ation and made to missing and documented

НМІН13

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE: COMPI	.ETED
65,152		HAL047015	B. WING			₹ 21/2023
	ROVIDER OR SUPPLIER	0000 #4	ADDRESS, CITY, S			172420
			RD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIE!	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC 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 358}	preparation and add prescription and no by associates were prescribing practition the residence recomprepared by associate qualifications to do: —Medications were the residents within 1 herescribed or schedents within 1 herescribed or schedents administration administration administration of an resident (Pre-charting administration of an resident (Pre-charting assured implementation of prescribed professional and resident administration of the phealthcare professional and resident	policy to assure that the ministration of medications, inprescription, and treatments ordered by a licensed mer which were maintained in d and administered and ates who met the so. The properties of the purpose of th	{D 358}	attempts and outer efforts.  The RCC/MCC/LE reviewed and doc efforts to obtain daily to ensure the are not without on the ED/Designee. Cart audits to en proactive plan was to obtain any madications.  The community we complete weekly to assure that the and administration prescription and no and treatments in accordance with or prescribing practition are maintained in trecords.  Those cart audits	umented a medication of resident nedication review weeks initiated dications number and of medications preparation of medications by staffare ders by a loner which the resident	12/22/22/22/22/22/22/22/22/22/22/22/22/2

STATEMEN	OT HEALTH SERVICE REQ IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED  R 12/21/2023
	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST YETTEVILLE RO		12/21/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YY 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)	09/22/23 revealed: -Diagnoses included kidney disease stage of insomnia, and atria-There was an order treat certain mental/r for mood.  Observation of the 8: 12/21/23 revealed: -The medication aide medications for Resider RisperdalThe MA documenter medication administr Risperdal was not avobservation of Resident on 12/12/23 at no Risperdal 0.5mg (mental/mood disorder administration.  Review of Resident frevealed: -There was an entry daily for mood schedd-Risperdal 0.5mg was administered at 8:00: -The reason listed for administered was donurses notes) from 1:  Review of Resident from 1:	Alzheimer's disease, chronic 3, history of anxiety, history al fibrillation. for Risperdal 0.5mg (used to mood disorders) give 1 daily  00am medication pass on  (MA) prepared morning dent #6 which did not include don't he electronic ation record (eMAR) that ailable for administration.  Jent #6's medications on 2:12pm revealed there was used to treat certain ars) on hand for  66's December 2023 eMAR  for Risperdal 0.5mg to give 1 alled at 8:00am. Sign documented as not being am from 12/17/23 - 12/21/23.  Risperdal not being cumented as 09 (other/see 2/17/23 - 12/21/23.  66's December 2023 nurses 12/21/23 revealed: erdal not being administered umented as awaiting meds. erdal not being administered 23 and 12/21/23 was	{D 358}	Lead Med-Tech   Designed those findings are parties of following up on any identified from a during audit. If any issues require a missing media be ordered or obtain ED   PCP   family will be to obtain an order or whichever is needed. The RCC/MCC/Lead in Designee will review   Call efforts to obtain a order daily to ensure are not without medical to that a proactive plan initiated to obtain an orders missing.	trech responsible issues the cort conse that ication to ed, the 24424 medication and Tech 24424 that residents itions.

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R HAL047015 B. WING 12/21/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) {D 358} Continued From page 3 {D 358} Review of the 24-hour shift report book revealed documentation dated 12/20/23: -The first shift remarks report for Resident #6 documented "Behaviors" with no other documentation. -The second shift remarks report for Resident #6 documented "check report for Resident's name" with no other documentation. -The third shift documented Resident #6 was "out of her regular medication and pharmacy was contacted" with no other documentation. -The assigned MAs signed the entries for the date 12/20/23. Review of Resident #6's December 2023 nurses notes dated 12/03/23 revealed: -There was documentation that Resident #6 was aggressive towards the staff when assisting with personal care and transfer. -There was documentation that Resident #6 screamed out and attempted to hit staff when redirection was attempted. Telephone interview a pharmacist at the facility's contracted pharmacy on 12/12/23 at 4:37pm revealed: -A 30-day supply of Risperdal 0.5mg was dispensed on 11/08/23 for Resident #6. -The effects of missing the number of combined doses of Risperdal, along with her other 2 medications that were used for major depressive disorder and social anxiety disorder could cause a more confused mental status; it could cause her dementia to be heightened. Interview with the Executive Director on 12/21/23 at 2:10pm revealed: -She was not sure why the cart audit did not reveal the missing meds for Resident #6.

