STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL060166	B. WING		03	C 2/12/2024
				7/0.0005	1 02	112/2024
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
WICKSHIP	RE STEELE CREEK		TRYON ST OTTE, NC 28278			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
D 000	Initial Comments		D 000			
	Services conducted a January 30, 2024 thro February 05, 2024, w	Department of Social a complaint investigation on ough February 02, 2024 and vith a desk review from rough February 09, 2024				
D 276	10A NCAC 13F .0902	2(c)(3-4) Health Care	D 276			
	following in the reside (3) written procedure a physician or other I and (4) implementation of	ssure documentation of the				
	This Rule is not met TYPE A1 VIOLATION					
	facility failed to ensur implemented for 2 of #5) related to taking I	and record reviews the re physician's orders were 5 sampled residents (#1 and blood pressures twice daily r stick blood sugars (FSBS)				
	The findings are:					
	08/21/23 revealed dia hypertension, chronic and severe chronic k	at #1's current FL2 dated agnoses included congestive heart failure, idney disease stage 4.  #1's Primary Care Provider's 0/13/23 revealed staff were				

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE COMF	SURVEY	
			7.1. 50.25.1.10.			0
		HAL060166	B. WING		02	C / <b>12/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
		13600 S	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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 276	Continued From page	÷ 1	D 276			
	to obtain Resident #1 and record it on the e Administration Record					
	Review of Resident # November 2023, and revealed there were r pressures twice daily.	December 2023 eMARs no entries for blood				
	12/26/23 revealed: -The resident was schan esophagogastroduvariceal screening (a enlarged veins in the beginning of small int-Resident #1's blood while at the procedure 180/90 at 8:42am, 18 at 9:20am (According	1's Gastrologist's note dated neduled on 12/26/23 to have undenoscopy (EGD) for procedure to screen for esophagus, stomach and estines). pressures on 12/26/23, e, were 183/87 at 7:58am, 9/86 at 8:52am, and 197/90 to the American Heart blood pressure should be				
	Telephone interview v member on 02/02/24 the EGD, Resident #	vith Resident #1's family at 10:10am revealed after I was not feeling well, and across the street to the ED.				
	(ED) provider's note of Resident #1 had crack sounds) on inspiration hypertensive (blood pf 120/80).  Resident #1's blood ff 198/84 at 10:02am ar ar ar ar trailure (CHF) (a cannot pump blood with the resident with the resident frailure (CHF) (a cannot pump blood with the resident #1 had crack frailure (CHF) (a cannot pump blood with the resident frailure (CHF) (a cannot	1's Emergency Department dated 12/26/23 revealed: ckles (abnormal lung and was significantly pressures greater than pressures on 12/26/23 were and 204/94 at 11:01am. Resident #1 had congestive condition when the heart rell enough to meet the eclinical impression was				

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STATE FORM 6899 EFK911 If continuation sheet 2 of 117

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			71. BOILBING.		С	
		HAL060166	B. WING		02/1	2/2024
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
WICKSHII	WICKSHIRE STEELE CREEK 13600 S					
(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 SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
D 276	hypertensive emerge blood pressure was valife-threatening symp -Resident #1 was addressed on the summary dated 01/02 -Resident #1 was addressed on the summary dated 01/02 -Resident #1 was addressed on the summary dated 01/02 -Resident #1 was districted for the heart cannot fill properties of the heart failure the heart cannot fill properties of the heart failure the hea	ncy (a condition where the very high with potentially toms). mitted to the hospital.  21's hospital discharge 22/24 revealed: mitted on 12/26/23 for ncy and acute on chronic (when the left ventricle of roperly due to stiffness).  Itiple hospitalizations for di hypertension recently. Itiple hospitalizations for di hypertension recently. It is charged to a skilled nursing with Resident #1's PCP on evealed she ordered the sure to be checked twice ent #1 had hypertension and or Resident #1's blood  Interview with Resident #1's 2:35pm revealed: Interview with Resident #1's obtained twice daily was not e spoke to the surveyor on the third specific to the surveyor on the emals and the emals are could be visited the facility.  Interview with Resident #1's obtained twice daily was not e spoke to the surveyor on the emals and the emals are could be visited the facility.	D 276			

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STATE FORM 6899 EFK911 If continuation sheet 3 of 117

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
			B. WING		С	
		HAL060166	B. WING	<del></del>	02/12/2024	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE STEELE CREEK	13600 S TI CHARLOT	RYON ST TE, NC 28278			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPL	LETE
D 276	Continued From page		D 276			
	daily was entered into incorrectly.  -Because it was entered show up on Resident complete it.  -There was no process were entered correctly.  Interview with the fact 02/12/24 at 3:18pm results -She was hired as the in October 2023.  -The RCC, SCC, or a trained and responsible the eMAR system.  -The RCC and the SC entry by a corporate results -After orders were to system, the order was in the copy room.  -She was responsible the orders placed in the eMAR -Resident #1's blood would have had to be show up for the MAS -She was not aware or pressure order because employment at the fact -She had not audited she began in October Interview with the Res (RDO) on 01/05/24 at	clity's Compliance Nurse on evealed:				
	eMAR by the RCC, S few MAs that were traentry.	CC, Compliance Nurse, or a nined in medication order				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			71. BOILBING.		С	
		HAL060166	B. WING		02/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHII	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICENCY)	D BE COMPLETE	
D 276	Continued From page	e 4	D 276			
	copy room in which to entered into the eMAI order to be reviewed -He did not know the	o place orders that had been R system for the entered for accuracy. Compliance Nurse had not s record since she began				
		t #5's current FL2 dated agnoses included dementia, diabetes, and anxiety.				
	12/12/23 revealed to	5's physician order dated check finger stick blood efore breakfast and before				
	January 2024 eMAR -There was an entry t 8:00am.	5's December 2023 and revealed: o check FSBS daily at o check FSBS daily before				
	(ED) note on 01/26/24 -Resident #5 was adr sugar of 45 in the faci insulinOral glucose was giv medical technician) p admitted to the EDResident #5 blood gl she was returned to the she was retu	nitted to the ED for a blood ility after receiving the wrong een by EMT's (emergency rior to Resident #5 being ucose was stabilized and he facility on 01/26/24.  n 02/01/24 at 10:20am esident #5 was to have a st and before supper. Resident #5 was to have				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
			A. BOILBING.			
		HAL060166	B. WING		C 02/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	TE, ZIP CODE		
MICKELII	WICKSHIRE STEELE CREEK 13600 S T					
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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 276	Continued From page	÷ 5	D 276			
	she followed the order-She did not do any of thought the SCC did to	art audits on orders and them.				
	revealed: -He did not know Res FSBS before breakfa -He entered physician the SCC, but he did n Resident #5's FSBS I -Sometimes the order corporate office and t the eMAR wrongWe do medication ca the audits are for med Interview with the Cor at 3:35pm revealed: -She did not do the audits	n orders for the residents in not recall seeing an order for perfore breakfast and supper. It is were entered in by the hey must have been put into art audits twice a week, but dications.  Impliance Nurse on 01/31/24 audits.				
	given to the Administration morning meetings.  Telephone interview of 02/05/24 at 2:39pm results. She was not aware for a FSBS as ordered by the she reviewed saw there were no FSS as wrote an order of done daily before breche would expect the she was aware Resilted emergency department of the she was aware for	Resident #5 was not getting efore breakfast and supper. Resident #5's record, she SBS being completed. on 12/12/23 for a FSBS to be akfast and supper. e staff to follow orders. dent #5 went to the nt (ED) for a medication				

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any detriment with not having the FSBS done

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
			B. WING		С	
		HAL060166	b. WING		02/12/2024	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	WICKSHIRE STEELE CREEK 13600					
			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 276	Continued From page	e 6	D 276			
	twice daily before bre	akfast and before dinner.				
	Interview with the RD revealed:	O on 02/05/24 at 4:02pm				
	-He was not aware R daily FSBS before bro	esident #5 was not getting a eakfast and supper.				
		system did not put it in				
	correctly, so the FSBS did not show up on the eMAR to have them done.  -The Compliance Nurse received the medication cart and resident record audits after completion by the SCC and RCC and brought them to the morning meetings.					
	<ul> <li>-He did not know what completed.</li> </ul>	at audits were being				
	The facility failed to e	nsure the implementation of				
	a physician's orders f	or blood pressures twice				
		who was hospitalized after ve emergency with heart				
	failure and eventually	was discharged to a skilled				
		esident #5 who had an order kfast and supper who was				
		a medication error. The				
		ious physical harm and				
	constitutes a Type A1	violation.				
	The facility provided accordance with GS 2024.	a plan of protection in 131D-34 on JANUARY 31,				
	CORRECTION DATE VIOLATION SHALL N 2024.	FOR THE TYPE A1 NOT EXCEED MARCH 13,				
D 338	10A NCAC 13F .0909	Resident Rights	D 338			
	10A NCAC 13F .0909	Resident Rights				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE ( A. BUILDING:	(X3) DATE SURVEY COMPLETED		
			7 56.12516.			
		HAL060166	B. WING		C 02/12/2024	4
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
14/10/2011		13600 S T	RYON ST			
WICKSHII	WICKSHIRE STEELE CREEK CHAR					
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COM	X5) PLETE ATE
D 338	Continued From page	÷ 7	D 338			
	An adult care home s all residents guarante	hall assure that the rights of ed under G.S. 131D-21, nts' Rights, are maintained				
	This Rule is not met a					
	facility failed to ensure (Resident #2 and #3) abuse and exploitatio male staff member in hugging, and kissing	and record reviews, the e 2 of 5 sampled residents were free from neglect, n related to reports of a appropriately touching, while staff observed the intervene to protect the				
	The findings are:					
	or Financial Exploitati date of 08/01/21 reve -A resident currently libe free from mental, vabuse, neglect, involutinancial exploitationIf abuse, neglect, or witnessed, associates from the situation immediately notify you Wellness Director, Exresident is injuredDo not leave the resiresident until they care they are out of harm's -The Executive Direct	iving in the community must verbal, sexual and physical untary seclusion, and  financial exploitation is are to remove the resident nediately, bring the resident in the community and ur supervisor, Health and recutive Director or 911 if the dent alone, stay with the nobe assessed to ensure as way.  For will immediately (but no				
		otify orally or in writing the factorial Services and 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 PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
						С
		HAL060166	B. WING		02	/12/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
		13600 S	TRYON ST			
WICKSHIE	WICKSHIRE STEELE CREEK CHAR					
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETE DATE
D 338	Continued From page	e 8	D 338			
	HCPR.					
	-	nsible party or contact				
		on the Resident Register,				
		liately by the Executive				
		tor will notify the Health Care				
		HCPR) within 24 hours of				
	knowledge of all insta					
	-A thorough investiga	tion of all allegations must				
		igh documentation must be				
	completed by the Exe	ecutive Director.				
	1 Paview of Pasiden	t #3's current FL2 dated				
	11/10/23 revealed:	1 #33 Current i L2 dated				
		dementia, hypertension, and				
	anemia.	aemenia, nyperieneien, ana				
	-She was semi-ambu	latory.				
	-She was intermittent					
		of care was assisted living.				
		nt #3's family member on				
	01/31/24 at 2:30pm re					
	due to her dementia.	able to answer questions				
		on 01/02/24 at 5:35pm by the				
		rt an incident with Resident				
	#3.	it an incident wan i tesident				
	-The Administrator to	ld her the former				
	Maintenance Director Resident #3's feet.	was seen applying lotion to				
		mer Maintenance Director				
	previously but did not					
	personal care staff m					
		nistrator if Resident #3 was				
		nad been sexually abused				
	•	said no and that she just				
		ily know of the incident.				
		ived another call from the				
		it was protocol to take the				
	_	ency department (ED) and				

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NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE_ZIP CODE		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  13500 S TRYON ST  CHARLOTTE, NC 28278  CHARLOTTE, NC 28278  D PROVIDER'S PLAN OF CORRECTION FOR SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  TAG (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 338 Continued From page 9  that the Resident #3's Primary Care Provider (PCP) had recommended an ED evaluation.  -She asked if she could call the Administrator back due to her wanting to discuss this with another family member.  -She called the Administrator back at 6.08pm and said unless she knew of anything more serious than lotion being applied to resident's feet, pain, bleeding or if the Administrator suspected anything further than the maintenance director applying totion to resident's feet.  -She received a phone call from a Detective with the local police department on 01/03/24 at 3.07pm who asked for consent to send Resident #3's to the ED for an evaluation.  -The detective asked for an ED evaluation due to possible sexual assault.  -She was told the former Maintenance Director had been seen applying Iotion to Resident #3's feet by the Administrator and nothing else was mentioned even when the family member specifically asked.  -She spoke with a second detective several times afterwards.  -She mut with the second detective at the facility at 8:00pm or later, on 01/04/24 who had a search warrant.				A. BOILBING.			
C(4) D    SUMMARY STATEMENT OF DEFICIENCIES   D  PROVIDER'S PLAN OF CORRECTION (PLAN DEFICIENCY MUST BE PRECEDED BY FULL RECEX   DEFICIENCY MUST BE PRECEDED BY FULL REQUIATORY OR LSC IDENTIFYING INFORMATION)   D 338   Continued From page 9			HAL060166	B. WING	B. WING		2/2024
(X4) ID (X4) I	NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
CHAILOTTE, NC 28278    SUMMARY STATEMENT OF DEFICIENCIES   D   PROVIDER'S PLAN OF CORRECTION	MICKELL	MICKELINE STEEL E CREEK					
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  D 338  Continued From page 9  that the Resident #3's Primary Care Provider (PCP) had recommended an ED evaluation.  -She asked if she could call the Administrator back due to her wanting to discuss this with another family member.  -She called the Administrator back at 6:08pm and said unless she knew of anything more serious than lotion being applied to resident's feet, pain, bleeding or if the Administrator suspected anything further had happened to Resident #3, she did not wish for Resident #3 to go to the ED.  -The Administrator stated no suspicion of anything further than the maintenance director applying lotion to resident's feet.  -She received a phone call from a Detective with the local police department on 01/03/24 at 3:07pm who asked for consent to send Resident #3 to the ED for an evaluation.  -The detective asked for an ED evaluation due to possible sexual assault.  -She was told the former Maintenance Director had been seen applying lotion to Resident #3's feet by the Administrator and nothing else was mentioned even when the family member specifically asked.  -She spoke with a second detective several times afterwards.  -She met with the second detective at the facility at 8:00pm or later, on 01/04/24 who had a search warrant.	WICKSHII	NE STEELE GREEK	CHARLOT	TE, NC 28278			
that the Resident #3's Primary Care Provider (PCP) had recommended an ED evaluationShe asked if she could call the Administrator back due to her wanting to discuss this with another family memberShe called the Administrator back at 6:08pm and said unless she knew of anything more serious than lotion being applied to resident's feet, pain, bleeding or if the Administrator suspected anything further had happened to Resident #3, she did not wish for Resident #3 to go to the EDThe Administrator stated no suspicion of anything further than the maintenance director applying lotion to resident's feetShe received a phone call from a Detective with the local police department on 01/03/24 at 3:07pm who asked for consent to send Resident #3 to the ED for an evaluationThe detective asked for an ED evaluation due to possible sexual assaultShe was told the former Maintenance Director had been seen applying lotion to Resident #3's feet by the Administrator and nothing else was mentioned even when the family member specifically askedShe spoke with a second detective at the facility at 8:00pm or later, on 01/04/24 who had a search warrant.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETE
(PCP) had recommended an ED evaluationShe asked if she could call the Administrator back due to her wanting to discuss this with another family memberShe called the Administrator back at 6:08pm and said unless she knew of anything more serious than lotion being applied to resident's feet, pain, bleeding or if the Administrator suspected anything further had happened to Resident #3, she did not wish for Resident #3 to go to the EDThe Administrator stated no suspicion of anything further than the maintenance director applying lotion to resident's feetShe received a phone call from a Detective with the local police department on 01/03/24 at 3:07pm who asked for consent to send Resident #3 to the ED for an evaluationThe detective asked for an ED evaluation due to possible sexual assaultShe was told the former Maintenance Director had been seen applying lotion to Resident #3's feet by the Administrator and nothing else was mentioned even when the family member specifically askedShe spoke with a second detective several times afterwardsShe met with the second detective at the facility at 8:00pm or later, on 01/04/24 who had a search warrant.	D 338	Continued From page	e 9	D 338			
-Evidence was taken from Resident #3's person along with clothing and beddingShe again notified the Detectives that she was only informed of lotion being applied to Resident #3 by the former Maintenance Director or she would have agreed to send Resident #3 to the ED for an evaluationA detective informed her that a staff member had		that the Resident #3's (PCP) had recommer -She asked if she couback due to her wantianother family membrane -She called the Admir said unless she knew than lotion being applied bleeding or if the Admanything further had have did not wish for Family in the received a phone of the local police departs 3:07pm who asked for #3 to the ED for an evaluation and been seen applying letter by the Administration and been seen applying letter by the Administration and been seen applying feet by the Administration and been seen applying the possible sexual assautures. She was told the form had been seen applying feet by the Administration and the specifically asked.  She spoke with a second s	s Primary Care Provider nded an ED evaluation.  uld call the Administrator ing to discuss this with er.  nistrator back at 6:08pm and of anything more serious lied to resident's feet, pain, ministrator suspected nappened to Resident #3, Resident #3 to go to the ED. ated no suspicion of the maintenance director dent's feet.  The call from a Detective with the threat on 01/03/24 at the consent to send Resident valuation.  For an ED evaluation due to cult.  The family member  The family				

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mentioned to him by the Administrator that

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:			X3) DATE SURVEY COMPLETED		
						С	
		HAL060166	B. WING	<del></del>	02	2/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE			
		13600 S	TRYON ST				
WICKSHI	RE STEELE CREEK	CHARLO	OTTE, NC 28278				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 338	Continued From page	e 10	D 338				
	above and the Admin	nistrator to ask her about the istrator stated this was the ard about Resident #3's					
	Review of Resident # revealed an admission	3's Resident Register n date of 10/25/22.					
	Report dated 01/02/2 -There was an electron County Department of timestamp of 4:04pm -The report was compliance Nurse with documented at 9:00aUnder section for the documentation stating the facility Compliance was observed in the I hands on her genital escorted out of the compending an investigate. There was documented being notified at 11:11	onic fax confirmation to the of Social Services with a soleted by the facility the the incident time of the accident, of the Administrator notified to provide personal care Resident #3's room with his area and staff member was community and suspended ion.  I tation of Resident #3's PCP flam.  I the tation that Resident #3's offied.  I the tation that Law					
	aide (PCA) on 02/05/ -She had reported to November 2023 that Maintenance Director forehead.	with a former personal care 24 at 10:45am revealed: the Administrator in early she had seen the former kiss Resident #3 on the					

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STATE FORM 6899 EFK911 If continuation sheet 11 of 117

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		HAL060166	B. WING		02/12/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MICKEHIE	RE STEELE CREEK	13600 S TF	RYON ST			
WICKSIIII	CL STEELE CKEEK	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	(X5) COMPLETE DATE
D 338	Continued From page	e 11	D 338			
	Resident #3's room was former Maintenance In Resident's face.  -She noticed that the pulled down to the and changed the Resident pulled her pants all that time.  -She did not ask the fit to leave.  -She left Resident #3'  -She and the MA return where the resident's pher knees.  -She and the MA imm SCC, leaving the form unsupervised in the real and asked the former leave.  -She was asked to will did and gave to the A					
	nutritional supplemen Maintenance Director					
	ankles which were not left earlierShe noticed Resident when they were initial -After giving out room Resident #3's room, so Director was still therefour times.	ot left like that when she had nt #3's blinds were closed				

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Resident on the forehead and rubbed her feet

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DIVISION	or riealin Service Negu	lation	_		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			-		
					C
		HAL060166	B. WING	· · · · · · · · · · · · · · · · · · ·	02/12/2024
NAME OF D	DOVIDED OD CUDDUED	CTDEET AD	DDECC CITY CTA	TE 710 000E	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	II E, ZIP CODE	
WICKSHIE	RE STEELE CREEK	13600 S T	RYON ST		
	•	CHARLO	TTE, NC 28278		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE
			1	DEFICIENCY)	
D 338	Continued From page	12	D 338		
2 000	Continued From page	, 12			
	when he was leaving	the room.			
	Interview with a medic	cation aide (MA) on			
	01/30/24 at 4:44pm re	evealed:			
		rmer Maintenance Director			
	in the middle of Nove	mber kiss Resident #3 in the			
	mouth in the dining ro	oom.			
		the SCC who told her to			
		ormer Maintenance Director.			
	,	d about this situation or			
		gement or the Administrator.			
	,	8:30am she was notified by			
	_	Maintenance Director was			
		with his hand underneath			
	the resident's covers.				
		CA entered Resident #3's			
		record using her cellular			
	device, where she wit				
	Maintenance Director	sitting in the resident's			
	wheelchair, beside the	e resident laying in her bed			
	with his hand rubbing	her underneath the covers,			
	over her private area.				
	-She asked the forme	r Maintenance Director if			
	Resident #3 needed a	anything in which the former			
	Maintenance Director	stated no.			
	-She and the PCA the	en left Resident's #3 room,			
		intenance Director in the			
	room alone with Resid				
	-She and the PCA imi				
	current SCC.	,			
		e SCC all went to Resident			
		former Maintenance Director			
	was still sitting beside				
	_	Resident #3's room to call			
	the Administrator.	NOSIGETIL #3 3 TOOTH TO CAIL			
		ince Director was not asked			
		d no one stayed in the room			
		ed to remove Resident #3			
	from the room		1	1	

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-She and the PCA then returned to Resident #3's

STATE FORM 6899 EFK911 If continuation sheet 13 of 117

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 NOMBER.	A. BUILDING: _		COMPLETE	יט
		HAL060166	B. WING		C 02/12/2	2024
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZIP CODE	1 02/12/2	1024
NAIVIL OF T	KOVIDEK OK 301 1 EIEK	13600 S TF		11, 211 GGDE		
WICKSHIE	RE STEELE CREEK		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 SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		COMPLETE DATE
D 338	Continued From page	<del>:</del> 13	D 338			
	asked the former Mail					
	O1/02/24 revealed: -She was in the dining came and reported to being touched inappro-She immediately wer #3's room, took out he noticed the former Ma Resident #3 under the -She asked the formet the resident needed a former Maintenance I -She left the room and sure she was seeing 1 -The resident was being memberShe then asked the fit to leaveShe sat by Resident	nt down the hall to Resident er phone to record, and aintenance Director rubbing e covers. er Maintenance Director if any assistance and the Director said no. d got management to make				
	on 01/30/24 at 4:08pr 11:45am revealed: -He reported to the Admember had witnessed Director kiss Residen not know what happe -The former Maintena taking residents to the reported to the Admin	dministrator that a staff ed the former Maintenance t #3 in the mouth, but he did ned after he reported it. ance Director was witnessed be bathroom which was				

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STATE FORM 6899 EFK911 If continuation sheet 14 of 117

	of Health Service Regu				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					С
		HAL060166	B. WING		02/12/2024
			1		1 VEITEIEVET
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
MICKSHIE	RE STEELE CREEK	13600 S	TRYON ST		
	- OILLL OILLIN	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)	JLD BE COMPLETE
D 338	Continued From page	e 14	D 338		
		cation to the Administrator.			
		eld a stand-up meeting, he			
	was uncertain of the				
	Maintenance Director				
	Administrator informe	ed everyone that non-care			
	staff were not to prov	ide personal care to			
	residents.				
	-On 01/02/24 he was	asked to come to Resident			
	#3's room by an MA a	and a PCA where he			
	witnessed the former	Maintenance Director with			
	his hand under the re	sident's blanket rubbing			
	over her private area.				
	-He left the room to c	all the Administrator and			
	inform her that he and	d two other staff had			
	witnessed the former	Maintenance Director with			
	his hand under the re	sident's blanket rubbing			
	over her private area.	•			
	-The MA and PCA as	ked the former Maintenance			
	Director to leave the	room.			
	-The Administrator ca	me to the facility shortly			
	after and suspended	the former Maintenance			
	Director.				
		te a statement which he did			
	and gave the stateme	ent to the Administrator.			
	Review of the SCC's	signed statement dated			
	01/02/24 revealed:				
	-A MA came and got	him due to her being			
		rmer Maintenance Director			
	in Resident #3's room				
	-When he approache	d Resident #3's room, he			
	witnessed the former	Maintenance Director with			
	his hand under the bl	anket rubbing in Resident			
	#3's private area.				
	-He asked the former	Maintenance Director if he			
	was okay, and the for	rmer Maintenance Director			
	answered yes.				
	-He then left the room	n and called the			
	Administrator.				

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STATE FORM 6899 EFK911 If continuation sheet 15 of 117

	or Regulation		0/0) 4## 7101 5	CONCERNATION	Take BATE 6	110) (5) (
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S	
, and i Law		.BERTH IS ATOM HOWBER.	A. BUILDING: _		J JOINI LI	
						;
		HAL060166	B. WING		1	2/2024
					, , , , ,	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
MICKSHIE	RE STEELE CREEK	13600 S T	RYON ST			
Wiortonii	TE OTELLE ONLLIN	CHARLO	TTE, NC 28278			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(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 APPROPI DEFICIENCY)	TIATE	DATE
				,		
D 338	Continued From page	e 15	D 338			
	Telephone interview v	vith a law enforcement				
	detective on 01/31/23					
		ility Administrator waited				
	until after normal busi					
		to notify law enforcement of				
	a possible sexual ass					
		01/02/24 between 8:30am				
	and 9:00am which ha					
	reported to the Admin					
		ninistrator to immediately				
		nt on 01/02/24 to reduce the				
	_	vidence to be contaminated				
	or discarded.					
		ormer Maintenance Director				
	in January 2024.					
	•	erviewed and felt the former				
		had spent too much time in				
		out a need for maintenance				
	services.					
	-He felt the former Ma	aintenance Director's				
	behavior was inappro	priate.				
	Telephone interview v	vith a second law				
	enforcement detective	e on 02/01/24 at 11:30am				
	revealed:					
	-He conducted numer	rous interviews with facility				
	staff after an incident	on 01/02/24 which involved				
	the former Maintenan					
		n interview with the former				
		in January 2024 related to				
	~	al assault to a resident.				
		laintenance Director had				
		otion to Resident #3's face,				
	,	ging her thighs to help with				
	circulation.					
		laintenance Director had				
	_	esident #3 on the forehead.				
	-He said the former M					
	admitted to feeding R					
	-The detective stated	the facility should have				

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STATE FORM 6899 EFK911 If continuation sheet 16 of 117

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY IPLETED
		HAL060166	B. WING		0:	C <b>2/12/2024</b>
	ROVIDER OR SUPPLIER	13600 S	ADDRESS, CITY, STATE TRYON ST DTTE, 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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 338	obtained prior to resic change of clothing or -He felt the former Mabehavior was inapproduced in the felt the former Mabehavior was inapproduced in the felt the former Maintena at 3:36pm revealed: -The former Maintena at 3:36pm revealed: -The former Maintena at 3:5 room, sitting in a of resident and resided resident and resided resident and resided resident and a bid her body which had be her left sideResident at 3:5 pants her left knee, leaving completely exposed, and the former Maintena forward in the wheeled resident at 3:5 left har right hand, on top of the former Maintena with the former I hand placed on top/or-The former Maintena viewed under the blatt above resident's exposed abdominal area.  Telephone interview with the former I hand placed on 102/01/24 resident area.	dence could have been dent receiving a bath, change of bedding. aintenance Director's apriate.  cording by a MA from tamp of 8:33am on 02/01/24  ance Director in Resident wheelchair on the left side ent's bed. If the second towards the left. It is anket laying over the top of the folded under, exposing covered her left leg, up to her left knee, thigh and hip uncovered and bare. In the blanket, over her chest was crossed over her he blanket, over her chest waintenance Director's left over resident's hands. In the property is ance Director's right arm was the property in the former Maintenance with the former Maintenance at 3:50pm revealed:  Maintenance Director	D 338			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
						;
		HAL060166	B. WING		02/1	2/2024
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	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETE DATE
D 338	Continued From page	e 17	D 338			
	-He stated he provide giving her juice and we chapstick to her lips a face, hands, feet, legal He admitted that he help with circulation.  -He did not tell any st chapstick, lotion or he He assisted Residen bed due to her not be own.  -He visited her five to ten minutes per visit.  -In October 2023, the that a PCA had a con affection towards resilled.	ad Resident #3 care by vater, feeding her, applying and putting lotion on her s, and thighs. would massage her thighs to aff he had been applying e was feeding Resident #3. t #3 with sitting up in the ing able to sit up on her six times a day for around Administrator notified him cern for how he showed dents. Administrator talked with afful' of how he showed dents could be				
	Officer (COO) on 02/0 -On 01/02/24 at approa telephone call with a instructed the Administrator enforcement related the assault to Resident #DirectorShe expected the Administrator had 01/02/24 to notify law allegation of sexual a former Maintenance II. She was unaware the Resident #3's family in telephone call for the sexual and th	o the allegation of sexual 3 by the former Maintenance  Iministrator to immediately on 01/02/24.  Intil late January 2024, that waited till after 5:00pm on enforcement of an ssault to Resident #3 by the				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		HAL060166	B. WING		02/1	, 2/2024
NAME OF PI	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	(X5) COMPLETE DATE
D 338	Continued From page	e 18	D 338			
	-She said Resident #3 have been notified of the Accident and Incid	3's family member should what was documented in				
	-The Administrator entered the documentationLate entry was documented with an effective date of 01/02/24 at 5:25amThe Administrator spoke with the Department of					
	Social Services about the incident filed, instructed to file a 24-hour report.  -The 24-hour report was filed, faxed, and emailed with confirmation.					
	did not arrive until afte	is contacted at 5:25pm and er 10:40pm. acted at 5:42pm notifying				
	them of the incidentThe PCP sent an up	date stating it would not hurt				
	to send Resident #3 out for an evaluationFamily refused to send out resident, stating that if no signs of injury were seen they did not want her in the Emergency Department where she could catch an infectious virus that is going around and due to her age, it was likely.					
	on 02/02/24 at 3:55pr	f had documented written				
	statements constitute termination of the forr -He stated the facility	Itent of the staff's written d grounds for immediate mer Maintenance Director. should have notified law an a 24-Hour report for the				
		ns, interviews, and record ined that Resident #3 was				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _			
		HAL060166	B. WING			C / <b>12/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		13600 S T	RYON ST			
WICKSHII	RE STEELE CREEK	CHARLO <sup>*</sup>	TTE, NC 28278			
(X4) ID		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF (EACH CORRECTIVE AC		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	DATE
D 338	Continued From page	e 19	D 338			
	2. Review of Resider	nt #2's current FL2 dated				
	11/10/23 revealed:					
		Alzheimer's disease, bursitis				
		ression, and other symptoms ognitive functions and				
	awareness.					
		and constantly disoriented.				
	-Resident #2's recommended level of care was					
	Special Care Unit (SCU)Resident #2 was admitted to the SCU on 07/26/21.					
	Review of Resident #					
	the facility on 07/26/2	esident #2 was admitted to 21.				
	Review of a signed d 11/01/23 revealed:	ietary aide's statement dated				
	-She observed the fo	rmer Maintenance Director				
		ons touch female residents,				
	touched.	where residents shouldn't be				
		ance Director was observed				
	taking Resident #2 fr	om the Living room and				
		no one could see them.				
		ance Director entered				
	style it was in.	and took her hair out of the				
		ary aide on 01/30/24 at				
	11:46am revealed:	previous Special Care				
		owards the end of October				
	, , ,	ncomfortable with the former				
		r hugging and kissing				
	Resident #2 who resi					
		Maintenance Director hug				
	and kiss Resident #2 -She reported this to	three or more times. the Administrator in October				

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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	
					С
		HAL060166	B. WING		02/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STAT	E, ZIP CODE	
WICKSHII	DE STEEL E CDEEK	13600 S T	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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 338	Continued From page	20	D 338		
	2023, but stated noth was aware of.	ing was done as far as she			
	along with two other s former Maintenance I	ovide a written statement staff who had witnessed the Director's inappropriate e written statement to the			
	Review of a signed PCA's statement dated 11/01/23 revealed: -She observed the former Maintenance Director on numerous occasions touch female residents, mainly Resident #2, where residents shouldn't be touchedThe former Maintenance Director was observed taking Resident #2 from the living room and				
	walked somewhere n -The former Maintena	o one could see them.			
	02/01/24 at 10:40am -She witnessed the fortake Resident #2, to the stood beside the resident was uncertain of the she witnessed the fortal most every time her hair down and witnes resident's hair which the she reported the fortal mappropriate behavior times and to the Admof October 2023She was asked to proal of the she was asked to proal of the she was asked to other she was asked to	ormer Maintenance Director he bathroom where he dent as she sat on the toilet			
		Director's inappropriate e written statement to the			

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AND DUAN OF CORDECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO			E SURVEY IPLETED	
		HAL060166	B. WING		02	C <b>2/12/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
WICKSHII	RE STEELE CREEK		TRYON ST OTTE, NC 28278			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 338	Continued From page	e 21	D 338			
	revealed: -She observed the formappropriately touch -The former Maintenance show extra attention in the rub her back and hair.  Telephone interview of 02/01/24 at 12:40 pmIn the fall of 2023, the Director would massather back rubs and kisten the fall of 2023, she maintenance Director bedroom but did not be Resident #2She provided a written Administrator related Director on 11/01/23She was never internor management staff statement dated 11/0In the fall of 2023, she staff concerns related Director's behavior to Administrator, "would she never tried to in Administrator already multiple staff of the for Director's inappropriate continued.  Telephone interview of Director on 02/01/24	with a former MA on revealed: e former Maintenance age Resident #2's head, give as her on her cheek. he had observed the former rescort Resident #2 to her know why he did this with en statement to the to the former Maintenance viewed by the Administrator related to her written 1/23. he told the Administrator of the to the former Maintenance wards Resident #2 and the laugh it off". tervene due to the being made aware by ormer Maintenance it behaviors which he had with the former Maintenance at 3:50pm revealed:				
	07/03/23 and 01/03/2 -He frequently greete	ance Director between 4. d residents in the SCU daily their backs over their shirts,				

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DIVISION	n nealth Service Regu	iation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			B WING		C
		HAL060166	B. WING		02/12/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE	
		13600 S T		•	
WICKSHIP	RE STEELE CREEK		TE, NC 28278		
			TE, NC 20276	T	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	( - /
PREFIX TAG		Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPI	
iAO		,	l lAG	DEFICIENCY)	
			<b>+</b>		
D 338	Continued From page	22	D 338		
	and kissing foreheads	8.			
	•	n one occasion, he was in			
		epairing a telephone and			
		the room while she was			
		n and was defecating on the			
		to the toilet and left the			
	room to locate a PCA				
		Administrator notified him cern for how he showed			
	-				
	affection towards resi				
		Administrator talked with			
		dful' of how he showed			
	affection towards resi				
	uncomfortable for car	e staff.			
	Telephone interview v	vith Resident #2's Power of			
	Attorney on 02/05/24				
	-	nitted to the SCU in July			
	2021.	•			
	-Resident #2 required	l assistance with bathing,			
	toileting, dressing, an	d grooming.			
		bulatory and constantly			
	disoriented.				
	-She was not aware o	of any allegations of abuse,			
		n involving Resident #2.			
	J , 1	3			
	Telephone interview v	vith a former agency PCA on			
	02/05/24 at 10:50am	• •			
	-She occasionally wo	rked in the SCU.			
	-When she worked in				
	Maintenance Director				
	spending time with Re				
		quently hugged, had her			
		clothing, and walked down			
		ne former Maintenance			
	Director's hand.				
		the former Maintenance			
	Director in Resident #				
	-one did not leel com	fortable with the amount of	1		

Division of Health Service Regulation

affection the former Maintenance Director

STATE FORM 6899 EFK911 If continuation sheet 23 of 117

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S	
					c	
		HAL060166	B. WING		1	2/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
W#0K01	DE OTEEL E ODEEK	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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 338	Continued From page	23	D 338			
	provided to Resident #2She did not intervene when she witnessed the former Maintenance Director's inappropriate behaviors towards Resident #2.					
	11:30am revealed: -She worked first and -She worked in the So -Between September she notified the Admin because she had obs Maintenance Director brief at her bedsideShe was not aware of involved the former M between September 2 until an incident occur Maintenance Director  Interview with a first s 11:30am revealed:	CU. 2023 and October 2023, nistrator of a concern served the former changing Resident #2's of any investigation which laintenance Director 2023 and November 2023, rred with the former				
	Director's level of phy -She had notified the SCC of her concerns Director's physical co -She had frequently of Maintenance Director female residents on the mouths. -She felt uncomfortab Maintenance Director hugging residents. -On 01/02/24, around former Maintenance I #2's feet in the Living -She did not intervent	rsical contact with residents. former SCC and the current for the former Maintenance ntact with residents. observed the former rub residents' backs, kiss heir cheek close to their ole around the former due to him constantly 17:00am, she observed the Director rubbing Resident				

feet.