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RIVLEMEN	of Health Service Reg	(X1) PROVIDER/SUPPLIER/CLIA	T ago		r.	RM APPROVE
JUND HEVI	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DAT	E SURVEY
		HAL047015	B. WING			R
IAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E. ZIP CODE		2/21/2023
ЛСКЅН	RE CREEKS CROSSING	8398 FA	YETTEVILLE ROAD			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 358}	Continued From page	ө 4	{D 358}		***	
	-She thought there "r	may be too many hands in				
	tne cookie jar" meani	ing too many staff (MAs				
	thing (reordering med	pected to be doing the same				
Î	Refer to interview with	h a personal care aide				
	(PCA) on 12/21/23 at	a personal care aide 3:40pm.				
	Refer to interview with 12/21/23 at 3:35pm.	h a medication aide (MA) on				
	Refer to interview with (MA) on 12/20/23 at 3	n a second medication aide :31pm.				
	Refer to interview with Coordinator (RCC) on	the Resident Care 12/21/23 at 2:45pm.				
	Refer to interview with 12/21/23 at 2:10pm.	the Executive Director on				
10	09/22/23 revealed ther	#6's current FL-2 dated re was an order for Zoloft come types of depression				
a	and social anxiety diso	order) give 1 daily for mood.				
1	Observation of the 8:00 2/21/23 revealed:	Dam medication pass on				
n	The medication aide (I	MA) prepared morning int #6 which did not include				
-	The MA documented o	on the electronic			ļ	
l II	nedication administrati	On record (eMAR) that				
Z	oloft was not available	for administration.				
0	bservation of Residen	t #6's medications on				1
j ha	and on 12/21/23 at 2:1 Dizeloft 100mg on han	2pm revealed there was				
R	eview of Resident #6's vealed:	December 2023 eMAR				

STATEMEN	of Health Service Red TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) 48 (T2P) = -	201/201/201			
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		HAL047015	B. WING		1	R 12/21/2023	
IAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE			
MCVeur	7E 0055/0 0000000	339	YETTEVILLE ROAL				
	RE CREEKS CROSSING		RD, NC 28376				
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	PECTION		
PREFIX TAG	(EACH DEFICIEN REGULATORY OF	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLET DATE	
(D 358)	Continued From pag	ge 5	{D 358}				
	-There was an entry	for Zoloft 100mg give 1 daily	1			ĺ	
- 1	for mood scheduled	at 8:00am.					
		locumented as not being					
ĺ	administered at 8:00	oam from 12/07/23, 12/08/23,					
	12/10/23 -12/13/23,	and 12/15/23 - 12/21/23.				1	
1	-The reason listed for	or Zoloft not being					
	administered was do	ocumented as 09 (other/see				ļ	
a.a.	nurses notes) from 1	2/07/23, 12/08/23, 12/10/23				İ	
×	-12/13/23, and 12/15	5/23 - 12/21/23.					
İ		#6's December 2023 nurses					
	notes for 12/07/23, 1	2/08/23, 12/10/23 -12/13/23,				1	
	and 12/15/23 - 12/21						
	-The reason for Zolo	ft not being administered on					
	to deliver.	ented as waiting pharmacy					
		ft mat haling a desirable of the					
	12/20/23 was doors	ft not being administered on ented as awaiting meds.					
J	-The reason for Zolol	ft not being administered on					
	12/15/23 - 12/19/23 v	was documented as on					
	order.	ndo documented as off					
1		ft not being administered on					
	12/11/23 - 12/13/23 v	vas documented as on order.				İ	
	-The reason for Zolof	ft not being administered on					
	12/10/23 was docume	ented as N/A (not available).					
	-The reason for Zolof	ft not being administered on					
	12/08/23 was docume	ented as awaiting meds.					
1	<ul> <li>The reason for Zolof</li> </ul>	t not being administered on					
	12/07/23 was docume	ented as meds not on cart.					
	Review of the 24-hou	r shift report book revealed					
	documentation dated		1				
		s report for Resident #6					
	documented "Behavio documentation.	ors" with no other					
		narks report for Resident #6					
	documented "check e	eport for Resident's name*					
	with no other docume	entation					
	The third shift docum	nented Resident #6 was "out					
1	of her regular medical	tion and pharmacy was				i	