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STATE FORM 6899 EFK911 If continuation sheet 24 of 117

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	(X2) MULTIPLE CONSTRUCTION (			
7.1.12 . 27.1.1	o. 001.11.2011011	.52	A. BUILDING:			PLETED
		1141 000400	B. WING			C
		HAL060166	5		02	2/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
WICKSHII	RE STEELE CREEK		TRYON ST			
		CHARLO	OTTE, NC 28278			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 338	Continued From page	e 24	D 338			
	4:45pm revealed: -Sometime in the Fall staff meeting directed -The Administrator no employees were perr	shift MA on 01/30/24 at  I of 2023, she attended a I by the Administrator.  otified staff that facility mitted to touch residents' was not to be considered				
	o1/31/24 at 4:20pm re-She worked in the Stand December 2023She and facility staff Maintenance Director other residentsStaff had observed to Director frequently how the back, and would former Maintenance In Resident #2's bedrooperform maintenance In early November 2 in reference to their conformer Maintenance I behaviors.	were concerned the former refavored Resident #2 over the former Maintenance olding hands with Resident refate the hallway, and rubbing occasionally observe the Director walking out of the mand he was not in there to be repairs.  023, staff wrote statements concerns related to the Director's inappropriate  023, she provided the the Administration.				
	revealed: -The former SCC had with staff statements Maintenance Director	C on 01/30/24 at 4:10pm  I provided the Administrator related to the former r's inappropriate behaviors. at was written in the staff				

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STATE FORM 6899 EFK911 If continuation sheet 25 of 117

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL060166	B. WING		C <b>02/12/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MICKSHIE	RE STEELE CREEK	13600 S TF	YON ST			
WICKSIIII	NE STEELE ONLER	CHARLOT	ΓE, NC 28278			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 338	Continued From page	e 25	D 338			
	statementsIn the fall of 2023, so they witnessed the fo show affection toward kissing the resident or -In the fall of 2023, the interview him related Director's interactions -In the fall of 2023, the of staff concerns for the Director providing cannotified all department to ensure only staff as performed resident cannot be supported to the fall of 2023, the of staff concerns for the different providing cannot field all department to ensure only staff as performed resident cannot be supported to the fall of 2023, so the fall of 2023, the fall o	ome staff had informed him rmer Maintenance Director ds Resident #2, including in the cheek and forehead. The e Administrator did not to the former Maintenance is with residents. The e Administrator was aware the former Maintenance in the former Mainte				
	Interview with the facility Compliance Nurse on 01/31/24 at 5:35pm revealed: -Prior to 01/02/24, she was not aware staff had expressed concerns about the former Maintenance Director's physical interactions with residentsSometime prior to 01/02/24, during management meetings, the Administrator had instructed non-care staff to avoid assisting residents with					
	Interview with the Adr 2:55pm revealed: -On 10/19/23, a dieta uncomfortable with the Director providing hug residents on their fore -She interviewed add former Maintenance I giving hugs to Reside	ry aide reported she felt re former Maintenance gs to residents, and kissing sheads. itional staff and was told the Director was often observed				
	-She determined the Director's hugging of inappropriate due to I					

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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. BOILBING.			<b>.</b>
		HAL060166	B. WING	B. WING		, 2/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MICKENIE	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 APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 338	8 Continued From page 26		D 338			
	having episodes of cr staff for hugsShe did not documer interviewsOn 10/20/24, she me Maintenance Director uncomfortable with hi affection towards resi he interacted with res -On 10/20/24, she not Maintenance Director was not permittedBetween 10/19/23 ar provided any written sformer Maintenance Director -She did not know of provided by staff cond Maintenance Director -Between 10/19/23 ar notified of any addition former Maintenance Director related to allegations  Telephone interview wofficer (COO) on 02/0-She was not aware of statements in referencinappropriate behavior-From her perspective hugged a resident, it is inappropriate and wor rightsShe did feel it was in a resident.	ying where she sought out  Int the staff concerns or  It with the former and notified him staff felt is physical expressions of dents and to be careful how idents. Itified the former that kissing of residents  Ind 01/02/24, staff had not statements related to the Director. In ywritten statements Iterring the former dated 11/01/23. Ind 01/02/24, she was not Inal concerns related to the Director, or any other staff of inappropriate behaviors.  In yith the Chief Operating O1/24 at 1:00pm revealed: If any signed staff Iter to any of the staff's Iters. Iters she did not feel if staff Iters would be considered Iters and output of the staff to kiss Iters appropriate for staff to kiss Iters and not feel if staff Iters and output of the staff to kiss Iters and output out				
	-In late January 2024 Administrator had wa 01/02/24 to notify law allegation of sexual a Maintenance Director	ited until after 5:00pm on enforcement of an ssault by the former				

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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	
					С
		HAL060166	B. WING		02/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
WICKSHIE	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 338	were free of neglect, a including inappropriate kissing by a male staff observed and did not remove the residents ensure the male staff the inappropriate behincident involving Resinappropriately expost ouching her genitalia resulted in serious ne constitutes a Type A1  The facility provided a January 30, 2024, and accordance with G.S.  CORRECTION DATE	nsure two female residents abuse and explotation e touching, hugging and if member that staff intervene or attempt to from during the incidents or was not allowed to continue avior which included an sident #3 where she was ed and the male staff was . The facility's failure glect and exploitation which Violation.  a plan of protection on d on February 12, 2024, in 131D-34 for this violation.	D 338		
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 (2) rules in this Sectional procedures.  This Rule is not met a TYPE A1 VIOLATION	Medication Administration me shall assure that the nistration of medications, prescription, and treatments ance with: and prescribing practitioner in the resident's record; and on and the facility's policies as evidenced by:	D 358		

Division of Health Service Regulation

STATE FORM 6899 EFK911 If continuation sheet 28 of 117

	n riealth Service Regu				1	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	בובט
						:
		HAL060166	B. WING		1	<i>2</i> /2024
		1			1 02/1	<u> </u>
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
MIOKOLII	NE OTEE! E ODEE!	13600 S	RYON ST			
WICKSHIP	RE STEELE CREEK	CHARLO	TTE, 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		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
D 358	Continued From page	e 28	D 358			
	. •					
		illed to ensure medications				
		ordered for 4 of 6 sampled				
	residents (#1, #2, #4	, and #5) which included a				
	medication to lower b	lood pressure (#1, #4), a				
	medication to treat ar	n intestinal disorder (#1), a				
	medication to treat va	iginal dryness (#1), a				
	medication to treat de	epression (#2), a medication				
	to treat Alzheimer's di	isease (#2), a medication to				
		4), and a medication used				
	to control high blood					
	The findings are:					
		t #1's current FL2 dated				
	08/21/23 revealed:					
		hypertension, chronic				
	~	re, severe chronic kidney				
	_	irritable bowel syndrome				
	without diarrhea.					
	-There was an order t					
		gh blood pressure) 50mg,				
	one tablet three times					
		for linaclotide (a medication				
		l syndrome) 290mcg, one				
	capsule daily.					
		for estrone vaginal cream (a				
		aginal dryness) 0.1mg/mg,				
	2gms vaginally daily.					
	a Davious of Danisters	t #11a Drimon, Cara				
	a. Review of Residen					
		ers dated 09/07/23 revealed				
	-	ne 50mg, one tablet three				
	times daily.					
	Deview of Desident #	dle December 2022				
	Review of Resident #					
		Administration Record				
	(eMAR) revealed:					
		for hydralazine 50mg, one				
		ly, at 8:00am, 2:00pm and				
	8:00pm.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С
		HAL060166	B. WING		02/12/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
WICKSHIE	RE STEELE CREEK	13600 S TF	RYON ST		
		CHARLOT	TE, NC 28278		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Continued From page	29	D 358		
	three times daily from on 12/22/23 at 8:00ar and on 12/25/23 at 8:10ar and on 12/25/23 at 8:10ar and on 12/25/23 at 8:10ar and 8:00pm, on 12/23 8:00pm and on 02/26.10ar and 2:00pm and on 12:00pm.  The entry was docum the resident was hosp 8:00pm through 12/33	nented with "09" indicating s", on 12/22/23 at 2:00pm s/23 at 8:00am, 2:00pm and s/23 at 8:00am and 2:00pm. nented with "05" indicating " on 12/24/23 at 8:00am and 2/25/23 at 8:00am and nented with "06" indicating pitalized from 12/26/23 at 1/23 at 8:00pm.			
	-Hydralazine 50mg was Resident #1 on 12/22 was on orderHydralazine 50mg was Resident #1 on 12/22 8:00pm, 12/24/23 at 8:00pm be pharmacyHydralazine 50mg was 12/23/23 at 8:00am be could not be located i medication room or in -Hydralazine 50mg was 12/23/23 at 2:00pm as because the medicatire. Hydralazine 50mg was 12/26/23 at 8:00am be seed to 12/26/24 at 8:00am	as not administered on ecause the medication on the medication cart, in the overstock. as not administered on and 12/25/23 at 8:00am on was not in the building. as not administered on ecause the resident was out norning and was only to			

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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: _				
			B WING			C	
		HAL060166	B. WING		02/	12/2024	
NAME OF PI	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 ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
D 358	Continued From page	e 30	D 358				
D 358	Review of Resident # 12/26/23 revealed: -The resident was sole esophagogastroduod screening (a procedu veins in the esophago of small intestines)Resident #1's blood procedure, on 12/26/2 180/90 at 8:42am, 18 at 9:20am (According Association a normal less than 120/80)Anesthesia was cons 9:20am at Resident # aware the resident was her blood pressure m  Review of Resident # (ED) provider note da -Resident #1 had crassounds) on inspiration hypertensive (blood pressure metal)Resident #1's blood 198/84 at 10:02am ar -There was concern freedom sources and the sources of the sident #1's blood 198/84 at 10:02am ar -There was concern freedom sources and the sident #1's blood 198/84 at 10:02am ar -There was concern freedom sources and the sident #1's blood 198/84 at 10:02am ar -There was concern freedom sources and the sident #1's blood 198/84 at 10:02am ar -There was concern freedom sources and the sident #1's blood 198/84 at 10:02am ar -There was concern freedom sources and the sident #1's blood 198/84 at 10:02am ar -There was concern freedom sources and the sident #1's blood 198/84 at 10:02am ar -There was concern freedom sources and the sident #1's blood 198/84 at 10:02am ar -There was concern freedom sources and the sident #1's blood 198/84 at 10:02am ar -There was concern freedom sources and the sident #1's blood 198/84 at 10:02am ar -There was concern freedom sources and the sident #1's blood 198/84 at 10:02am ar -There was concern freedom sources and the sident #1's blood 198/84 at 10:02am ar -There was concern freedom sources and the sident #1's blood 198/84 at 10:02am ar -There was concern freedom sources and the sident #1's blood 198/84 at 10:02am ar -There was concern freedom sources and the sident #1's blood 198/84 at 10:02am ar -There was concern freedom sources and the sident #1's blood 198/84 at 10:02am ar -There was concern freedom sources and the sident #1's blood 198/84 at 10:02am ar -There was concern freedom sources and the sident #1's blood 198/84 at 10:02am ar -There was concern freedom sou	reduled to have an enoscopy (EGD) for variceal re to screen for enlarged us, stomach and beginning pressures, while at the 23 were 183/87 at 7:58am, 9/86 at 8:52am, and 197/90 to the American Heart blood pressure should be sulted on 12/26/23 at 21's bedside and made as administered only one of edications that morning.  The Emergency Department ated 12/26/23 revealed: ckles (abnormal lung on and was significantly pressure greater than pressures on 12/26/23 were and 204/94 at 11:01am.  Resident #1 had congestive	D 358				
		condition when the heart rell enough to meet the					
	body's needs) and the	e clinical impression was					
		ncy (a condition where the					
		ery high with potentially					
	life-threatening sympti- Resident #1 was add						
	-Resident #1 was admitted to the hospital.  Review of Resident #1 hospital discharge summary dated 01/02/24 revealed: -Resident #1 was admitted on 12/26/23 for hypertensive emergency and acute on chronic						
	diastolic heart failure	(when the left ventricle of					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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 NOWIBER.	A. BUILDING: _		COMP	LETED
			D WING		l l	С
		HAL060166	B. WING		02/	12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, 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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 358	Continued From page	e 31	D 358			
	the heart cannot fill pro-Resident #1 had multiple CHF and uncontrolled -Resident #1's hydral for better blood press	roperly due to stiffness). Itiple hospitalizations for d hypertension recently. azine dose was increased				
	Observations of medications on hand for Resident #1 on 01/05/24 revealed: -There were three bubble packs containing hydralazine 50mg for Resident #1All three bubble packs had a fill date of 12/25/23The first bubble pack contained 30 tablets of hydralazine 50mg with no medications missing from the packThe second bubble pack contained 30 tablets of hydralazine 50mg with no medications missing from the packThe third bubble pack contained 9 tablets of hydralazine 50mg with no medications missing from the pack.					
	Telephone interview with a representative from the facility's contracted pharmacy on 01/31/24 at 10:03am revealed:  -The facility was on cycle fill which meant the residents' medications were dispensed to the facility every 28 days.  -Resident #1's hydralazine 50mg, one tablet three times daily, 84 tablets were dispensed to the facility on 09/28/23.  -Resident #1's hydralazine 50mg should have run out around 10/25/23 or 10/26/23 from the 09/28/23 dispensed date.  -Hydralazine 50mg was not automatically dispensed on 10/25/23 because the pharmacy needed a new order.  -She notified the facility by email each month of residents needing a new order for the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE ( A. BUILDING:	(X3) DATE SURVEY COMPLETED		
			7 20.12310		
		HAL060166	B. WING		C 02/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E, ZIP CODE	
		13600 S	TRYON ST		
WICKSHII	RE STEELE CREEK		TTE, NC 28278		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION (X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
D 358	Continued From page	e 32	D 358		
	medications to be dis	pensed for the next cycle.			
		the new order on 12/13/23			
	-	ralazine 50mg, three times			
	daily.	<b>5</b> .			
	-The order dated 12/1	13/23 was not automatically			
		ity because it was received			
	outside of the window				
		ve needed to request the			
		ensed to catch them up to			
		cle-fill would begin again. 9 tablets were dispensed on			
	12/25/23 for Resident				
		with a pharmacist from the harmacy on 01/31/24 at			
	_	nedication used to lower			
	blood pressure.				
		t receive her hydralazine			
	50mg as ordered it co	ould lead to elevated blood			
	pressures and possib				
	_ · · · · · · · · · · · · · · · · · · ·	should have been notified of			
	any missed doses of	hydralazine 50mg.			
	Telephone interview v	with Resident #1's family			
	member on 02/02/24				
	-	scribed two different blood			
	•	s, one to be administered			
	· ·	her to be administered three			
	times daily.	neduled for an EGD on			
		tructed to only take her			
	blood pressure medic	•			
	procedure with a sip				
		nber when, but she informed			
		ne medication instructions			
	-She was at the facilit	ty on 12/26/23 before			
		was taking Resident #1 out			

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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
					С
		HAL060166	B. WING		02/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
WICKSHIE	RE STEELE CREEK	13600 S T			
			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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
D 358	Continued From page	e 33	D 358		
	administered to Residentially for the EGD pressure medically for the EGD pressure medically for the Resident #1 were EGD her blood pressure systolic number (top resident #1 were 200 (normall than 120).  After the EGD, Resident #1 told the being administered the medication she received.	esident #1 was to receive two seations in the morning. It was being prepared for her pure was high, with the number of a blood pressure) all systolic pressure is less dent #1 was not feeling well, ted across the street to the ED physician she was not le blood pressure			
	Telephone interview with Resident #1's PCP on 01/18/24 at 3:20pm revealed: -Resident #1 was ordered hydralazine 50mg three times daily for hypertensionHydralazine is a short acting medication and that was the reason it was prescribed three times dailyIf Resident #1 did not receive hydralazine 50mg, three times daily as ordered she could have elevated blood pressures and possibly a vascular accident (stroke)Resident #1's hypertensive crisis on 12/26/23 could be related to not receiving her hydralazine 50mgThe facility did not notify her Resident #1 was not receiving hydralazine 50mg as ordered.  Interview with the Resident Care Coordinator (RCC) on 02/05/24 at 10:54am revealed she was				
	(RCC) on 02/05/24 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 FLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING: _	A. BUILDING:		
		HAL060166	B. WING	B. WING		,,
					02/12/202	24
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIP	RE STEELE CREEK	13600 S TI CHARLOT	TE, NC 28278			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N I	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE CO	MPLETE DATE
D 358	Continued From page	e 34	D 358			
	not available for admi	inistration.				
		with the Resident Care n 02/05/24 at 10:54am.				
	Refer to the interview Nurse on 02/05/24 at	with the facility Compliance 2:39pm.				
		with the Regional Director on 01/05/24 at 4:02pm.				
	b. Review of Residen 09/07/23 revealed an 290mcg, one capsule					
	revealed: -There was an entry f capsule daily at 8:00a -The entry was docur from 12/01/23 through 12/15/23 through 12/2 -The entry was docur "other/see nurse note 12/14/23 and on 12/2 -The entry was docur the resident was hosp through 12/31/23.	nented as administered daily h 12/10/23 and from 25/23. nented with "09" indicating ss", from 12/11/23 through 6/23. nented with "06" indicating bitalized from 12/27/23  was documented as not 4 opportunities from				
	-Linaclotide 290mcg v 12/11/23 because the order. -Linaclotide 290mcg v 12/12/23 because it w -The facility's pharma					

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STATE FORM 6899 EFK911 If continuation sheet 35 of 117

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. BOILDING		c	
		HAL060166	B. WING		1	2/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
WICKSHIP	RE STEELE CREEK		TRYON ST			
	CLIMMADY CT		TTE, NC 28278	DDOWNERIC DLAN OF 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	(X5) COMPLETE DATE
D 358	Continued From page	35	D 358			
	not available for Resident #1 because the pharmacy needed a new scriptLinaclotide 290mcg was not administered on 12/14/23 because it was unavailable.  Observations of medications on hand for Resident #1 on 01/05/24 revealed: -There was a bubble pack containing linaclotide 290mcg for Resident #1The label indicated linaclotide 290mcg, 30 capsules were dispensed on 12/13/23There were 19 capsules remaining.					
	Telephone interview with a representative from the facility's contracted pharmacy on 02/05/24 at 9:10am revealed: -Linaclotide 290mcg, 30 capsules were dispensed for Resident #1 on 11/04/23 and 12/13/23.					
		t receive linaclotide 290mcg sult in diarrhea or				
	Refer to the interview at 10:54am.	with the RCC on 02/05/24				
	Refer to the interview Nurse on 02/05/24 at	with the facility Compliance 2:39pm.				
	Refer to the interview at 4:02pm.	with the RDO on 01/05/24				
	c. Review of Resident #1's PCP orders dated 09/07/23 revealed an order for estrone cream 1%, insert 2 grams vaginally daily.					
	revealed:	1's December 2023 eMAR or estrone cream 1%, insert				

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2 grams vaginally daily.

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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:		EIED
		HAL060166	B. WING		02/1	; 2/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
		13600 S TI	RYON ST			
WICKSHIE	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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
D 358	from 12/01/23 through 12/09/23, from 12/14/12/25/23.  -The entry was docum other/see nurse note 12/07/23 and from 12/24/23.  -The entry was docum refused on 12/24/23.  -The entry was docum the resident was host through 12/31/23.  Review of Resident #-Resident #1's estron not administered on 1 available, and the phanight (12/03/23).  -On 12/04/23, 12/10/2 the nurse notes reveawas not available for -On 12/05/23, 12/06/2 notes did not specify was not administered -On 12/07/23 the nurse provider had been coit would be escribed to Observations of media Resident #1 on 01/05 partial tube of estrone label with a dispense Telephone interview was the facility's contracted 9:10am revealed:  -Estrone cream 1%, 4	nented as administered daily in 12/02/23, from 12/08/23 to 23 through 12/23/23, and on mented with "09" indicating is", from 12/03/23 through /10/23 through 12/13/23. In the day in the first of the fi	D 358			
	-A 42.5gm tube of est	rone should last about 21				

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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		C <b>02/12/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE	
WICKSHIE	RE STEELE CREEK	13600 S T	RYON ST		
WICKSIIII	NE STELLE ONLER	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 CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
D 358	Continued From page	e 37	D 358		
	days if 2gms were ad for Resident #1. -If Resident #1 did no	Iministered daily as ordered of receive estrone cream 1% sult in decreased estrogen			
	Refer to the interview at 10:54am.	with the RCC on 02/05/24			
	Refer to the interview Nurse on 02/05/24 at	with the facility Compliance 2:39pm.			
	Refer to the interview at 4:02pm.	with the RDO on 01/05/24			
	06/19/23 revealed dia	nt #5's current FL2 dated agnoses included dementia, diabetes, and anxiety.			
	11/23/23 revealed an insulin (a long acting inject 17 units subcut	5's PCP orders dated order for Lantus 100 unit/ml insulin to treat diabetes) aneously in the morning and neously in the evening.			
	revealed: -There was an entry figive 17 units subcutaneous -The entry was docur from 01/01/24 throug -The entry for 01/25/2 "09" indicating other/s -The entry for 01/26/2 indicating other/see manual contents of the entry for 01/26/2	mented as administered daily h 01/24/24. 24 was documented with see nurse notes. 24 was documented as "06" nurse notes.			
	-Lantus 100 unit/ml ir	5's nurse notes revealed: nsulin was not administered the facility was waiting on			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					OMPLETED	
		HAL060166	B. WING		02	C / <b>12/2024</b>
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E, 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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 358	high blood sugar) was around 8:00am from a because Resident #5 unit/ml insulin.  -At 11:30am Resident her blood sugar was 4-A nurse practitioner to assessed Resident #5 followed by sugar was Review of Resident #5 followed by sugar was Review of Resident #6 (ED) visit on 01/26/24 She was given oral general secondary to a medicular presented to the secondary to a me	medication used to control is administered on 01/26/24 another resident's insulin was out of Lantus, 100 at #5 was not at baseline, and 45. For another resident is and ordered orange juice ter and to call EMS.  5's emergency department is revealed: glucose by EMS. Is ED for hypoglycemia reation error. It is attain error. It is attain error. It is attained back to the insulin was returned back to the insulin was returned back to the insulin was dispensed on 11/29/23 for 2 pens and 11/29/23 for 2 pens and 11/29/24 at 10:57am and 02/08/24 at 10:57am and 0	D 358			

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DIVISION	n nealth Service Negu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
		1141 000400	B. WING		C	2/2024
		HAL060166			02/12	2/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		13600 S T	RYON ST			
WICKSHIRE STEELE CREEK CHARLOT		TTE, NC 28278				
0(1) 15	SLIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		0/5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
D 358	Continued From page	20	D 358			
D 330	Continued From page	: 39	D 330			
	Interview with Reside	nt #5's PCP on 02/02/24 at				
	10:18am revealed:					
	-She was aware the fa	acility ran out of				
	medications.					
	-She was made awar	e of Resident #5 not getting				
	her Lantus, 100 unit/r	nl on 01/26/24 because				
	Resident #5 was give	n another residents insulin.				
	-She was told the facility does cart audits but did not know why Resident #5 did not have any					
	Lantus on the medica	ition cart.				
	-If Resident #5 did no	t get her insulin, her blood				
	sugar would increase	and over time this could				
	cause other complica	tions.				
	•					
	Interview with the faci	ility compliance nurse on				
	01/31/24 at 3:35pm re	evealed:				
	-She did not know wh	y the insulin was not on the				
	cart for Resident #5.					
	-All staff who adminis	tered medication knew they				
	were not to borrow me	edications from other				
	residents.					
	-Resident #5's Lantus	s 100 unit/ml insulin was to				
	be reordered by the N	//As when there was 1 pen				
	left.					
	Interview with the SC	C on 02/02/24 at 9:58am				
	revealed:					
		dits 2 or 3 times a week.				
		identify if any medications				
	were not on the cart.					
		t have a place to put how				
	• •	hen the audit was done.				
		esident #5 did not have any				
	insulin.					
		as missed, we were to notify				
	-	er aware and this was not				
	done for Resident #5.					
	Interview with the RD	O on 02/05/24 at 4:02pm				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. BOILBING.		c	
		HAL060166	B. WING		02/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHII	RE STEELE CREEK	13600 S TI				
			TE, NC 28278		T 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	Ξ
D 358	Continued From page	<del>2</del> 40	D 358			
D 358	revealed: -The best practice ware-A 24 hour report was which identified any not this report was brough this report was brough the facility compliant for making sure cart are the facility compliant for following up with the sure medications were reported by the facility compliant for following up with the sure medications were reported by the facility compliant for following up with the sure medications were refer to interview with the facility of the facilit	is to do cart audits daily. Is run by the facility nurse medications not given and that to the morning meeting. It ce nurse was responsible audits occurred. It ce nurse was responsible the RCC and SCC to make the available for the residents. In the facility Compliance 2:39pm. In the RCC on 02/05/24 at the RCC on 02/05/2	D 358			
	administered daily on	01/27/24 and 01/30/24.				
	Review of Resident # notes revealed:	2's January 2024 progress				

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		SURVEY PLETED				
			A. BUILDING:			
			P WING			С
		HAL060166	B. WING		02	2/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
WIOKOLIII	DE OTEEL E ODEEK	13600 S	TRYON ST			
WICKSHII	RE STEELE CREEK	CHARLO	OTTE, NC 28278			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETE DATE
D 358	Continued From page	e 41	D 358			
	-There was an entry of	dated 01/27/24 at 4:42pm				
		azodone 50mg medication				
	was not available for	administration.				
		dated 01/30/24 at 8:19pm				
		azodone 50mg medication				
	was not available for	administration.				
	Observation of Resid	ent #2's medications				
	available for administ					
		zodone 50mg daily at				
	bedtime was not avai	lable for administration.				
	Telephone interview with the facility's contracted					
	-	4 at 12:30pm revealed:				
		one 50mg medication daily				
	was on a every 28-da	-				
	-Resident #2's trazod	one 50mg medication was				
		28 doses and delivered to				
	the facility on 11/20/2					
		one 50mg medication was				
	the facility on 12/18/2	28 doses and delivered to				
		d a refill of Resident #2's				
	trazodone 50mg med					
	-Resident #2's trazod	one 50mg medication was				
		14 doses and delivered to				
	the facility on 01/31/2					
		one 50mg was used to				
	assist with sleeping th	rroughout the night.				
	Telephone interview v	with Resident #2's Nurse				
		/24 at 10:18am revealed:				
		scribed trazodone 50mg				
		ninistered every night to aid				
	in staying asleep.	2				
		Resident #2's trazodone				
	50mg medication was					
	administration in Janu					
		cility to administer Resident medication as ordered.				

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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 MINO		С
		HAL060166	D. WING		02/12/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
WICKSHIE	RE STEELE CREEK		RYON ST		
		CHARLO	TTE, NC 28278		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIMENCY)	D BE COMPLETE
D 358	Continued From page	e 42	D 358		
	Interview with a first since 12:30pm revealed: -Resident #2's had ar medication to be adminated adminated and resident #2's trazod refilled by the facility's monthly for 28 dosesShe did not know who 50mg medication was administration.  b. Review of Resident electronic medication (eMAR) revealed: -There was an entry of 5mg tablet daily scheen about administered daily scheen and administered daily scheen and revealed: -There was an entry of which documented downs 'awaiting pharmated and the side of the s	shift MA on 01/31/24 at n order for trazodone 50mg sinistered every night. one 50mg medication was inistration. one 50mg medication was is contracted pharmacy by Resident #2's trazodone is not available for  It #2's January 2024 administration record  Idated 07/28/21 for donepezil duled for 9:00am. cation was documented as y on 01/28/24 and 01/29/24.  Idated 01/28/24 at 8:21am onepezil 5mg medication acy'. Idated 01/29/24 at 9:17am onepezil 5mg medication acy'. Idated 01/29/24 at 9:17am onepezil 5mg medication acy'. In the facility's contracted Idated 01/23/25 contracted			
	-Resident #2's donep was on a every 28-da -Resident #2's donep	ezil 5mg medication daily ly cycle fill schedule. ezil 5mg medication was			
	the facility on 11/20/2				
		ezil 5mg medication was 28 doses and delivered to			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
		HAL060166	B. WING		02/1	; 2/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	•	
WICKSHIRE STEELE CREEK 13600 S T						
			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 358	Continued From page	<del>2</del> 43	D 358			
	the facility on 12/18/2 -The facility requested donepezil 5mg medicing-Resident #2's donep filled on 01/30/2 -Resident #2's donep memory impairmentResident #2's donep memory impairmentResident #2's donep cycle fillThe facility should not unless the facility was fill to replenish the old line in the property of the facility was fill to replenish the old line in the property of the facility was fill to replenish the old line in the property of the facility was fill to replenish the old line in the property of the facility was fill to replenish the old line in the property of the facility was fill to replenish the old line in the property of the facility was fill to replenish the old line in the facility was fill to replenish the facility was fill to replenish the facility was fill to replenish the facility was administration on 01/2-MAs and the SCC was administration on 01/2-Resident #2 was premedication to be adminished in the facility of the facility was premedication to be adminished in the facility of the facili	d a refill of Resident #2's ation on 01/30/24. ezil 5mg medication was 15 doses and delivered to 4. ezil 5mg was used to treat ezil 5mg was on a 28 day of run out of donepezil 5 mg susing the new 28 day cycle 128 day cycle fill. ehift MA on 01/31/24 at an order for donepezil 5mg inistered daily. ezil 5mg medication was a contracted pharmacy by Resident #2's donepezil not available for 28/24 and 01/29/24. ere responsible to audit as on a weekly basis. evith Resident #2's Nurse 24 at 10:18am revealed: scribed donepezil 5mg				
	#2's donepezil 5mg m	cility to administer Resident nedication as ordered. t #4's current FL2 dated				

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11/09/23 revealed diagnoses included essential

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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			С	
		HAL060166	B. WING		02	2/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E. ZIP CODE	·		
			TRYON ST	2,2 0002			
WICKSHI	RE STEELE CREEK		TTE, NC 28278				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
D 050			D 050	DEFICIENC	1)		
D 358	Continued From page	e 44	D 358				
	hypertension, vascula cardiopulmonary dise peripheral vascular di	ase, hyperlipidemia, and					
	11/09/23 revealed an	a medication to treat high					
	revealed: -There was an entry f mg, one tablet daily s -The entry was docur "other/see nurse note and 01/09/24-01/11/2 -Amlodipine besylate	nented with "09" indicating es" on 01/06/24 to 01/07/24, 4. 10mg was documented as ut of 6 opportunities from					
	-On 01/06/24 amloding was not administered was unavailableOn 01/07/24 amloding was not administered was unavailableOn 01/09/24 amloding was not administered was pending deliveryOn 01/10/24 amloding was not administered in medication for refill notified this MA will for today."	oine besylate 10mg tablet , the note read; "MA called s last week, family was ollow up with family again oine besylate 10mg tablet because waiting for					
		ations on hand for Resident					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
		HAL060166	B. WING		02	C <b>2/12/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MICKELII	RE STEELE CREEK	13600 S	TRYON ST			
WICKSHII	RE 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 OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 45	D 358			
		Opm revealed there was a sesylate 10mg available with a dispense date of				
	Resident #4's pharma revealed: -Resident #4 had and besylate 10mg 1 table	et daily. ere 30 tablets of amlodipine				
	revealed: -The facility called whe medications, and the she could not recall amlodipine besylate. She needed a threeto get the medication delivered to the facility.	nen Resident #4 was out of y called consistently. when they notified her the 10mg tablets needed refills. Ito-four-day turnaround time filled, picked up and y. mlodipine besylate and				
	02/05/24 at 2:55pm re-When Resident #4's down to 10 to 15 pills Resident #4's Responsive up the medication bring them to the facility the medications we notifying the Responsithe facility's contracted medication and the fact the cost of the medication.	medications would get the MAs were to notify nsible Party and she would ns from her pharmacy and lity. ere not available after sible Party, the MAs called ad pharmacy to get the acility would bill the family for				

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STATE FORM 6899 EFK911 If continuation sheet 46 of 117

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
					C	;	
		HAL060166	B. WING	B. WING		02/12/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
WICKSHIRE STEELE CREEK 13600 S TR			RYON ST				
WIOROIM	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 358	Continued From page	<del>2</del> 46	D 358				
D 358	of his amlodipine bes-She did not call the camlodipine besylate woon-1/11/24 because she Party, and she was be besylate to the facility-If the medication was would document a "Orprogress note.  If a Resident missed would call the Responded call the Responded call the Responded call the Responded call the Compliance Nurse Interview with the factor on time, the factor of the medication because arrive on time, the factor reach out to the facilitities an extra supply of Refer to the interview at 9:58am  Refer to the interview at 9:58am  Refer to the telephond Compliance Nurse on Refer to the interview at 4:02pm.  b. Review of Resident	ylate on 01/06/24. contracted pharmacy for when she worked on a contacted the Responsible ringing in the amlodipine on 01/11/24. Is not available, the MAs 9" code and enter a more than 2 doses, she is ible Party to get the spossible. PCP, pharmacy, SCC, and a of the missing medication. Ility Compliance Nurse on evealed Resident #4 missed the medications did not is ility waited too long to in and the facility did not by's contracted pharmacy to it medication for Resident #4.  with the SCC on 02/02/24  with the facility Compliance 2:39pm.  The interview with the facility in 02/07/24 at 2:31pm.  with the RDO on 02/05/24	D 358				
	11/09/23 revealed an	order for losartan potassium medication to treat high					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
ANDILAN	or connection	IDENTIFICATION NOWIDER.	A. BUILDING: _		COMIT LETED
		HAL060166	B. WING		C 02/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
WICKSHIE	RE STEELE CREEK	13600 S T			
			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 CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
D 358	Continued From page	e 47	D 358		
	revealed: -There was an entry f 25mg one tablet daily -The entry was docur	nurse notes" on 01/09/24,			
	-On 01/09/24 losartar was not administered pending delivery." -On 01/10/24 losartar was not administered in medication for refill notified, this MA will fitoday." -On 01/11/24 losartar 1 tablet daily was not "waiting for daughter"	s nurses notes revealed: In potassium tablet 25mg I because medication was In potassium tablet 25mg I, the note read; "MA called Is last week, family was collow up with family again In potassium tablet 25mg give I administered, the note read; I to bring in medication." I cations on hand for Resident Copm revealed there was a			
	bottle of losartan pota	assium 25mg tablets macy label with a dispense			
	Resident #4's pharma revealed: -Resident #4 had an 25mg 1 tablet daily. -On 01/02/24 there w	with a representative from acy on 02/06/24 at 10:02am order for losartan potassium ere 30 tablets of losartan on 01/11/2024 by Resident ty.			
	revealed:	with Resident #4's n 02/02/24 at 12:15pm nen Resident #4 was out of			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
			A. BOILDING.			_
		HAL060166	B. WING		02	C 2/ <b>12/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
WIOKOLIII	DE OTEEL E ODEEK	13600 S	TRYON ST			
WICKSHII	RE STEELE CREEK	CHARLO	TTE, NC 28278			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL 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 358	358 Continued From page 48		D 358			
	medications, and they-She could not recall losartan potassium 28-She needed a three-to get the medication delivered to the facilitit-She picked up the lodelivered it to the facilitit-She picked up the lodelivered it to the facilitit-She picked up the lodelivered it to the facility-She picked up the lodelivered it to the facility-She sident #4's Responsive up the medication bring them to the facility has notifying the Responsithe facility's contracted medication and the facility contracted the cost of the medication-She was not working of his losartan potass 01/09/24.  She did not call the contracted who told her she was potassium to the facility has not would document a "00 progress note.  If a Resident missed would call the Response medication as soon anshe would notify the	when they notified her the comp tablets needed refills. Ito-four-day turnaround time filled, picked up and y. It is sartan potassium and lity on 01/11/24.  In 1/31/24 at 3:54pm and evealed: In medications would get the MAs were to notify insible Party and she would insible Party and she would insible Party, the MAs called and pharmacy to get the incility would bill the family for action.  If when Resident #4 ran out it ium 25mg tablets on contracted pharmacy for the worked on 01/11/24 and the Responsible Party bringing in the losartan ity on 01/11/24. It is not available, the MAs 19 code and enter a 1 more than 2 doses, she insible Party to get the insible Party				
		ility Compliance Nurse on evealed Resident #4 missed				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE Co			E SURVEY PLETED	
		HAL060166	B. WING		02	C 2 <b>/12/2024</b>
	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 ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	medications because arrive on time, the fact receive the medication reach out to the contrextra supply of medical Refer to the interview at 9:58am  Refer to the interview Nurse on 02/05/24 at Refer to the telephonic Compliance Nurse on Compliance Nurse on Refer to the interview at 4:02pm.  c. Review of Resident 11/09/23 revealed an medication to prevent tablet daily.  Review of Resident # revealed:  -There was an entry for daily scheduled for 8:  -The entry was docur "other/see nurse note 01/10/24 and 01/11/2  Review of Resident # -On 01/07/24 plavix 7 on 01/07/24 because unavailable.  -On 01/09/24 plavix 7 because the medicatirular -On 01/10/24 plavix 7	the medications did not cility waited too long to n and the facility did not acted pharmacy to get an ation for Resident #4.  with the SCC on 02/02/24  with the facility Compliance 2:39pm.  e interview with the facility n 02/07/24 at 2:31pm.  with the RDO on 02/05/24  t #4's PCP orders dated order for plavix (at blood clots) 75mg one  4's January 2024 eMAR  for plavix 75mg one tablet 00am.  nented with "09" indicating is on 01/07/24, 01/09/24, 4.  4's nurses notes revealed: 5mg was not administered the medication was  5mg was not administered on was pending delivery. 5mg was not administered, sation Aide (MA) called in	D 358			

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HALOGOAGE	B. WING		0.0	C
		HAL060166			02	2/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	E, ZIP CODE		
WICKSHI	RE STEELE CREEK		TRYON ST			
		CHARLO	OTTE, NC 28278			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 358	D 358 Continued From page 50		D 358			
	today."	ollow up with family again 5mg was not administered daughter to bring in				
	#4 on 01/31/24 at 3:5	ations on hand for Resident 0pm revealed plavix 75mg 2/24 medications were de.				
	Telephone interview with a representative from Resident #4's pharmacy on 02/06/24 at 10:02am revealed: -Resident #4 had an order for plavix 75mg 1 tablet dailyOn 01/02/24 there were 30 tablets of plavix 75mg picked up on 01/11/2024 by Resident #4's Responsible Party.					
	revealed: -The facility called wh medications, and the She could not recall plavix needed refillsShe needed a threeto get the medication delivered to the facility	n 02/02/24 at 12:15pm  then Resident #4 was out of a called consistently.  When they notified her the to-four-day turnaround time filled, picked up and				
	02/05/24 at 2:55pm re- -When Resident #4's down to 10 to 15 pills Resident #4's Respon	medications would get the MAs were to notify nsible Party and she would ns from her pharmacy and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
A. Boll		A. BOILDING		C			
		HAL060166	B. WING		1	2/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
WICKSHII	RE STEELE CREEK		RYON ST				
	Г		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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE	
D 358	Continued From page	e 51	D 358				
	the facility's contracted medication and the factor the medication and the factor the cost of the medication are the cost of the medication of his plavix 75 mg tares and she did not call the contracted and she was bringing on 01/11/24.  If the medication was would document a "Or progress note.  If a Resident missed would call the Response medication as soon and she would notify the	sible Party, the MAs called ed pharmacy to get the acility would bill the family for ation.  g when Resident #4 ran out blets on 01/07/24.  contracted pharmacy for e worked on 01/11/24 ed the Responsible Party, in the plavix to the facility in the plavix to the facility so not available, the MAs 9" code and enter a more than 2 doses, she insible Party to get the					
	01/31/24 at 4:54pm re medications because arrive on time, the face receive the medication reach out to the contrextra supply of medical Refer to the interview at 9:58am  Refer to the interview Nurse on 02/05/24 at Refer to the telephonic Compliance Nurse or 100 per medical Refer to the telephonic Refer to the telepho	e interview with the facility					

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at 4:02pm.