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D PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DAT	TE SURVEY	
			A. BUILDING:			PLETED	
		HAL047015	B. WING		4-	R #2/04/0000	
E OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE		2/21/2023	
KSHII	RE CREEKS CROSSING	8398 FA	YETTEVILLE ROAD				
4) ID	Others		RD, NC 28376				
EFIX AG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE	
358}	Continued From pag	ge 6	{D 358}				
	contacted" with no o	ther documentation					
	-The assigned MAs:	signed the entries for the					
	date 12/20/23.						
	Review of Resident a	#6's December 2023 nurses					
	notes dated 12/03/23	B revealed:					
	-There was documer	ntation that Resident #6 was					
	aggressive towards t	he staff when assisting with					
	personal care and transfer.  There was documentation that Resident #6						
1	Screamed out and att	itation that Resident #6 tempted to hit staff when					
	redirection was atter	ipted.					
-	racility's contracted pl 4:37pm revealed: -A 30-day supply of Z on 10/26/23 for Resid -The effects of missin	g the number of combined					
10	loses of Zoloft, along	with her other 2					
Ċ	liedications that were	used for mental/mood epressive disorder could	1				
0	ause a more confuse	ed mental status: it could					
c	ause her dementia to	be heightened.					
ii	nterview with the Exe t 2:10pm revealed:	cutive Director on 12/21/23			*		
	She was not sure why	the cart audit did not					
LE	eveal the missing med	ds for Resident #6			ł		
-S	She thought there "ma	av be too many hands in			ļ		
R	ie cookie jar" meanin .CC. MCD) were ever	g too many staff (MAs, ected to be doing the same					
th	ing (reordering meds	).					
R (F	efer to interview with PCA) on 12/21/23 at 3	a personal care aide :40pm.					
Re 12	efer to interview with a 2/21/23 at 3:35pm.	a medication aide (MA) on					

Division	of Health Service Rec	ulation			FORM APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL047015	B. WING		R 12/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE	
Mickelin	RE CREEKS CROSSING	9200 EA	YETTEVILLE ROAL		
WICKSHI	RE CREEKS CROSSING		RD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OULD BE COMPLETE
{D 358}	Continued From pag	je 7	{D 358}		
	Refer to interview wi (MA) on 12/20/23 at	th a second medication aide 3:31pm.			
		th the Resident Care on 12/21/23 at 2:45pm.			
	Refer to interview w 12/21/23 at 2:10pm.	ith the Executive Director on			
	09/22/23 revealed th	nt #6's current FL-2 dated ere was an order for Vitamin a dietary supplement for give 1 tablet daily.			
	Observation of the 8: 12/21/23 revealed:	00am medication pass on			
		(MA) prepared morning dent #6 which did not include			
	-The MA documented medication administra Vitamin D was not av	d on the electronic ation record (eMAR) that ailable for administration.			
	hand on 12/21/23 at 2	ent #6's medications on 2:12pm revealed there was on hand for administration.			
	revealed:	6's December 2023 eMAR			
ĺ	tablet daily scheduled				
	12/10/23 -12/13/23, a	m from 12/06/23-12/08/23, rid 12/15/23 - 12/21/23.			
	administered was doo nurses notes) from 12	Vitamin D3 not being cumented as 09 (other/see 2/06/23-12/08/23, ad 12/15/23-12/21/23.			
		6's December 2023 nurses			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		HAL047015	B. WING		1:	2/21/2023
	ROVIDER OR SUPPLIER	8398 F	ADDRESS, CITY, STATI AYETTEVILLE ROAI ORD, NC 28376			
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFIGIENCY)	SHOULD BE	(X5) COMPLETE DATE
	notes for 12/06/23-12 and 12/15/23 -12/21/ -The reason for Vitan administered on 12/2 waiting pharmacy to a street on 12/2 awaiting medsThe reason for Vitan administered on 12/1 documented as on or -The reason for Vitan administered on 12/1 N/A (not available)The reason for Vitan administered on 12/1 documented as on or -The reason for Vitan administered on 12/1 documented as on or -The reason for Vitan administered on 12/1 N/A (not available)The reason for Vitan administered on 12/0 awaiting medsThe reason for Vitan administered on 12/0 meds not on cartThe reason for Vitan administered on 12/0 meds not on cartThe reason for Vitan administered on 12/0 meds not on cartThe reason for Vitan administered on 12/0 meds not on cartThe reason for Vitan administered on 12/0 meds not on cartThe reason for Vitan administered on 12/0 meds not on cartThe reason for Vitan administered on 12/0 meds not on cartThe reason for Vitan administered on 12/0 meds not on cartThe reason for Vitan administered on 12/0 meds not on cartThe reason for Vitan administered on 12/0 meds not on cartThe reason for Vitan administered on 12/0 meds not on cartThe reason for Vitan administered on 12/0 meds not on cartThe reason for Vitan administered on 12/0 meds not on cartThe reason for Vitan administered on 12/0 meds not on cartThe reason for Vitan administered on 12/0 meds not on cartThe reason for Vitan administered on 12/0 meds not on cart.	2/08/23, 12/10/23-12/13/23, 23 revealed: nin D3 not being 1/23 was documented as deliver. nin D3 not being 0/23 was documented as nin D3 not being 5/23-12/19/23 was documented as nin D3 not being 3/23 was documented as nin D3 not being 1/23-12/12/23 was documented as nin D3 not being 1/23-12/12/23 was documented as nin D3 not being 1/23 was documented as nin D3 no	{D 358}			