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DIVISION	n nealth Service Regu	ialion			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			1	<del></del>	
			P WING		С
		HAL060166	B. WING		02/12/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		13600 S T		,	
WICKSHIP	WICKSHIRE STEELE CREEK		TE, NC 28278		
			TE, NC 20276		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	( - /
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
IAG	NEGOEMONI ON E	iso is a real first or the state of the stat	TAG	DEFICIENCY)	W. (1)
			+		
D 358	Continued From page 52		D 358		
	Interview with the PC	 C on 02/05/24 at 10:54am			
		C 011 02/03/24 at 10.34a111			
	revealed:	naible for ardering the			
	-	nsible for ordering the			
		s when there were about			
	_	ation available to administer.			
		MAs to order medications			
	early in case a new so				
		s were to be completed two			
	•	ek by her and the SCC.			
		e did not get the medication			
		and she asked the MAs to			
	complete them.				
		fill out when completing the			
		was to be reviewed by the			
	facility's compliance n				
		completed by comparing			
		with the medications on			
	hand for that resident				
		running low or unavailable,			
	-	vith the pharmacy and			
	indicate it on the cart	audit form.			
		not available on the cart and			
	the pharmacy had an	order, she would have them			
	dispense it to the faci	- ·			
	-She was responsible				
	medication audit repo	rt five times per week for			
	assisted living.				
		C on 02/02/24 at 9:58am			
		n cart audits were being			
	performed 2 to 3 days				
		d identify if the medication			
	was not on the cart.				
	-He did not have a co	lumn to indicate how many			
	pills or supply of med	ication was remaining on the			
	medication cart audit				
	-The audit results wer	re given to the facility			
		er they were completed, and			

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she was aware of the resident's missing

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>'</b>	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		_	
		HAL060166	B. WING		C 02/12/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE STEELE CREEK	13600 S TF	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	E
D 358	Continued From page 53		D 358			
	medications.  -If the resident's Responsible pharmacy, staff were the medications are de-When medications at the PCP and the Resmedication missing aput in the progress notif the Responsible Pamedication after a we pharmacy and bill the would try to give the Responsible in the medication after a well-would try to give the Responsible in the medication after a well-would try to give the Responsible in the medication in the medication in the medication.	consible Party used an d not the facilities contracted to contact the family when lown to 7 pills.  The missing, they would notify ponsible Party of the not a note should have been been on the for that resident.  The party had not brought in the new or two, we would call the expensible Party, but we responsible Party a chance attion.				
	02/05/24 at 2:39pm re-The MAs were responsed in the beginning and SCC were to run missed medications report.  -Since the beginning responsible for running and a code was put in "09", the medications responsible for running and a code was put in "espons	ensible for ordering the s when there was about a vailable to administer. It is gof January 2024, the RCC two reports each day, the eport and the 24-hour of January 2024, she was age the 24-hour report. In the eMAR system, such as would not appear on the eport, but it would appear on the edications on the 24-hour at the morning management essed medications was				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. BOILBING.			
		HAL060166	B. WING		C <b>02/12/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE STEELE CREEK	13600 S TF				
			TE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	e 54	D 358			
D 358	every Tuesday and Ti SCC.  -The audit compared residents' eMARs witi -There was a paper of the medication cart at -The paper document of medication availabin the cart.  -If a medication was rup with the RCC and -She saw occasions of medications were not relephone interview where Nurse on 02/07/24 at -If the resident did not pharmacy, their Responsible Party hamedication the medication sup Responsible Party hamedication.  -The PCP should have the Responsible Party missed.  -When the medication should be signed that	medications on the medications on hand. ocument completed during udit. It did not include the quantity le, just if the medication was not on the cart, she followed the SCC. On the 24-hour report when available for administration. With the facility Compliance 2:31pm revealed: It use the contracted onsible Party should be medication. It is down to zero, and the did not brought in the ation should be ordered did pharmacy and the facility sible Party for the le been notified as well as a factor of the sit was brought to the facility it it was delivered and	D 358			
	person who received MA or their superviso					
	brought the medication	ber of pills and the progress				
	Interview with RDO o	n 02/05/24 at 4:02pm				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SI		
,		.5	A. BUILDING: _		""	
			D WING		C	
		HAL060166	B. WING		02/1	2/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MICKELIE	DE STEEL E CDEEK	13600 S TR	YON ST			
WICKSHIP	RE STEELE CREEK	CHARLOT	TE, NC 28278			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 55	D 358			
	revealed: -He began coming to of January 2024Resident medication the beginning of the five which was about 8 do -Reordering medication problem in the facility -Medication cart audit weekly prior to the minow they were to be on -The RCC and the SC medication cart audits -The facility Compliant for following up on the medicationsWhen residents chost pharmacy and the medications were to order the medication pharmacy, the facility medication and then in Party for the medications were the Responsible Party to document in the elemany pills were broughted.	the facility the second week s were to be re-ordered at ourth row of the bubble pack bees left to administer. ons timely seemed to be a . Its were being done twice ddle of January 2024 and done daily. OC were responsible for the s. Ince Nurse was responsible the 24-hour report for missed see to use an outside redication was not brought to reponsible Party the SCC was on from the contracted would pay for the in turn bill the Responsible on. orought into the facility by y, the best practice would be rectronic health record how ght in.				
	administered as order	nsure medications were red for 4 of 6 residents (#1,				
		dent #1 did not receive				
	multiple doses of bloc medication including	· ·				
		when she had higher than				
		es, was taken to the ED				
	following the procedu					
	hypertensive emerge					
		charged to a skilled nursing				
	facility. Resident #5 w	vas administered short of the physician ordered				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL060166	B. WING		C <b>02/12/2024</b>
	ROVIDER OR SUPPLIER	13600 S	DDRESS, CITY, STATE TRYON ST OTTE, NC 28278	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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	ED with a blood sugaresulted in serious ne A1 Violation.  The facility provided a February 12, 2024, in 131D-34 for this viola CORRECTION DATE VIOLATION SHALL N 2024.	sulting in being sent to the r of 45. The facility's failure eglect and constitutes a Type a plan of protection on accordance with G.S. tion.  FOR THE TYPE A1 NOT EXCEED MARCH 13,	D 358		
D 367	(j) The resident's me record (MAR) shall be following: (1) resident's name; (2) name of the medic (3) strength and dosa administered; (4) instructions for ad or treatment; (5) reason or justifica medications or treatm documenting the resu (6) date and time of a (7) documentation of medications or treatm omission, including re (8) name or initials of the medication or treasignature equivalent in the state of the medication of the signature equivalent in the following state of the medication or treasignature equivalent in the following state of the medication or treasignature equivalent in the following state of the medication or treasignature equivalent in the following state of the medication or treasignature equivalent in the following state of the medication or treasignature equivalent in the following state of the medication or treasignature equivalent in the following state of the medication or treasignature equivalent in the following state of the medication or treasignature equivalent in the following state of the medication or treasignature equivalent in the following state of the medication or treasignature equivalent in the following state of the medication or treasignature equivalent in the following state of the medication or treasignature equivalent in the following state of the medication or treasignature equivalent in the following state of the medication or treasignature equivalent in the following state of the medication of the me	Medication Administration dication administration e accurate and include the cation or treatment order; age or quantity of medication ministering the medication tion for the administration of ments as needed (PRN) and alting effect on the resident; administration; any omission of ments and the reason for the efusals; and, the person administering atment. If initials are used, a to those initials is to be intained with the medication	D 367		

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		C
		HAL060166	B. WING		02/12/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
WICKSHIE	RE STEELE CREEK		TRYON ST		
		CHARLO	TTE, NC 28278		,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	BE COMPLETE
D 367	7 Continued From page 57		D 367		
	This Rule is not met as evidenced by: TYPE B VIOLATION				
	facility failed to ensure Administration Record 2 of 5 residents (#1 a documentation of a m hypertension (#1, #4) vaginal dryness (#1), blood clots (#4). The findings are:	ds (MAR) were accurate for nd #4) including inaccurate nedication to treat , a medication to treat and a medication to prevent			
	1. Review of Resident #1's current FL2 dated 08/21/23 revealed:  -Diagnoses included hypertension, chronic congestive heart failure, and severe chronic kidney disease stage 4.  -There was an order for hydralazine (a medication to treat high blood pressure) 50mg, one tablet three times daily.  -There was an order for estrone vaginal cream (a medication to treat vaginal dryness) 0.1mg/mg, 2gms vaginally daily.				
		t #1's Primary Care ers dated 09/07/23 revealed ne 50mg, one tablet three			
	(eMAR) revealed: -There was an entry f tablet three times dail 8:00pmThe entry was documents	Administration Record for hydralazine 50mg, one by at 8:00am, 2:00pm and mented as administered ept on 11/04/23 at 8:00am			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			SURVEY PLETED	
						0
		HAL060166	B. WING		02	C / <b>12/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATI	E ZIP CODE	·	
NAME OF T	NOVIDEN ON OUR FEIEN		TRYON ST	L, Zii OODL		
WICKSHI	RE STEELE CREEK		TTE, NC 28278			
	CHMMADV CT			DDOV/DEDIS DI ANI OF C	CORRECTION	0.5
(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 ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From page 58		D 367			
	hospitalized.					
	revealed: -There was an entry fitablet three times dail 8:00pmThe entry was docur three times daily from on 12/22/23 at 8:00al and on 12/25/23 at 8:  Interview with a represent contracted pharmacy revealed: -The facility was on coresidents' medication facility every 28 days -Resident #1's hydral times daily, 84 tablets facility on 09/28/23.	esentative from the facility's on 01/31/24 at 10:03am  ycle fill which meant the swere dispensed to the azine 50mg, one tablet three swere dispensed to the azine 50mg should have run				
	09/28/23 dispensed of -Hydralazine 50mg w	late.				
	needed a new orderShe notified the facil residents needing a r	ity by email each month of				
	for Resident #1's hyd daily.	the new order on 12/13/23 ralazine 50mg, three times				
	dispensed to the facil outside of the window -The facility would ha medication to be disp	ve needed to request the ensed to catch them up to				
		cle-fill would begin again. 9 tablets were dispensed on				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	or Connection	IBENTI TOATION NOMBER.	A. BUILDING: _		OOMI EETEB	
		HAL060166	B. WING		C <b>02/12/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE	•	
MICKELII	DE OTEEL E ODEEK	13600 S T	RYON ST			
WICKSHIP	RE STEELE CREEK	CHARLOT	TE, NC 28278			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLET	E
D 367	7 Continued From page 59		D 367			
	12/25/23 for Resident	t #1.				
	(RCC) on 02/05/24 at unsure why Resident	sident Care Coordinator : 10:54am revealed she was #1's hydralazine was being nistered if it was not in the				
	Refer to the interview at 10:54am revealed:	with the RCC on 02/05/24				
	Refer to the interview Nurse on 02/05/24 at	with the facility Compliance 2:39pm.				
		with the Regional Director on 02/05/24 at 4:02pm.				
		t #1's PCP orders dated order for estrone cream nally daily.				
	Review of Resident #	1's November 2023 eMAR				
	2gms vaginally dailyThere was no schedindicated for the estro-The entry was documents.	uled administration time				
	hospitalized.					
	revealed: -There was an entry f 2gms vaginally dailyThere was no schedindicated for the estro -The entry was document from 12/01/23 to 12/0	or estrone cream 1%, insert uled administration time one 1% entry. Inented as administered daily 12/23, from 12/08/23 to 12/23/23 and on				

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STATE FORM 6899 EFK911 If continuation sheet 60 of 117

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		02	C 2 <b>/12/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
WICKSHI	RE STEELE CREEK		TRYON ST OTTE, NC 28278			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 367	the facility's contracted: 9:10am revealed: -Resident #1's estror dispensed to the faciliand 12/28/23Resident #1's order daily and 42.5gms where we will be seen to the interview at 10:54am revealed.  Refer to the interview Nurse on 02/05/24 and 10:54am revealed.	with a representative from ed pharmacy on 02/05/24 at the cream 1%, 42.5gms were lity on 10/31/23, 12/07/23 was to insert 2gms vaginally ould last about 21 days.  If with the RCC on 02/05/24 is with the facility Compliance	D 367			
	11/09/23 revealed did hypertension, vascul cardiopulmonary disc peripheral vascular of a. Review of Resider 11/09/23 revealed ar amlodipine besylate blood pressure) 10m Review of Resident arevealed: -There was an entry mg, one tablet daily some t	ar dementia, ease, hyperlipidemia, and lisease.  Int #4's PCP orders dated a order for order for (a medication to treat high g tablet daily.  #4's January 2024 eMAR  for amlodipine besylate 10 scheduled for 8:00am. mented with "09" indicating es" on 01/06/24 to 01/07/24,				

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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:			
		HAL060166	B. WING		C 02/12/2024	
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 APPROPE DEFICIENCY)	BE COMPLETE	
D 367	Continued From page	e 61	D 367			
	-Amlodipine besylate not administered 5 ou 01/06/24 to 01/11/24.	10mg was documented as tt of 6 opportunities from				
	was not administered was unavailable.	bine besylate 10mg tablet because the medication bine besylate 10mg tablet				
	was not administered was unavailable.	because the medication bine besylate 10mg tablet				
	was pending delivery.	because the medication  bine besylate 10mg tablet				
	was not administered in medication for refill	, the note read; "MA called s last week, family was llow up with family again				
	-On 01/11/24 amlodip	ine besylate 10mg tablet because of waiting for nedication.				
	Interview with a MA o revealed:	n 02/05/24 at 2:55 am				
		odipine besylate 10mg was 11/06/24, 01/07/24, 01/09/24 medication was not				
	available and should an "09" code indicating	have been documented with g "other/see nurse notes".				
	given on 01/08/24.	n why it was documented as				
	revealed:	C on 02/02/24 at 9:58am				
	-When medications w	rere not available for nould be documented in the				
		the medicine was not				
		s should call Resident #4's get the amlodipine besylate				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY IPLETED	
		HAL060166	B. WING		0:	C <b>2/12/2024</b>
	PROVIDER 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 367	refilledHe expected the MA as administered when medicationHe could not explain amlodipine besylate when the medication 01/08/24.  Refer to the interview at 10:54am.  Refer to the interview at 10:54am.  Refer to the interview at 4:02pm.  b. Review of Residen 11/09/23 revealed an medication to prevent tablet daily.  Review of Resident # revealed: -There was an entry f dailyThe entry was docur 01/01/24 through 01/01/12/24 through 01/101/12/24 through 01/101/12/24 and 01/11/12 -The documented 09 of 1/10/24 and 01/11/12 -The documented 09 of 1/10/12/24 plavix 7 on 01/07/24 plavix 7 on 01/07/24 because unavailable.	s to document medications in the resident took the  why Resident #4's was documented as given was not available on  with the RCC on 02/05/24  with the facility Compliance 2:39pm.  with the RDO on 02/05/24  t #4's PCP orders dated order for plavix (a tobood clots) 75mg one  4's January 2024 eMAR  for plavix 75mg one tablet  mented as administered from 06/24, 01/08/24, and 30/24.  sode on 01/07/24, 01/09/24, 4.  code reasons were ses."  4's nurses notes revealed: 5mg was not administered	D 367			

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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:		LEIED
		1141 000400	R WING	B. WING		C
		HAL060166			02	12/2024
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIP	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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 367	Continued From page	e 63	D 367			
	because the medicating -On 01/10/24 plavix 7 the note read; "MA callast week, family was up with family again to -On 01/11/24 plavix 7 because "waiting for of medication."  Interview with a MA or revealed: -If Resident #4's plavit delivery for 01/06/24, 01/11/24 the medicating should have been door indicating "other/see"	on was pending delivery. 5mg was not administered, alled in medication for refills notified, this MA will follow oday." 5mg was not administered daughter to bring in  n 02/05/24 at 2:55 am  ix 75mg was pending 01/07/24, 01/09/24 through on was not available and cumented with an "09" code				
	Resident #4's pharmarevealed: -Resident #4 had an oftablet dailyOn 01/02/24 there w 75mg picked up on 00 Responsible Party.  Interview with the SC revealed: -When medications w Resident #4 a note shresident's record that available, and the MA Responsible Party to -He expected the MA as administered wher medication.	nould be documented in the the medicine was not as should call Resident #4's				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			E SURVEY PLETED	
		HAL060166	B. WING		02	C 2/ <b>12/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
WICKSHII	RE STEELE CREEK		TRYON ST			
	-	CHARLO	OTTE, NC 28278			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From page	e 64	D 367			
	was not available on	01/08/24.				
	Refer to the interview at 10:54am.	with the RCC on 02/05/24				
	Refer to the interview Nurse on 02/05/24 at	with the facility Compliance 2:39pm.				
	Refer to the interview at 4:02pm.	with the RDO on 02/05/24				
	Interview with the RC revealed: -The MAs were response.	C on 02/05/24 at 10:54am				
		tion administration on the				
	twice weekly became	go, medication cart audits her responsibility. onsible for medication cart				
	audits prior to two mo	onths ago.				
		audit process compared the medications available on the				
	_	s sometime accidentally ation was administered				
	when it was not availa	able to administer.				
	02/05/24 at 2:39pm re					
	-The MAs were traine accurately document	on the eMAR.				
	-If a MA documented administered when it					
	-Disciplinary actions r					
	termination.	The state of the s				
	Interview with the RI revealed:	0O on 02/05/24 at 4:02pm				

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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: _		COMPLETED	
		HAL060166	B. WING		C <b>02/12/2024</b>	
NAME OF D			DEGG OITY OTA	TE 710 000E	02/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	13600 S TF	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIP	RE STEELE CREEK		TE, NC 28278			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	<del></del>	PROVIDER'S PLAN OF CORRECTION	d (VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 367	Continued From page	e 65	D 367			
	the medication was n was falsifying information	administration.  medication as given when ot on the medication cart ation. s to accurately document				
	The facility failed to ensure the Medication Administration Records were accurate for 2 of 5 residents (#1 and #4) including inaccurate documentation of a medication to treat hypertension (#1, #4) and a medication to prevent blood clots (#4). This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.					
	The facility provided accordance with G.S. 2024, for this violation	. 131D-34 on February 12,				
	CORRECTION DATE VIOLATION SHALL N 2024.	FOR THIS TYPE B NOT EXCEED MARCH 28,				
D 438	10A NCAC 13F .1205 Registry	5 Health Care Personnel	D 438			
	Registry The facility shall com	5 Health Care Personnel ply with G.S. 131E-256 and A NCAC 13O .0101 and				
	This Rule is not met TYPE A1 VIOLATION					
	Based on interviews a	and record reviews, 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 PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLETED
		HAL060166	B. WING		C <b>02/12/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
MICKELL	RE STEELE CREEK	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 OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 438	Continued From page	e 66	D 438		
	facility failed to report by a staff member rel	allegations of alleged abuse ated to him inappropriately ad kissing 2 of 2 sampled to the Health Care			
	The findings are:				
	Reporting policy date date of 01/01/24 reverse -It is policy of the facito the appropriate autincidents.  -The Executive Direct Director will immediated Department of Social physical abuse, negler resident.  -The Executive Direct Director will report an incident to the state we subsequent report with -The Executive Director will assure the responsible person of possible but no later to find the initial discovery or illness by staff and resident's file.  -The Executive Director responsible for ensur reporting of all critical -Timely and accurate	lity to ensure timely reporting thorities for resident tor or Health Services sely notify the County Services of any mental or ect, or exploitation of a tor or Health Services y applicable accident or within 24 hours, followed by a thin the next five days. Tor or Health Services are notification of a resident's recontact person as soon as than 24 hours from the time or knowledge of the injury documented in the			
	11/10/23 revealed:	t #3's current FL2 dated dementia, hypertension, and			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1, ,			SURVEY PLETED	
			A. BUILDING:			
						С
		HAL060166	B. WING	· · · · · · · · · · · · · · · · · · ·	02	/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
			TRYON ST			
WICKSHII	RE STEELE CREEK		OTTE, NC 28278			
0/10/15	STIMMADA ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 438	Continued From page	e 67	D 438			
	anemia.					
	-She was semi-ambu	latory				
	-She was intermittent					
		level of care was assisted				
	living.	level of care was assisted				
	g.					
	Review of Resident #	3's resident register				
	revealed an admissio	•				
		3's Accident and Incident				
	Report dated 01/02/2					
	-The report was comp	· · · · · · · · · · · · · · · · · · ·				
	Compliance Nurse wi	ith the incident time				
	documented at 9:00a					
		e description of the accident,				
		g the Administrator notified				
		e Nurse that a staff member				
	•	provide personal care was				
		dent #3's room with his				
	_	area and staff member was				
		ommunity and suspended				
	pending an investigat					
		tation of Resident #3's				
	11:11am.	er (PCP) being notified at				
		nentation that Resident #3's				
	family member was n					
	Telephone interview \	with a former agency				
		PCA) on 02/05/24 at 10:45am				
	revealed:	0/1) 01/ 02/00/24 at 10.40am				
		the Administrator in early				
		she had seen the former				
		kiss Resident #3 on the				
	forehead.					
	-The Administrator to	ld her it was creepv				
		ot necessarily inappropriate.				
		8:30am she walked into				
		where she witnessed the				
		Director rubbing lotion on the				