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	IT OF DEFICIENCIES OF CORRECTION	ON IDENTIFICATION NUMBER:  A. BUILDING:			1	E SURVEY  MPLETED
		HAL047015	B. WING		1.	2/21/2023
WICKSHI	ROVIDER OR SUPPLIER	G 8398 FA RAEFO	ADDRESS, CITY, STATE AYETTEVILLE ROAI RD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(XS) COMPLETE DATE
(D 358)	Continued From pa	ge 9	{D 358}			
	(MA) on 12/20/23 a	3:31om				
	Refer to interview w	ith the Resident Care on 12/21/23 at 2:45pm.				
	Refer to interview v 12/21/23 at 2:10pm.	vith the Executive Director on				
	09/22/23 revealed: -Diagnoses included kidney disease stage	nt #6's current FL-2 dated  Alzheimer's disease, chronic e 3, history of anxiety, history				
- Period - Inches	of insomnia, and atri -There was an order to treat major depres bedtime for sleep.	al ilbrillation. for Trazodone 100mg (used ssive disorder) give 1 at				
	hand on 12/21/23 at	dent #6's medications on 2:12pm revealed there was nd for administration.				
1	revealed:	#6's December 2023 eMAR				
196-197-19	at bedtime for sleep : -Trazodone was doct administered at 8:00 -The reason listed for	for Trazodone 100mg give 1 scheduled at 8:00pm. Umented as not being pm from 12/10/23 -12/20/23. Trazodone not being cumented as 09 (other/see 2/10/23 -12/20/23.				
1   -   8   7   7	notes for 12/10/23 -12 -The reason for Trazca administered on 12/20 medication isn't availa pharmacy name' at 5 43 minutes to no availa -The reason for Trazca	odone not being 0/23 was documented as able' attempted to call :15pm and was on hold for I will try again tomorrow".				

Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE O  A. BUILDING:  B. WING		COM	E SURVEY PLETED R
		HAL047015	D. \$1114G		12	2/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
WICKSHII	RE CREEKS CROSSING		YETTEVILLE ROAI RD, NC 28376	)		
040.15	CHANADY		ND, NC 20376			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  THE MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
{D 358}	Continued From pag	e 10	{D 358}			
	awaiting meds.					
	-The reason for Traze	odone not heina				
	administered on 12/1					
	documented as N/A					
	-The reason for Traz		,			
	administered on 12/1	6/23 was documented as				
	'medication isn't avai					
	-The reason for Traze					
		5/23 was documented as	1			
	N/A (not available).					
	-The reason for Traze					
		4/23 was documented as				
	'medication isn't avail -The reason for Traze					
100		3/23 was documented as				
1	N/A (not available).	3/23 was documented as				
f		n documented for Trazodone	1			
		ed on 12/11/23 and 12/12/23.				
	-The reason for Traze					
	administered on 12/1	0/23 was documented as				
	medication ordered.					
		r shift report book revealed				
	documentation dated					1
		s report for Resident #6				
	documented *Behavio	ors" with no other				
	documentation.	and a second for the second				
		narks report for Resident #6				
	with no other docume	eport for Resident's name"				
		nented Resident #6 was "out	] .			
		tion and pharmacy was				
	contacted" with no oth	ner documentation				
		gned the entries for the				
	date 12/20/23.					
	Review of Resident #	6's December 2023 nurses				
	notes dated 12/03/23	revealed:				
	-There was document	ation that Resident #6 was				
	aggressive towards th	e staff when assisting with				] [