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Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					С
		HALOCOACC	B. WING		
		HAL060166			02/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		13600 S T	RYON ST		
WICKSHIE	RE STEELE CREEK	CHARLO <sup>1</sup>	TE, NC 28278		
(VA) ID	SLIMMADV ST.	ATEMENT OF DEFICIENCIES	15	PROVIDER'S PLAN OF CORRECTION	N (VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	( - /
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE
				DEFICIENCY)	
D 438	Continued From page	- 68	D 438		
	resident's face.				
		resident's pants were pulled			
		nd states she had changed			
	the resident around 7	:30am and had pulled her			
	pants all the way up t	o her waist.			
	-She left Resident #3	's room and notified the			
	medication aide (MA)				
	-She and the MA retu	rned to Resident #3's room			
	where the resident's p	pants were now pulled up to			
	her knees.				
	-She and the MA imm	nediately notified the current			
	SCC and all three ret	urned to Resident #3's room			
	and asked the former	Maintenance Director to			
	leave the room.				
	-She was asked to wr	rite a statement which she			
	did and gave it to the	Administrator.			
	Interview with a MA o	n 01/30/24 at 4:44pm			
	revealed:				
		of 2023, she attended a			
		I by the Administrator.			
	-The Administrator no	otified staff that facility			
	employees were pern	nitted to touch residents'			
	shoulders and that it	was not to be considered			
	inappropriate.				
	-She witnessed the fo	ormer Maintenance Director			
	in the middle of Nove	mber 2023 kiss Resident #3			
	in the mouth in the di				
		the current special care			
	, ,	no told her to keep an eye on			
	the former Maintenan				
		d about this situation or			
		gement or the Administrator.			
		8:30am a PCA informed her			
	that the former Mainte	enance Director was in			
	Resident #3's room w	vith his hand underneath the			
	resident's covers.				
	-She and the PCA we	ent to Resident #3's room			
	where she witnessed	the former Maintenance			

Director sitting in the resident's wheelchair,

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C		, , ,	E SURVEY PLETED	
			A. BUILDING:	A. BUILDING:		
			D. MINIC			С
		HAL060166	B. WING		02	2/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
		13600 S	TRYON ST			
WICKSHII	RE STEELE CREEK		TTE, NC 28278			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	F CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
D 438	Continued From page	e 69	D 438			
	beside the resident la hand rubbing her und private areaShe and the PCA lef former Maintenance I needed anything in w Director stated noShe and the PCA im current SCCShe, the PCA and th #3's room where the was still sitting beside -All three left Resider Administrator to notify witnessed incidentShe and the PCA the room and asked the fito leave.	leging in her bed with his legineath the covers, over her at the room after asking the Director if Resident #3 hich the former Maintenance mediately notified the e SCC all went to Resident former Maintenance Director at the resident. It #3's room and called the y the Administrator of the en returned to Resident #3's former Maintenance Director wite a statement which she				
	4:08pm and on 02/12 -He reported to the Admember had witnessed Director kiss Residen did not know what ha -The former Maintenataking residents to the reported to the Admir -The Administrator he the former Maintenan she informed everyor not to provide person -He did not document events or any notifica -On 01/02/24 he was #3's room by a MA ar witnessed the former	eld a stand-up meeting with one Director present in which he that non-care staff were all care to residents. It any of these reported tion to the Administrator.  asked to come to Resident				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
		HAL060166	B. WING		C <b>02/12/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE	
WICKOLIII	DE OTEEL E ODEEK	13600 S	TRYON ST		
WICKSHI	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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 438	-The MA and PCA as Director to leave the rand suspended DirectorHe was asked to writand gave it to the Adra-He was later intervied.  Review of the former HCPR 5-Working Day date of 01/02/24 reveathere was an attach with a documented fareceived confirmation 01/09/24The report was composite the incident time 01/02/24Under section for the stated, the Maintenar in Resident #3's room covers rubbing on her asked by several care remove himself and reputting lotion on her least the state with the with	called the Administrator. ked the former Maintenance coom. me to the facility shortly the former Maintenance the a statement which he did ministrator. wed by law enforcement.  Maintenance Director's report with an incident aled: ed fax confirmation sheet x date of 01/09/24 and a time at 6:28pm on  Deleted by the Administrator documented at 8:57am on redescription of the incident ace Director was witnessed with his hands under her relower extremities, he was redescripted to be stated he was redescripted to the facility Compliance	D 438	DEFICIENCY)	
	expressed concerns f Director's physical int -She was notified of the Resident #3 and the f by the Administrator of -She completed the A	e was not aware staff had or the former Maintenance eractions with residents.			

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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		C <b>02/12/2024</b>
		HALUOU 100			02/12/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
WICKSHIE	RE STEELE CREEK		TRYON ST		
		CHARLO	TTE, NC 28278		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 438	Continued From page	<del>2</del> 71	D 438		
	Director on 02/01/24 and requently greete scratching their backs kissing foreheads. The stated he provide giving her juice and with chapstick to her lips a face, hands, feet, legander admitted that he help with circulation. The did not tell any stochapstick, lotion or head the help with circulation. The assisted Residen bed due to her not be own. The visited her five to ten minutes per visit. In October 2023, the that a PCA had a con affection towards resident.	d residents daily with hugs, sover their shirts, and and Resident #3 care by vater, feeding her, applying and putting lotion on her so, and thighs. Would massage her thigh to aff he had been applying a was feeding Resident #3. It #3 with sitting up in the sing able to sit up on her six times a day for around a Administrator notified him cern for how he showed dents. Administrator talked with dfull of how he showed dents could be			
	1:18pm and on 02/02 -Staff reported inappr of the former Mainten	ministrator on 01/30/24 at /24 at 2:53pm revealed: opriate behaviors witnessed ance Director on 10/19/23. member notified her that			
	she felt uncomfortable Maintenance Director and kissing residents -She did not make a r -She did not documer interviewsShe denied being no	e with the former providing hugs to residents, on their foreheads.			

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL060166	B. WING		C <b>02/12/2024</b>	
			DE00 0171/ 071	TE 7/0 0005	OZI IZIZOZ-	
NAME OF P	ROVIDER OR SUPPLIER	13600 S TF	DRESS, CITY, STA	I E, ZIP CODE		
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 SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
D 438	Continued From page	: 72	D 438			
	former Maintenance [and 01/02/24.	Director between 10/19/23				
	2. Review of Residen 11/10/23 revealed:	t #2's current FL2 dated				
	of left hip, major depre and signs involving co	Alzheimer's disease, bursitis ession, and other symptoms ognitive functions and				
	-Resident #2's recom	and constantly disoriented. mended level of care was				
	Special Care Unit (SC -Resident #2 was adr 07/26/21.					
	Review of Resident # Register revealed Ret the facility on 07/26/2	sident #2 was admitted to				
	Review of a signed di 11/01/23 revealed:	etary aide statement dated				
		mer Maintenance Director				
		ns touch female residents, /here residents shouldn't be				
	taking Resident #2 fro	nce Director was observed om the Livingroom and o one could see them.				
	-The former Maintena					
	style it was in.					
	11:46am revealed:	ry aide on 01/30/24 at				
		s Special Care Unit wards the end of October comfortable with the former				
	Maintenance Director Resident #2 who resident	hugging and kissing				

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STATE FORM 6899 EFK911 If continuation sheet 73 of 117

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
					С
		HAL060166	B. WING		02/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
MICKELIII	DE STEELE SDEEK	13600 S T	RYON ST		
WICKSHII	RE STEELE CREEK	CHARLO <sup>*</sup>	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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
D 438	Continued From page	e 73	D 438		
	hug and kiss Resider -She also reported to 2023, but stated noth was aware ofShe was asked to pr along with two other s former Maintenance I	at #2 three or more times. the Administrator in October ing was done as far as she ovide a written statement staff who had witnessed the Director's inappropriate e written statement to the			
	statement dated 11/0 -She observed the formation on numerous occasion mainly Resident #2, with touchedThe former Maintenataking Resident #2 frowalked somewhere numerous occasion.	rmer Maintenance Director ons touch female residents, where residents shouldn't be ance Director was observed om the Livingroom and o one could see them.			
	O2/01/24 at 10:40am -She witnessed the for take Resident #2, to the stood beside the residual was uncertain of the she witnessed the for almost every time he hair down and witnes resident's hair which she reported the forminappropriate behavior times and to the Admof October 2023She was asked to proalong with two others.	ormer Maintenance Director the bathroom where he dent as she sat on the toilet			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN (	OF CORRECTION	A. BUILDING:			COMPLE	IED
					c	
		HAL060166	B. WING		02/1	2/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE STEELE CREEK	13600 S TR	YON ST			
Wickerin	CE OTELLE ORLER	CHARLOT	ΓE, 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 438	Continued From page	e 74	D 438			
		e written statement to the				
	Review of a signed m statement dated 11/0 -She observed the for inappropriately touch occasionsThe former Maintena show extra attention for the back and hair. Telephone interview w 02/01/24 at 12:40pm -In the fall of 2023, the Director would massa her back rubs and kis -In the fall of 2023, she maintenance Director bedroom but did not be Resident #2She provided a writte Administrator related Director on 11/01/23She was never intervor management staff statement dated 11/0 -In the fall of 2023, she staff concerns related Director's behavior to Administrator walked -She never tried to interview and the fall of the form of the following the follow	1/23 revealed: rmer Maintenance Director Resident #2 on different ance Director appeared to to Resident #2 and would  with a former MA on revealed: e former Maintenance age Resident #2's head, give as her on her cheek. he had observed the former rescort Resident #2 to her know why he did this with en statement to the to the former Maintenance viewed by the Administrator related to her written 1/23. he told the Administrator of I to the former Maintenance wards Resident #2 and the away from her, laughing. tervene due to the being made aware by ormer Maintenance the behaviors which he had				
	Director on 02/01/24	with the former Maintenance at 3:50pm revealed: ance Director between				

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STATE FORM 6899 EFK911 If continuation sheet 75 of 117

DIVISION	of Health Service Regu	lation				
	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		HAL060166	B. WING		C <b>02/12/2024</b>	
		HALUOU 100			02/12/2024	_
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		13600 S 7	RYON ST			
WICKSHIRE STEELE CREEK CHARLOTTE, NC 28278						
	CUMMA DV CT			DDOV/DEDIC DI ANI OF CODDECTION		—
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	()	Ξ
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		
				DEFICIENCY)		
D 438	Continued From page	. 75	D 438			
D 430	Continued From page	÷ 75	D 430			
	07/03/23 and 01/03/2	4.				
	-He frequently greete	d residents in the SCU daily				
	with hugs, scratching	their backs over their shirts,				
	and kissing foreheads	S.				
	-In the fall of 2023, or	n one occasion, he was in				
	Resident #2's room re	epairing a telephone and				
	Resident #2 entered t	the room while she was				
	pulling her pants dow	n and was defecating on the				
	floor, he assisted her	to the toilet and left the				
	room to locate a PCA	<b>.</b> .				
		Administrator informed him				
	_	cern for how he showed				
	affection towards resi					
		Administrator talked with				
		dful' of how he showed				
		dents because it could be				
	uncomfortable for car	e staff.				
	Talambana intanciaww	with a farmer arrange DCA ar				
	02/05/24 at 10:50am	with a former agency PCA on revealed:				
	-She occasionally wo					
	-When she worked in					
		was frequently spending				
	time with Resident #2					
		guently hugged, had her				
	back rubbed over her	clothing, and walked down				
		ne former Maintenance				
	Director's hand.					
	-She did not feel com	fortable with the amount of				
	affection the former M	laintenance Director				
	provided to Resident	#2.				
	-She never tried to int	tervene due to the				
	Administrator already	being made aware of the				
	former Maintenance [	_				
	-She did not intervene	e when she witnessed the				
	former Maintenance [	Director's inappropriate				
	towards Resident #2.	* * *				
	Telephone interview v	with another PCA on				
	02/07/24 at 11:30am	revealed:				

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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	SI CONTECTION	IDENTIFICATION NOWBER.	A. BUILDING: _		COM	LLTLD
						С
		HAL060166	B. WING		02	12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
W// O// O/ / /	DE OTEE! E ODEE!	13600 S T	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 C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLETE DATE
D 438	Continued From page	e 76	D 438			
	-She worked on first a -Between September she notified the Admir observed the former I changing residents' b -She was not aware of involved the former IV between September 2 until an incident occu Maintenance Director Interview with a first s 4:45pm revealed: -Sometime in the Fall staff meeting directed -The Administrator not employees were perm	and second shift in the SCU.  2023 and October 2023, nistrator that she had Maintenance Director riefs from bedside. of any investigation which laintenance Director 2023 and November 2023, rred with the former on 01/02/24. shift MA on 01/30/24 at of 2023, she attended a				
	o1/31/24 at 4:20pm re-She worked in the Se and December 2023She and other facility Maintenance Director other residents"Staff had observed to Director frequently her back, and would of Maintenance Director #2's bedroom without roomIn early November 2 with concerns about to DirectorIn early November 2 written statements to	ry staff were concerned the "favored Resident #2 over the former Maintenance olding hands with Resident in the hallway, and rubbing occasionally observe the walking out of Resident is a maintenance need in the 1023, staff wrote statements the former Maintenance				

Division of Health Service Regulation

STATE FORM 6899 EFK911 If continuation sheet 77 of 117

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1.			(X3) DATE SURVEY COMPLETED	
7.11.2.1.2.11.1	5. GGTLGTGT.	152.** 167.1.161.**.161.152.1	A. BUILDING:			
						С
		HAL060166	B. WING		02	2/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
			TRYON ST	,		
WICKSHII	RE STEELE CREEK		TTE, NC 28278			
0// 15	STIMMADA ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 438	Continued From page	e 77	D 438			
	other staff related to t	he written statements.				
		e when she witnessed the				
		Director's inappropriate				
		esident #2, she only reported				
	witnessed behaviors.	,,,,,				
	Interview with the SC	C on 01/30/24 at 4:10pm				
	revealed:					
		I provided the Administrator				
		related to concerns for the				
	former Maintenance I					
		at was written in the staff				
	statements.					
		ome staff informed him they				
		Maintenance Director show				
	her on the cheek and	sident #2, including kissing				
		e Administrator did not				
		to the former Maintenance				
	Director's interactions					
		e Administrator was aware				
	· ·	ut the former Maintenance				
	Director providing car	re to residents because she				
		nt managers during meetings				
	to ensure only staff as	ssigned to resident care,				
	performed resident ca	are needs.				
		ministrator on 02/02/24 at				
	2:55pm revealed:					
		for reporting any concerns				
		eglect, or exploitation to local				
	_ ·	partment of Social Services,				
	-	ealth Service Regulation				
	(HCPR).					
		ry aide told her that she felt				
		e former Maintenance				
		gs to residents, and kissing				
	residents on their fore	eneads. itional staff and was told the				
		Director was often observed				

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	n riealth Service Regu				1	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		URVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		HAI 060466	B. WING		1	
		HAL060166			02/1	2/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		13600 S	TRYON ST			
WICKSHIE	RE STEELE CREEK		TTE, NC 28278			
	OLUMANA DV OT			DDOVIDEDIO DI ANI OF CODDECTIO	<u> </u>	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	•	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI		DATE
				DEFICIENCY)		
D 420	0	- 70	D 438			
D 438	Continued From page	e 78	D 436			
	giving hugs to Reside	ent #2.				
	-She determined the					
	Director's hugging of	Resident #2 was not				
	inappropriate.					
		nt the staff concerns or				
	interviews.					
		HCPR investigation report				
		Maintenance Director's				
	alleged behaviors at t					
	-On 10/20/24, she me					
	•	and informed him staff felt				
		s physical expressions of				
		dents and to be careful how				
	he interacted with res					
	-On 10/20/24, she no					
		that kissing of residents				
		en though I know you don't				
	mean any harm."	104/00/04 1 551 1 1				
		nd 01/02/24, staff had not				
		statements related to the				
	Maintenance Director					
		any written statements				
	provided by staff cond					
	Maintenance Director					
		nd 01/02/24, she was not				
		nal concerns for the former				
		r, or any other staff related to				
	allegations of abuse,	neglect, or exploitation.				
	Talanta 111 1	with the Object O				
	•	with the Chief Operating				
		01/24 at 1:00pm revealed:				
	-She was at the facilit					
		oncerns about the former				
	Maintenance Director	kissing or hugging				
	residents.					
	-She was not aware o					
	statements after 10/1					
	-The Administrator wa					
		of a resident to the HCPR.				
	-If a staff statement d	ocumented concerns for				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
74101274	or contraction	ISERTII IOMITOR NOMBER.	A. BUILDING: _	A. BUILDING:		
		HAL060166	B. WING		02/1	; 2/2024
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 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 438	Continued From page	e 79	D 438			
	inappropriate touching staff should have been and a report made to Health Service Regulate The facility failed to reincluding inappropriate kissing of two female male staff that was first to the HCPR at that the forthree and a half more resulted in serious neconstitutes a Type A1.  The facility provided a January 30, 2024, and	g of a resident, the accused immediately suspended the NC Department of ations and law enforcement.  eport allegations of abuse the touching, hugging, and residents (#2 and #3) by a set reported in October 2023 imme leaving it uninvestigated tonths. The facility's failure reglect and exploitation and Violation.  a plan of protection on d on February 12, 2024, in 131D-34 for this violation.				
	VIOLATION SHALL N 2024.	NOT EXCEED MARCH 13,				
D 453	10A NCAC 13F .1212 and Incidents	2(d) Reporting of Accidents	D 453			
	Incidents (d) The facility shall i department of social G.S. 108A-102 and the authority as required	Reporting of Accidents and mmediately notify the county services in accordance with ne local law enforcement by law of any mental or ect or exploitation of a				

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING			
		HAL060166	B. WING		C 02/12/2024	
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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	BE COMPLETE	
D 453	Continued From page	e 80	D 453			
	This Rule is not met TYPE A1 VIOLATION	as evidenced by: I				
	facility failed to immed Department of Social law enforcement about exploitation of 2 of 2 st	and record reviews, the diately notify the county Services (DSS) and local ut potential abuse and sampled residents (#2 and opriately touched by a male				
	The findings are:					
	or Financial Exploitatic date of 08/01/21 reversed to 1/21 reversed from mental, was abuse, neglect, involuting financial exploitation. If abuse, neglect, or witnessed, associates from the situation immoved to a safe location with immediately notify you wellness Director, Expresident is injured. In Jurian India Popular of the executive Direct later than 24 hours) in County Department of HCPR. In The resident's responsesson, as indicated of will be notified immediated.	iving in the community must verbal, sexual and physical untary seclusion, and  financial exploitation is are to remove the resident nediately, bring the resident nin the community and ur supervisor, Health and recutive Director or 911 if the ident alone, stay with the nibe assessed to ensure				
		tor will notify the HCPR owledge of all instances of				

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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	
			7.1. 50.125.1.10.		C
		HAL060166	B. WING		02/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
MICKSHII	RE STEELE CREEK	13600 S T	RYON ST		
WICKSHII	NE STEELE CREEK	CHARLO	TE, NC 28278		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 453	Continued From page	e 81	D 453		
	abuseA thorough investigatake place and thorough investigatake place and thorough investigation in the place and the resploitation while the sexploitation while the left there is an allegatifinancial exploitation associate, the associate pay until a thorough incompletedThe investigation mudocumented, and a coassociate and the resploitation of successing the sexploitation of successing and the sexploitation of successing and the sexploitation of successing and the sexploitation outcomes.	tion of all allegations must all documentation must be ecutive Director. Thus to be taken to prevent puse, neglect, or financial investigation is in progress. On of abuse, neglect, or of a resident involving an atte will be suspended with investigation has been ust be thoroughly opy kept on file for the sident involved.			
	Reporting policy date date of 01/01/24 reverse	lity to ensure timely reporting thorities for resident tor or Health Services			

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of the initial discovery or knowledge of the injury