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R HAL047015 B. WING 12/21/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE 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 TAG DATE **DEFICIENCY** {D 358} Continued From page 11 {D 358} personal care and transfer. -There was documentation that Resident #6 screamed out and attempted to hit staff when redirection was attempted. Telephone interview with the pharmacist at the facility's contracted pharmacy on 12/21/23 at 4:37pm revealed -A 30-day supply of Trazodone 100mg was dispensed on 11/08/23 for Resident #6. -The effects of missing the number of combined doses of Trazodone, along with her other 2 medications that were used for mental/mood disorders and social anxiety disorder could cause a more confused mental status; it could cause her dementia to be heightened. Interview with the Executive Director on 12/21/23 at 2:10pm revealed: -She was not sure why the cart audit did not reveal the missing meds for Resident #6. -She thought there "may be too many hands in the cookie jar" meaning too many staff (MAs, RCC, MCD) were expected to be doing the same thing (reordering meds). Refer to interview with a personal care aide (PCA) on 12/21/23 at 3:40pm. Refer to interview with a medication aide (MA) on 12/21/23 at 3:35pm. Refer to interview with the medication aide (MA) on 12/20/23 at 3:31pm, Refer to interview with the Resident Care Coordinator (RCC) on 12/21/23 at 2:45pm. Refer to interview with the Executive Director on 12/21/23 at 2:10pm.

Divisio	n of Health Service Re	gulation			FOR	RM APPROVED
STATEM	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION		E SURVEY PLETED
		HAL047015	B. WING		12	R 2/21/2023
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{D 358	Continued From pa	ge 12	{D 358}			
	09/22/23 revealed: -Diagnoses included kidney disease stag of insomnia, and attract here was an order for treat sleeplessness/bedtime for insomnia.  Observation of Resishand on 12/21/23 at no Melatonin 3mg of Review of Resident: revealed: -There was an entry tablet at bedtime for 8:00pmMelatonin 3mg give insomnia was documadministered at 8:00 and 12/09/23-12/20/2The reason listed for administered was donurses notes) from 1 12/09/23-12/20/23.  Review of Resident # notes for 12/01/23-12 12/09/23-12/20/23 re-There was no reason 3mg not being admin 12/20/23The reason for Melaton 12/18/23 was docton 12/17/23 was do	or Melatonin 3mg (used to finsomnia) give 1 tablet at a.  dent #6's medications on 2:12pm revealed there was in hand for administration.  #6's December 2023 eMAR  for Melatonin 3mg give 1 insomnia scheduled at  1 tablet at bedtime for mented as not being pm from 12/01/23-12/07/23 and  r Melatonin 3mg not being cumented as 09 (other/see 2/01/23-12/07/23 and  #6's December 2023 nurses 2/07/23 and vealed: In documented for Melatonin istered on 12/19/23 and  tonin not being administered umented as not available, tonin not being administered tonin not being administered				