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 2012510		c	
		HAL060166	B. WING		02/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE STEELE CREEK		TRYON ST			
			OTTE, NC 28278		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
D 453	Continued From page	e 82	D 453			
	Director will immediate resulting in harm to a the facility to the local responsible party and notified when requires situation.  The Executive Direct responsible for ensure reporting of all critical remains and accurate	tor or Health Services rely report any assault resident or other person in I law enforcement authority. ent/accident, the resident's I appropriate authorities are d and as appropriate to the tor/designee will be ing timely and accurate events. reporting of critical events				
	-Timely and accurate reporting of critical events to state agencies will occur as required by state regulations.  Review of a search warrant motion for employee information and surveillance dated 01/04/24 revealed: -Request of footage from January 2, 2024, request for other incidents the suspect has been investigated for including the incident in the memory care floorRequest the facility provide human resources files and all information involving any and all previous incident involving the former Maintenance Director.  Review of a search warrant for affidavit of law enforcement Detective dated 01/04/24 revealed: -Law enforcement was conducting an ongoing criminal investigation related to second-degree sexual offense and sexual activity by a custodianOn 01/02/24 Resident #3, a resident was touched inappropriately by the maintenance worker while he was on duty at the facilityDuring a follow up investigation to collect evidence it was brought to the Detective's					

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STATE FORM 6899 EFK911 If continuation sheet 83 of 117

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL060166	B. WING		C <b>02/12/2024</b>	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE STEELE CREEK	13600 S T	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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
D 453	Continued From page	e 83	D 453			
	been suspected of proacts, which the staff for enforcementMultiple staff member	eviously committing similar				
	Review of Resident #3's current FL2 dated 11/10/23 revealed:     -Diagnoses included dementia, hypertension, and anemia.     -She was semi-ambulatory.     -She was intermittently disoriented.     -Recommended level of care was assisted living.					
	Review of Resident # revealed an admissio	3's Resident Register n date of 10/25/22.				
	revealed: -She had reported to	CA) on 02/05/24 at 10:45am the Administrator in early				
	forehead.	she saw the former kiss Resident #3 on the nistrator told her it was,				
	"creepy behavior but inappropriate".					
	former Maintenance I resident's face.	here she witnessed the Director rubbing lotion on the				
	pulled down to the an changed the Residen pulled her pants all th -She left Resident #3' medication aide (MA) -She and the MA retu	Resident's pants were kles and states she had t around 7:30am and had be way up to her waist. It's room and notified the state to Resident #3's room pants were now pulled up to				

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STATE FORM 6899 EFK911 If continuation sheet 84 of 117

_ ` · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		HAL060166	B. WING		02/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	WICKSHIRE STEELE CREEK 13600 S					
		CHARLOT	TE, NC 28278			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 453	Continued From page	e 84	D 453			
	her kneesShe and the MA immorare coordinator (SCOResident #3's room a Maintenance Director	nediately notified the special C) and all three returned to nd asked the former to leave. ite a statement which she				
	nutritional supplemen Maintenance Director -She noticed Residen ankles which were no left earlier. -She noticed Residen when they were initial -After giving out room Resident #3's room, s Director was still there four times. -The former Maintena	2/24 revealed: ident #3's room to give her a t and noticed the former rubbing lotion on her face. it #3's pants were at her it left like that when she had it #3's blinds were closed lly open. it trays, she returned to saw the former Maintenance e and asked him to leave ince Director kissed the lead and rubbed her feet				
	staff meeting directed -The Administrator no employees were pern shoulders and that it v inappropriateShe witnessed the fo in the middle of Nove mouth in the dining ro -She reported this to	of 2023, she attended a by the Administrator. diffied staff that facility nitted to touch residents' was not to be considered from Maintenance Director mber kiss Resident #3 in 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	
					c	
		HAL060166	B. WING		02/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE STEELE CREEK	13600 S T				
			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 453	Continued From page	e 85	D 453			
ם 493	-She was never asker interviewed by manage -On 01/02/24 around that the former Mainte Resident #3's room we resident's coversShe and the PCA we where she witnessed Director sitting in the beside the resident lath hand rubbing her und private areaShe and the PCA left former Maintenance In needed anything in we Director stated, "no"She and the PCA important recommendation with the PCA and the Was still sitting besides -All three left Resident Administrator to notify witness incidentShe and the PCA the room and asked the followerShe was asked to will did and gave it to the -She was later questive enforcement Detective.	d about this situation or gement or the Administrator. 8:30 am a PCA informed her enance Director was in with his hand underneath the ent to Resident #3's room the former Maintenance resident's wheelchair, sying in her bed with his lerneath the covers, over her asking the Director if Resident #3 which the former Maintenance mediately notified the e RCC all went to Resident former Maintenance Director in the Administrator of the en returned to Resident #3's former Maintenance Director in the Administrator. Oned by two law the on 01/04/24.	D 433			
	Review of the MA's signed statement dated 01/02/24 revealed: -She was in the dining room when a staff member came and reported to her that two residents were being touched inappropriately.					
	-She immediately wer #3's room, took out he	opinition): nt down the hall to Resident er phone to record, and aintenance Director rubbing				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A RIVE PLAN OF COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
						С
		HAL060166	B. WING		02	/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
14/10/2011		13600 S T	RYON ST			
WICKSHII	RE STEELE CREEK	CHARLO	TTE, NC 28278			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C	OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	THE APPROPRIATE	COMPLETE DATE
D 453	Continued From page	e 86	D 453			
	Resident #3 under the	o covers				
		er Maintenance Director if				
		any assistance and the				
	former Maintenance I	=				
		d got management to make				
	sure she was seeing	-				
		ing mistreated by the staff				
	member.	,				
	-She then asked the	former Maintenance Director				
	to leave.					
	-She sat by Resident	#3's door to make sure the				
	staff member didn't re	eturn into the resident's				
	room.					
	Interview with the SC	C on 01/30/24 at 4:08pm				
	and on 02/12/24 at 1	•				
		dministrator that a staff				
	•	ed the former Maintenance				
	Director kiss Residen	it #3 in the mouth but was				
	uncertain what happe	ened after he reported it.				
	-The former Maintena	ance Director was witnessed				
	taking residents to the	e bathroom which was				
	reported to the Admir	nistrator.				
		ated in a stand-up meeting				
	with the former Maint	enance Director present that				
		ot to provide personal care				
	to residents.					
		t any of these reported				
	_	tion to the Administrator.				
		asked to come to Resident				
	#3's room by a MA ar	Maintenance Director with				
		esident's blanket rubbing				
	over her private area	<u> </u>				
	·	called the Administrator.				
		ked the former Maintenance				
	Director to leave the					
		me to the facility shortly				
		the former Maintenance				
	Director.					

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE	SURVEY
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMP	LETED
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		HAL060166	B. WING		02	/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
14/10/1601111		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 (EACH CORRECTIVE / CROSS-REFERENCED <sup>*</sup> DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
D 453	Continued From page	e 87	D 453			
2 .00	-He was asked to writ and gave it to the Adr -He was later intervie Review of the SCC's 01/02/24 revealed: -A MA came and got concerned that the fo in Resident #3's room -When he approache witnessed the former his hand under the bl #3's private area. -He asked the former	te a statement which he did ministrator. wed by law enforcement. signed statement dated him due to her being rmer Maintenance Director h. d Resident #3's room, he Maintenance Director with anket rubbing in Resident Maintenance Director if he				
	was okay, and the for answered yesHe then left the room Administrator.	mer Maintenance Director				
	Report dated 01/02/2 -An electronic fax cord Department of Social of 4:04pmThe report was compounded to the compliance nurse with documented at 9:00aUnder section for the documentation stating the facility compliance who is not qualified to observed in the reside on her genital area are escorted out of the compending an investigatThere was documen being notified at 11:11	Afirmation to the County Services with a timestamp  Deleted by the Facility the the incident time m.  It description of the accident, go the Administrator notified the nurse that a staff member to provide personal care was the the transfer of the incident was the transfer of the transfer of the incident was the transfer of the transfer of the incident was the transfer of the transfer of the incident was the transfer of the transfer of the incident was the transfer of the transfer of the incident was the transfer of the incident was the transfer of the transfer of the incident was the tra				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVAND PLAN OF CORRECTION IDENTIFICATION NUMBER: A RUN DIVIDENCE COMPLETED						
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMP	LETED
		HAL060166	B. WING			C <b>12/2024</b>
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE. ZIP CODE	, 3=	
	10112211 011 001 1 21211	13600 S T				
WICKSHIP	RE STEELE CREEK		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 T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	COMPLETE DATE
D 453	Continued From page	e 88	D 453			
	Enforcement was not	ified.				
	Review of the Mainte Care Personnel Regis Report with an incide -There was an attach with a documented fareceived confirmation 01/03/24.  -There was a docume of 01/02/24 at 8:57an -Under section for alle the Maintenance Directly resident #3's room with covers rubbing on he asked by several care remove himself and ruputting lotion on her least of 01/02/24 reversion of 01/02/24.  -The report was composite with the incident time 01/02/24.  -Under section for the stated, the Maintenar in resident #3's room covers rubbing on he asked by several care remove himself and received and received confirmation of the stated, the Maintenar in resident #3's room covers rubbing on he asked by several care remove himself and received confirmation of the stated, the Maintenar in resident #3's room covers rubbing on he asked by several care remove himself and received confirmation of the stated of th	nance Director's Health stry (HCPR) 24-Hour Initial nt date of 01/02/24 revealed: ed fax confirmation sheet ix date of 01/03/24 and a time at 8:34am on ented incident date and time in. egation description stated, ector was witnessed in the his hands under her rower extremities, he was enteam members to please efused, he stated he was egs. tation of law enforcement of 1/2/24 at 5:25pm.  Maintenance Director's of Report with an incident aled: ed fax confirmation sheet ix date of 01/09/24 and a time at 6:28pm on entered by the Administrator documented at 8:57am on the description of the incident ince Director was witnessed with his hands under her rower extremities, he was entered				
	putting lotion on her le					
	Interview with Reside	nt #3's family member on				

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STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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					С	
		HAL060166	B. WING		02/12/202	4
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
WIOKOLIII	DE OTEEL E ODEEK	13600 S T	RYON ST			
WICKSHII	RE STEELE CREEK	CHARLO	TTE, NC 28278			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COM	(X5) MPLETE DATE
D 453	Continued From page	e 89	D 453			
	01/31/24 at 2:30pm re	avealed:				
		able to answer questions				
	due to her dementia.	able to answer questions				
		on 01/02/24 at 5:35pm by the				
		rt an incident with Resident				
	#3.					
	-The Administrator tol	ld her the former				
	Maintenance Director	was seen applying lotion to				
	Resident #3's feet.					
		ner Maintenance Director				
	previously but did not					
	personal care employ					
		nistrator if Resident #3 was				
	_	nad been sexually abused				
		said no and that she just				
		ily know of the incident. ived another call from the				
	•	it was protocol to take the				
		ency department (ED) and				
		s PCP had recommended an				
	ED evaluation.					
	-She asked if she cou	ıld call the Administrator				
	back due to her wanti	ing to discuss this with				
	another family memb	er.				
		nistrator at 6:08pm and said				
		nything more serious than				
		o resident's feet, pain,				
	bleeding or if the Adm					
		nappened to Resident #3,				
		Resident #3 to go to the ED.				
	-The Administrator sta	ated no suspicion of the maintenance director				
	applying lotion to resi					
		ne call from a Detective with				
	the local police depar					
	· · · · · · · · · · · · · · · · · · ·	or consent to send Resident				
	#3 to the ED for an ev					
	*** *	for an ED evaluation due to				
	possible sexual assau					

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-She was told the former Maintenance Director

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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		C 02/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE		
		13600 S T	RYON ST			
WICKSHII	RE STEELE CREEK	CHARLO	TTE, NC 28278			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION (X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETE	E
D 453	Continued From page	90	D 453			
	feet by the Administra mentioned even wher specifically askedShe spoke with a sec afterwardsShe met with the sec at 8:00pm or later, on warrantEvidence was taken along with clothing an -She again notified th only informed of lotior #3 by the former Mair would have agreed to for an evaluationA detective informed taken a video of the ir mentioned to him by the Resident #3's pants we -She called the Adminatory.	cond detective several times cond detective at the facility 01/04/24 who had a search from Resident #3's person ad bedding. e Detectives that she was a being applied to Resident attenance Director or she a send Resident #3 to the ED  ther that a staff member had acident where it was the Administrator that were pulled down. aistrator to ask her about the istrator stated this was the rd about Resident #3's				
	Interview with the with Nurse on 01/31/24 at -Prior to 01/02/24, she expressed concerns f Director's physical int -She was notified of the Resident #3 and the f by the Administrator can she completed the Awhich was faxed to the Services at 5:04pm.	the facility Compliance 5:34pm revealed: e was not aware staff had for the former Maintenance eractions with residents. the incident involving former Maintenance Director on 01/02/24 around 9:00am. the local Department of Social inistrator at 4:08pm on tooken to Resident #3's the incident and the				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI II TIDI E	CONSTRUCTION	(X3) DATE S	ID\/EV
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLE	
			A. BUILDING: _			
			B. WING		C	
		HAL060166	B. WING		02/1	2/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		13600 S	TRYON ST			
WICKSHIE	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCE TO THE APPROPE	BE	(X5) COMPLETE DATE
				DEFICIENCY)		
D 453	Continued From page	91	D 453			
	-She was with the Ada Administrator receive local Department of Sinstructed the complia Administrator to notify resident's family mem Administrator stated such as present who Resident #3's family readministrator that the director was seen in Finands on her legsShe stated responsible seen and provided the stated responsi	ministrator when the d a call at 5:08pm from the social Services who ance nurse and the law enforcement and the laber immediately, after the she had not notified either. Len the administrator called member who was told by the former maintenance Resident #3's room with his labele party asked Administrator				
	01/31/24 at 5:47pm re -On 01/02/24 at 4:08 nurse messaged the a had notified Resident incidentAdministrators reply -The facility complian Administrator to notify contacted the respons incident report to the ServicesThere was no reply of	pm, the facility compliance Administrator asking if she #3's responsible party of  was, "not yet" at 4:08pm. ce nurse then asked the her when she has sible so she could send the Department of Social  or notification from the ng the Administrator had				
	with the Mecklenburg Social Services on 01 -He received the Acci Resident #3 on 01/02 former Maintenance I	alt Care Home Specialist County Department of 1/30/24 at 9:00am revealed: dent and Incident Report for 1/24 at 5:04pm regarding the Director was witnessed in 1/24 in this hands under her 1/25 in the county of the				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	SURVEY LETED
ANDILAN	or connection	IDENTIFICATION NOWBER.	A. BUILDING: _		COIVII	LLTLD
						С
		HAL060166	B. WING		02/	12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		13600 S T	RYON ST			
WICKSHIE	RE STEELE CREEK		TTE, NC 28278			
(V4) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 453	Continued From page	92	D 453			
	he was concerned ab asked her what time to and the Administrator 8:30am.  -He asked the Admini Law Enforcement and member and the Admini contacted law enforce family member.  -He advised the Admini nurse to call local law resident's family memincident occurring ear -He was concerned the	istrator if she had notified d Resident #3's family ninistrator stated she had not ement or Resident #3's inistrator and the compliance of enforcement and the inber immediately due to rely in the morning. The nat the Administrator did not ent or the resident's family				
	Detective on 01/31/23-On 01/02/24, the facuntil after normal bus 5:30pm and 6:00pm, a possible sexual assobserved by staff and Administrator on 01/09:00am.  -He would have expeimmediately notify law to reduce opportunities contaminated or discar-He interviewed the fain January 2024.  -A PCA had been interviewed the fain January 2024.  -A PCA had been interviewed the fain January 2024.  -A PCA had been interviewed the fain January 2024.  -A PCA had been interviewed the fain January 2024.  -A PCA had been interviewed the fain January 2024.  -A PCA had been interviewed the fain January 2024.  -A PCA had been interviewed the fain January 2024.  -A PCA had been interviewed the fain January 2024.  -A PCA had been interviewed the fain January 2024.  -A PCA had been interviewed the fain January 2024.  -A PCA had been interviewed the fain January 2024.  -A PCA had been interviewed the fain January 2024.  -A PCA had been interviewed the fain January 2024.  -A PCA had been interviewed the fain January 2024.	ility Administrator waited iness hours, between to notify law enforcement of cault crime which was a reported to the 12/24 between 8:30am and cted the Administrator to wenforcement on 01/02/24 es of any evidence to be arded. Former Maintenance Director erviewed and felt the former had spent too much time in out a need for maintenance anintenance Director's				
	behavior was inappro					

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		HAL060166	B. WING		02/12/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIRE STEELE CREEK 13600 S			RYON ST			
WICKSIIII	CE STEELE CKEEK	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPI	LETE
D 453	Continued From page	93	D 453			
	to reduce the opportu contaminated or disca					
	revealed:	re on 02/01/24 at 11:30am				
	-He conducted numerous interviews with facility staff after an incident on 01/02/24 which involved the former Maintenance DirectorHe had conducted an interview with the former Maintenance Director in January 2024 related to an allegation of sexual assault to a residentHe said the former Maintenance Director had admitted to applying lotion to Resident #3's face, feet, legs and massaging her thighs to help with					
	admitted to kissing Ro -He said the former M admitted to feeding R	esident #3.				
	enforcement immedia	dence could have been lent receiving a bath,				
	-He felt the former Ma behavior was inappro	aintenance Director's				
	timestamp of 8:33am revealed:	on 02/01/24 at 3:36pm				
	#3's room, sitting in a of resident and reside	nce Director in Resident wheelchair on the left side ent's bed. g flat on her back in the bed				
	with her head turned -Resident #3 had a bl	-				

Division of Health Service Regulation

her left side.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAL060166	B. WING		C <b>02/12/2024</b>
					02/12/2024
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	
WICKSHIP	RE STEELE CREEK	13600 S TI			
			TE, NC 28278		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 453	Continued From page	94	D 453		
	-Resident #3's pants her left knee, leaving completely exposed, -The former Maintena forward in the wheeld -Resident #3's left har right hand, on top of tarea with the former hand placed on top/or-The former Maintena viewed under the blar	covered her left leg, up to her left knee, thigh and hip uncovered and bare. Ince Director was leaning hair. Ind was crossed over her he blanket, over her chest Maintenance Director's left ver resident's hands. Ince Director's right arm was laket, with his arm leading ent's exposed hip area to			
	Director on 02/01/24 and 01/03/2 and 01/03/2 and 01/03/2 and 01/03/2 and 01/03/2 and o1/03/2 and o1/03	ance Director between 4. d residents daily with hugs, s over their shirts, and ad Resident #3 care by vater, feeding her, applying and putting lotion on her s, and thighs. would massage her thighs to aff he had been applying a was feeding Resident #3. t #3 with sitting up in the ing able to sit up on her six times a day for around Administrator notified him cern for how he showed			

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STATE FORM 6899 EFK911 If continuation sheet 95 of 117