	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE O		(X3) DATE SURVEY COMPLETED
		HAL047015	B. WING		12/21/2023
	F PROVIDER OR SUPPLIER HIRE CREEKS CROSSING	8398 FA	ADDRESS, CITY, STATE YETTEVILLE ROAL RD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
{D 35	on 12/16/23 was dod available'.  -The reason for Mela on 12/15/23 was dod available).  -The reason for Mela on 12/14/23 was dod available.  -The reason for Mela on 12/13/23 was dod available).  -The reason for Mela on 12/12/23 was dod available'.  -Ther ewas no entry 12/11/23 for the reason for Mela on 12/10/23 was dod ordered.  -The reason for Mela on 12/06/23 and 12/0 N/A (not available).  -The reason for Mela on 12/05/23 was dod provider.  -The reason for Mela on 12/05/23 was dod provider.  -The reason for Mela on 12/05/23 was dod provider.  -The reason for Mela on 12/01/23 was dod waiting on provider.  Based on observation review, it was determined interviewable.  Attempted telephone	cumented as 'medication isn't atonin not being administered cumented as N/A (not atonin not being administered cumented as medication not atonin not being administered cumented as N/A (not atonin not being administered cumented as 'medication isn't con the nurses notes on on the Melatonin was not atonin not being administered cumented as medication successful tonin not being administered cumented as medication atonin not being administered cumented as waiting on tonin not being administered cumented as waiting on tonin not being administered cumented as waiting on tonin not being administered cumented as out of refills, ans, interviews, and record ined that Resident #6 was interview with Resident #6's 12/21/23 at 3:10pm was	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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WICKSHI	PROVIDER OR SUPPLIER RE CREEKS CROSSIN	G 8398 FA	ADDRESS, CITY, STATI LYETTEVILLE ROAI RD, NC 28376			
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{D 358}			{D 358}			
	care aide (PCA) rev -Resident #6 had be than usual; she had month (December).	een worse as she fought more tried to hit and punch this ember, she would just talk as				
	Interview with a second medication aide (MA) on 12/21/23 at 3:35pm revealed: -He had worked at the facility for two weeksHe described Resident #6 as feisty because she got loud and tried to hit and pinch staff when being assisted with personal care, to bed, and upon awakening.					
	namesWhen she was in he good (when staff wa -She may have an o	and called staff vulgar er own element, she was s not assisting her). utburst at dinner time, but most part, as long as no				
-	care provider (PCP) revealed: -She was not aware to any of her medication	with Resident #6's primary on 12/21/23 at 4:53pm that Resident #6 had missed as. ad not requested any refills				
	or prescriptions for R -The hospice nurse n hospice; it had been i worked with hospiceHer main concern wa Risperdal, Zoloft, and had missed. Missing a dose or 2 o	esident #6. o longer worked with 2 weeks since she had as the numerous doses of Trazodone that Resident #6 could cause some nausea				

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: HAL047015 12/21/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY {D 358} Continued From page 15 {D 358} depression, hallucinations, difficulty sleeping, dizziness, irritability, and uncontrolled muscle movements. -She would contact the facility for new orders for resuming the Risperdal, Zoloft and Trazodone medications and gradually increase the dosages with a slow taper until the previous ordered doses were achieved. Attempted telephone interview with the hospice nurse on 12/21/23 at 4:50pm was unsuccessful. Interview with the Executive Director on 12/21/23 at 2:10pm revealed: -She was not sure why the cart audit did not reveal the missing meds for Resident #6. -She thought there "may be too many hands in the cookie jar" meaning too many staff (MAs, RCC, MCD) were expected to be doing the same thing (reordering meds). Refer to Interview with the medication aide (MA) on 12/20/23 at 3:31pm. Refer to interview with the Resident Care Coordinator (RCC) on 12/21/23 at 2:45pm. Refer to interview with the Executive Director on 12/21/23 at 2:10pm. 4. Review of Resident #3's current FL-2 dated 10/12/23 revealed: Diagnoses included infection and inflammatory reaction due to internal left hip prosthesis,

Division of Health Service Regulation

staphylococcal arthritis left hip, essential hypertension major depressive disorder, diabetes

-There was an order for Minocycline HCL 50mg (used to treat bacterial infections) to give 1 capsule at bedtime for bone infection.

mellitus, and atrial fibrillation.

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: HAL047015 12/21/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 16 {D 358} {D 358} Interview with Resident #3 on 12/20/23 at 8:55am revealed: -She was supposed to get her antibiotic every day and she had missed 3 days so far. -It was given to her to prevent MRSA-Methicillin Resistant Staphylococcus Aureus. -If she did not get her antibiotic, it could cause MRSA to start infecting her and she could wind up in the hospital and be deathly sick. -She had told several of the MAs about running out of her antibiotic. -She said it did not do any good to talk to the Resident Care Coordinator (RCC) or the Executive Director (ED) as they did not know what was happening at the facility since they stayed in their offices all the time. Review of Resident #3's December 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Minocycline HCL 50mg give 1 capsule at bedtime for bone infection scheduled at 8:00pm. - Minocycline HCL 50mg was documented as not being administered at 8:00pm from 12/17/23 -12/19/23. -The reason listed for Minocycline HCL 50mg not being administered was documented as 09 (other/see nurses notes) from 12/17/23 -12/19/23. Observation of Resident #3's medications on hand on 12/21/23 at 2:43pm revealed there were 30 capsules of Minocycline HCL 50mg on hand for administration which were dispensed on 12/18/23 for Resident #3. Review of Resident #3's December 2023 nurses notes for 12/16/23-12/19/23 revealed:

AND PLAN OF CORRECTION IDENTIFI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ON NUMBER: A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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{D 358}	HAL047015  IE OF PROVIDER OR SUPPLIER  STREET / SKSHIRE CREEKS CROSSING  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		{D 358}				

Division of Health Service Regulation

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FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R HAL047015 B. WING 12/21/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {D 358} Continued From page 18 {D 358} Interview with Resident #3's Primary Care Provider (PCP) on 12/21/23 at 5:22pm revealed: -He had not been notified of Resident #3 missing 3 doses of her Minocycline. -He would expect to be notified if she missed more than 2 doses but was not concerned as she had been taking it for some time now. Interview with the Executive Director on 12/21/23 at 2:10pm revealed: -She was not sure why the cart audit did not reveal the missing meds for Resident #3. -She thought there "may be too many hands in the cookie jar" meaning too many staff (MAs, RCC, MCD) were expected to be doing the same thing (reordering meds). Interview with a personal care aide (PCA) on 12/21/23 at 3:40pm revealed: -Resident #6 had been worse as she fought more than usual; she had tried to hit and punch this month (December). -Last month in November, she would just talk as opposed to becoming physical. Interview with a medication aide (MA) on 12/21/23 at 3:35pm revealed: -He had worked at the facility for two weeks. -He described Resident #6 as feisty because she got loud and tried to hit and pinch staff when being assisted with personal care, to bed, and upon awakening. -She cursed at staff and called staff vulgar -When she was in her own element, she was good (when staff was not assisting her). -She may have an outburst at dinner time, but she was calm for the most part, as long as no one bothered her.

Division	of Health Service Re	gulation			FO	RM APPROVED	
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	RE CREEKS CROSSIN	G 8398 FA	YETTEVILLE ROAL RD, NC 28376				
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	Interview with a sec 12/20/23 at 3:31pm -The MAs documen medication administ -The 09 was other/s -The n/a that was not available -When the MA documenthe nurse's notes woodly the resident Care Care Director (MCD) Charge (SIC) did the when those were doodly the house were doodly the house wordly the medication aided contact the Primary of the resident missed of the resident missed of the resident missed of the medication in the medication orderThe MAs were respective medications were missible for contact orderThe MAs documented medications were missible for contact the pharmacy was conshowing any behavious the pharmacy was a 24-hour MAs used to help repshifts to help the next	cond medication aide (MA) on revealed: It a number on the electronic tration record (eMAR). It is enurses notes. It is enurses notes. It is enurses notes. It is enurses notes. It is enurses notes. It is enurses notes. It is enurse's notes is enurse is notes. It is enurse is notes is enurse is notes is enurse in enurse is notes. It is enurse is	{D 358}				

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NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATI	E, ZIP CODE		
WICKSHI	RE CREEKS CROSSING		YETTEVILLE ROAI RD, NC 28376	0		
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	medication aides (Masupervisor.  -The MA was expected or remove the sticker and send it to the phase was a 7-10-day supple. The Resident Care Coresponsible for check sure medications were cart audits were don Director (MCD), RCC Thursdays and it was a The cart audit consisted medicated (eMAR), and if there were running reordered.  -There was no excuse of any of their meds as was right next door.  The facility failed to accordered to 1 of 4 reside medication passes on resulting in a 10% med medication passes on resulting in a 10% med medication used of her medication used she missed 13 doses of vitamin deficiency and history of an antibiotic acquired infection and doses of her antibiotic her at risk for an exace infection and Resident	and to contact the pharmacy from the medication card armacy for a refill when there by remaining. Coordinator (RCC) was fing behind the MAs to make the refilled. The by the Memory Care and the Lead MA weekly on done last Thursday. The cart, the the corders, checking for the mparing the actual order to done and the material order to do done and the material order to do done and the material order to do done and the material orders and the material	{D 358}			

Division of Health Service Regulation

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED R HAL047015 B. WING 12/21/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD **WICKSHIRE CREEKS CROSSING** RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) {D 358} Continued From page 21 (D 358) consecutive days of her medication used to treat insomnia. The failure of the facility to administer medications as ordered was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/21/23 for this violation. CORRECTION DATE FOR TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 4, 2024. Division of Health Service Regulation