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
,		152.111.16/11.16.11.16.11.1	A. BUILDING: _			
						0
		HAL060166	B. WING		02/1	12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MICKELLI	RE STEELE CREEK	13600 S T	RYON ST			
WICKSHII	NE STEELE OREEK	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 T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
D 453	Continued From page	e 95	D 453			
	uncomfortable for car	е ѕтап.				
	Officer (COO) on 02/0-On 01/02/24 at approx a telephone call with notified her that the fowas witnessed by stahis hand under her coshe instructed the Adenforcement.  -She expected the Adcall law enforcement -She did not know un the Administrator had 01/02/24 to notify law allegation of abuse by Director to Resident #3-She was unaware th Resident #3's family Maintenance Director resident's feet.  -She said the family resident with the said the family resident's feet.	Iministrator to immediately on 01/02/24. til late January 2024, that waited till after 5:00pm on enforcement of an y the former Maintenance				
		ministrator on 01/30/24 at				
		/24 at 2:53pm revealed:				
	•	e for reporting any concerns eglect, or exploitation to local				
		egiect, or exploitation to local partment of social services,				
	•	ealth service regulations.				
		inappropriate behaviors by				
	the Maintenance Dire					
		member notified her that				
	she felt uncomfortable					
	Maintenance Director	providing hugs to residents,				
	and kissing residents	on their foreheads.				
	-She did not make a	report to the HCPR.				
	-She did not docume	nt the staff concerns or				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL060166	B. WING		C <b>02/12/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	•	
		13600 S T	RYON ST			
WICKSHII	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 SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE	
D 453	Continued From page	e 96	D 453			
	interviewsShe denied being no abuse, neglect or exp former Maintenance I and 01/02/24She was not aware t Director had been app Resident #3She stated she would former Maintenance I -She stated she notificated member around 11:00 of the incident but condocumentationShe stated she told I that the former Maintenance I stated she told I that the former Maintenance I stated she told I that the former Maintenance I stated she told I that the former Maintenance I stated she told I stated she told I that the former Maintenance I stated she told she told she told she told she told she told she tol	otified of any allegations of ploitation related to the Director between 10/19/23 that the former Maintenance plying chapstick or lotion to d have suspended the Director if she had known. ed Resident #3's family 0 am to 12:00pm on 01/02/24 uld not provide  Resident #3's family member tenance Director was found in with his hands under the				
	01/02/24 revealed: -The Administrator en -Late entry was docui date of 01/02/24 at 5: -The Administrator sp Social Services about to file a 24-hour report -24-hour report filed, to confirmationLaw enforcement wadid not arrive until after -Family contacted at 4 incidentPCP sent an update send Resident #3 out -Family refused to se if no signs of injury we her in the Emergency	soke with the Department of the incident filed, instructed rt. faxed, and emailed with as contacted at 5:25pm and er 10:40pm. 5:42pm notifying them of the stating it would not hurt to for an evaluation. Indout resident, stating that ere seen they did not want by Department where she ous virus that is going				

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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
					С
		HAL060166	B. WING		02/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 453	Continued From page	97	D 453		
	12:56pm revealed: -The facility notified hoccurred on 01/02/24 former Maintenance I morning via text messishe was notified staff Maintenance Director Resident #3's blanked. The facility complian had completed an evwas observed at base. No recommendation: -The facility complian that afternoon after R had asked if there was abuse, and he instruct to the Emergency De Interview with the Regon 02/02/24 at 3:55pr. He did not know staff statements from 11/0. He stated due to constatements constitute termination of the forr. He stated the facility enforcement and the Based on observation review, it was determined interviewable.  2. Review of Residen 11/10/23 revealed: -Diagnoses included of left hip, major deprivation of the formulation of the formulat	had witnessed the former with his hands under to over her genital area. The centre informed him she aluation of Resident #3 who beline.  Is were given to the facility. The centre called him later esident #3's family member is any concern of possible of the her to send Resident #3 partment for an evaluation.  In gional Director of Operations in revealed:  If had documented written 1/23. Item of the staff's written digrounds for immediate mer Maintenance Director. Should have notified law			

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, JIP CODE  13800 S TRYON ST CHARLOTTE, NC 28278    CAN   ID   PROVIDER'S PLAN OF CORRECTION   PROVIDER'S PLAN OF CORRECTION   PRETER   PROVIDER'S PLAN OF CORRECTION   PROVIDER'S PLAN OF CORRECTION	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MANE OF PROVIDER OR SUPPLIER  WICKSHIRE STEELE CREEK  SIMMARY STATEMENT OF DEFOISACES  (AA) D PREFY PROVIDERS PLANGE CORRECTION  (AA) D PREFY PROVIDERS PLANGE  (AA) D PROVIDERS PLANGE  (AA) P PROVIDERS  (AB) P PROVIDERS  (AA) P PROVIDERS  (AA			HAL060166	B. WING		_
CARLOTTE, NC 28278   CHARLOTTE, NC 28278   DEPROVIDENS PLAN OF CORRECTION (CARLOTTE, NC 28278   CHARLOTTE, N	NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD		TE, ZIP CODE	,
PREFIX TAG    CACH DEPICIENCY MUST BE PRECEDED BY FULL   PREFIX TAG   CROSS-REFERENCE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DATE.    D 453	WICKSHIF	RE STEELE CREEK				
She was ambulatory and constantly disoriented. Resident #2's recommended level of care was Special Care Unit (SCU). Resident #2' was admitted to the SCU on 07/26/21.  Review of Resident #2's signed Resident Register revealed Resident #2 was admitted to the facility on 07/26/21.  Telephone interview with Resident #2's Power of Attorney on 02/05/24 at 9:18am revealed: Resident #2 was admitted to the SCU in July 2021. Resident #2 was admitted to the SCU in July 2021. Resident #2 required assistance with bathing, tolleting, dressing, and grooming. Resident #2 was ambulatory and constantly disoriented. She was not aware of any allegations of abuse, neglect, or exploitation involving Resident #2.  Interview with a dietary aide on 01/30/24 at 11:46am revealed: She reported to the previous Special Care Coordinator (SCC) towards the end of October 2023 that she was uncomfortable with the former Maintenance Director hugging and kissing Resident #2 who resided in the SCU. She witnessed the Maintenance Director hug and kiss Resident #2 who resided in the SCU. She witnessed the Maintenance Director hug and kiss Resident #2 three or more times. She reported this to the Administrator in October, but stated nothing was done as far as she was aware of. She was asked to provide a written statement at the end of October, the beginning of November 2023, along with two other staff who had	PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE COMPLETE
witnessed the former Maintenance Director's inappropriate behavior, and she gave the written statement to the SCC.	D 453	-She was ambulatory -Resident #2's recome Special Care Unit (SC) -Resident #2 was adn 07/26/21.  Review of Resident #2 Register revealed Resident facility on 07/26/2  Telephone interview was adn 2021Resident #2 was adn 2021Resident #2 required toileting, dressing, and -Resident #2 was ambulatorientedShe was not aware of neglect, or exploitation  Interview with a dietar 11:46am revealed: -She reported to the pr Coordinator (SCC) to 2023 that she was und Maintenance Director Resident #2 who resident #2 who resident #2 who resident #2 -She witnessed the M and kiss Resident #2 -She reported this to the properties of the propertie	and constantly disoriented. mended level of care was CU). nitted to the SCU on  2's signed Resident sident #2 was admitted to 1.  with Resident #2's Power of at 9:18am revealed: nitted to the SCU in July assistance with bathing, d grooming. oulatory and constantly  of any allegations of abuse, in involving Resident #2.  Ty aide on 01/30/24 at  previous Special Care wards the end of October comfortable with the former hugging and kissing ded in the SCU. aintenance Director hug three or more times. The Administrator in October, is done as far as she was covide a written statement at the beginning of November other staff who had Maintenance Director's r, and she gave the written	D 453		

Division of Health Service Regulation

STATE FORM 6899 EFK911 If continuation sheet 99 of 117

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  13600 S TRYON ST CHARLOTTE, NC 28278  (XA) ID PREFIX TAG  CONSTRUCTION PREFIX TAG  CONSTRUCTION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  D 453  Continued From page 99  Review of a signed dietary aide's statement dated 11/01/23 revealed: -She observed the former Maintenance Director on numerous occasions touch female residents, mainly Resident #2, where residents shouldn't be touchedThe former Maintenance Director was observed taking Resident #2 from the Living room and walked somewhere no one could see themThe former Maintenance Director entered Resident #2's room and took her hair out of the style it was in.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  13600 S TRYON ST CHARLOTTE, NC 28278    CHARLOTTE, NC 28278   CHARLOTTE, NC 28278						С
CX4) ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PREFIX   TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL   TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL   TAG   (EACH OERRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE		HAL060166	B. WING		02	2/12/2024
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 453 Continued From page 99  Review of a signed dietary aide's statement dated 11/01/23 revealed: -She observed the former Maintenance Director on numerous occasions touch female residents, mainly Resident #2, where residents shouldn't be touchedThe former Maintenance Director was observed taking Resident #2 from the Living room and walked somewhere no one could see themThe former Maintenance Director entered Resident #2's room and took her hair out of the style it was in.	NAME OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 453  Continued From page 99  Review of a signed dietary aide's statement dated 11/01/23 revealed: -She observed the former Maintenance Director on numerous occasions touch female residents, mainly Resident #2, where residents shouldn't be touchedThe former Maintenance Director was observed taking Resident #2 from the Living room and walked somewhere no one could see themThe former Maintenance Director entered Resident #2's room and took her hair out of the style it was in.	WICKSHIRE STEELE CREEK					
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 453  Continued From page 99  Review of a signed dietary aide's statement dated 11/01/23 revealed: -She observed the former Maintenance Director on numerous occasions touch female residents, mainly Resident #2, where residents shouldn't be touchedThe former Maintenance Director was observed taking Resident #2 from the Living room and walked somewhere no one could see themThe former Maintenance Director entered Resident #2's room and took her hair out of the style it was in.	CUMMA DV CTA			DDOVIDEDIC DI ANI O	AF CORDECTION	
Review of a signed dietary aide's statement dated 11/01/23 revealed: -She observed the former Maintenance Director on numerous occasions touch female residents, mainly Resident #2, where residents shouldn't be touchedThe former Maintenance Director was observed taking Resident #2 from the Living room and walked somewhere no one could see themThe former Maintenance Director entered Resident #2's room and took her hair out of the style it was in.	PREFIX (EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE THE APPROPRIATE	COMPLETE
11/01/23 revealed: -She observed the former Maintenance Director on numerous occasions touch female residents, mainly Resident #2, where residents shouldn't be touchedThe former Maintenance Director was observed taking Resident #2 from the Living room and walked somewhere no one could see themThe former Maintenance Director entered Resident #2's room and took her hair out of the style it was in.	D 453 Continued From page	99	D 453			
Telephone interview with a first shift PCA on 02/01/24 at 10:40am revealed:  -She witnessed the former Maintenance Director take Resident #2, to the bathroom where he stood beside the resident as she sat on the toilet but was uncertain of the date.  -She witnessed the former Maintenance Director almost every time he worked, take Resident #2's hair down and witnessed him playing with the resident's hair which she felt was inappropriate.  -She reported the former Maintenance Director's inappropriate behavior to the former SCC several times and to the Administrator starting at the end of October 2023.  -She was asked to provide a written statement along with two other staff who had witnessed the former Maintenance Director's inappropriate behavior and gave the written statement to the SCC.  Review of a signed PCA's statement dated 11/01/23 revealed:  -She observed the former Maintenance Director on numerous occasions touch female residents,	Review of a signed did 11/01/23 revealed: -She observed the form on numerous occasion mainly Resident #2, we touchedThe former Maintena taking Resident #2 frow walked somewhere note. The former Maintena Resident #2's room are style it was in.  Telephone interview we 02/01/24 at 10:40am respectively. She witnessed the footake Resident #2, to the stood beside the reside but was uncertain of the she witnessed the footal most every time here we hair down and witness resident's hair which sees resident's hair which sees reported the form inappropriate behavious times and to the Admit of October 2023She was asked to provide along with two others former Maintenance Dehavior and gave the SCC.  Review of a signed Pound of the provided signed Pound 1/01/23 revealed: -She observed the form	mer Maintenance Director ins touch female residents, where residents shouldn't be ince Director was observed im the Living room and to one could see them. Ince Director entered and took her hair out of the  with a first shift PCA on revealed: Inter Maintenance Director the bathroom where he lent as she sat on the toilet the date. Inter Maintenance Director worked, take Resident #2's seed him playing with the she felt was inappropriate. Inter Maintenance Director's Inter Maintenance Director  CA's statement dated  Mer Maintenance Director	D 433			

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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	
			D WING		С	
		HAL060166	B. WING		02/12/2024	_
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STA	TE ZIP CODE		
TWANE OF T	NOVIDEN ON OUT FIEN		, ,	(i, z.ii ) (i, z.ii )		
WICKSHII	RE STEELE CREEK		TRYON ST			
	-	CHARLO	OTTE, NC 28278			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
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				DEI IGIENCI)		_
D 453	Continued From page	100	D 453			
	Continuou i rom page	3 100				
	taking Resident #2 fro	om the Livingroom and				
	walked somewhere n	o one could see them.				
	-The former Maintena	ance Director entered				
	Resident #2's room a	nd took her hair out of the				
	style it was in.					
	Telephone interview v	with a former MA on				
	02/01/24 at 12:40pm					
	· ·					
	· ·	e former Maintenance				
		age Resident #2's head and				
		nd kiss her on her cheek.				
	· ·	ne had observed the former				
		escort Resident #2 to her				
	bedroom but did not l	know why he did this with				
	Resident #2.					
	-She provided a writte	en statement to the				
	Administrator related	to the former Maintenance				
	Director's inappropria	te behaviors on 11/01/23.				
	1	viewed by the Administrator				
	or management staff					
	statement dated 11/0					
		ne told the Administrator of				
	· ·	I to the former Maintenance				
		wards Resident #2 and the				
	Administrator, "wound					
	· · · · · · · · · · · · · · · · · · ·	<b>U</b>				
	-She never tried to int					
	_	being made aware of the				
	former Maintenance I	Director's behaviors.				
	Review of a signed M	ia's statement dated				
	11/01/23 revealed:					
		rmer Maintenance Director				
	inappropriately touch	Resident #2 on memory				
	care unit.					
	-The former Maintena	ance Director appeared to				
		to Resident #2 and would				
	rub her back and hair					
	Telephone interview v	with a former PCA on				
	01/17/24 at 3:04pm re					
	01/11/27 at 0.04piii it	ovodiou.	1			

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HAL060166  B. WING  DAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  WICKSHIRE STEELE CREEK  13600 S TRYON ST		OF CORRECTION	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA F CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  WICKSHIRE STEELE CREEK  STREET ADDRESS, CITY, STATE, ZIP CODE  13600 S TRYON ST				A. BOILDING	<del></del>		
WICKSHIRE STEELE CREEK 13600 S TRYON ST			HAL060166	B. WING			2024
WICKSHIRE STEELE CREEK	NAME OF PROVID	PROVIDER OR SUPPLIER	OVIDER OR SUPPLIER STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
WICKSTIRE STEELE CREEK	WICKSHIPE ST	IDE STEELE SDEEK	13600 S T	RYON ST			
CHARLOTTE, NC 28278	WICKSHIRE ST	RE STEELE CREEK	CHARLOT	TE, NC 28278			
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	PREFIX	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETE DATE
D 453 Continued From page 101 D 453	D 453 Cor	Continued From page	Continued From page 101	D 453			
-In the Fall of 2023, she had a concern for the former Maintenance Director's physical affection towards residentsShe notified the Administrator sometime in October 2023 that she did not like the former Maintenance Director hugging residentsOnly PCAs and MAs were to provide hands-on care to residents, no other staffShe resigned from the facility in November 2023 or December 2023The Administrator was rarely at the facility and did not engage with residents.  Telephone interview with a former agency PCA on 02/05/24 at 10:50am revealed: -She occasionally worked on the SCUWhen she worked in the SCU, the former Maintenance Director was frequently nugged, had her back rubbed over her clothing, and walked down the hallway holding the former Maintenance Director's handShe did not feel comfortable with the amount of affection the former Maintenance Director provided to Resident #2.  Telephone interview with a PCA on 02/07/24 at 11:30am revealed: -She worked first and second shift in the SCUBetween September 2023 and October 2023, she notified the Administrator of a concern she had observed the Maintenance Director changing Resident #2's brief from her bedsideShe was not aware of any investigation which involved the former Maintenance Director between September 2023 and November 2023, until an incident occurred with the former	-In the form town -She Octo Main -One care -She or E -The did Tele 02/0 -She -Wh Main spee -Re bace the Dire -She affe provided -She -She she had Ress -She involuded -She	-In the Fall of 2023, former Maintenance towards residentsShe notified the Adroctober 2023 that sl Maintenance Directors or December 2023The Administrator with did not engage with  Telephone interview 02/05/24 at 10:50am -She occasionally wrows when she worked in Maintenance Directors spending time with Fracial resident #2 was free back rubbed over he the hallway holding to Director's handShe did not feel coraffection the former provided to Resident  Telephone interview 11:30am revealed: -She worked first an -Between September she notified the Adminad observed the Markesident #2's brief first she was not aware involved the former between September between September she possible resident services and services was not aware involved the former between September september september september services and services was not aware involved the former between September services and services was not aware involved the former between September services and services was not aware involved the former between September services and services was not aware involved the former between September services and services was not aware involved the former between September services and services was not aware involved the former between September services was not services and services was not aware involved the former between September services was not services and services was	In the Fall of 2023, she had a concern for the former Maintenance Director's physical affection towards residents.  She notified the Administrator sometime in October 2023 that she did not like the former Maintenance Director hugging residents.  Only PCAs and MAs were to provide hands-on care to residents, no other staff.  She resigned from the facility in November 2023 or December 2023.  The Administrator was rarely at the facility and did not engage with residents.  Telephone interview with a former agency PCA on 02/05/24 at 10:50am revealed:  She occasionally worked on the SCU.  When she worked in the SCU, the former Maintenance Director was frequently on the unit spending time with Resident #2.  Resident #2 was frequently hugged, had her back rubbed over her clothing, and walked down the hallway holding the former Maintenance Director's hand.  She did not feel comfortable with the amount of affection the former Maintenance Director provided to Resident #2.  Telephone interview with a PCA on 02/07/24 at 11:30am revealed:  She worked first and second shift in the SCU.  Between September 2023 and October 2023, she notified the Administrator of a concern she had observed the Maintenance Director changing Resident #2's brief from her bedside.  She was not aware of any investigation which involved the former Maintenance Director between September 2023 and November 2023,	D 453			

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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	
			B. WING		С	
		HAL060166	B. WING		02/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		13600 S T	RYON ST			
WICKSHIRE STEELE CREEK			TTE, NC 28278			
			112, 140 20270	T		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	()	
PREFIX TAG	,	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		
1710		,	1,710	DEFICIENCY)		
			<b>—</b>			$\neg$
D 453	Continued From page	÷ 102	D 453			
	Interview with a first s	hift MA on 01/03/24 at				
	11:30am revealed:					
	-She had concerns at	oout the former Maintenance				
		sical contact with residents.				
	-She notified the form	er SCC and the current				
	SCC of her concerns	for the former Maintenance				
	Director's physical co	ntact with residents.				
	-She had frequently o	bserved the former				
	Maintenance Director	rub residents' backs, kiss				
	female residents on the	neir cheek close to their				
	mouths.					
	-She felt uncomfortab	le around the former				
	Maintenance Director	due to him constantly				
	hugging residents.	,				
		7:00am, she observed the				
		Director rubbing Resident				
	#2's feet in the Living	•				
	ŭ					
	Interview with a first s	hift MA on 01/30/24 at				
	4:45pm revealed:					
	-Sometime in the Fall	of 2023, she attended a				
	staff meeting directed	by the Administrator.				
	-The Administrator no	tified staff that facility				
	employees were pern	nitted to touch residents'				
		was not to be considered				
	inappropriate.					
		iscussion was upsetting to				
	her, and she left the r					
	Telephone interview v	vith a former PCA on				
	01/31/24 at 4:11pm re	evealed:				
	-She had worked on t					
	-Occasionally, she ha	d observed the former				
	Maintenance Director	hug Resident #2 which				
	"seemed odd".					
	-She did not report ev	ery instance witnessed				
		rator was already made				
	aware of former Main	-				
	inappropriate behavio	or.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURV COMPLETE	
					С	
		HAL060166	B. WING		02/12/2	2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHII	RE STEELE CREEK	13600 S TF	RYON ST			
WICKSHII	NE STEELE OREEK	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 APPROPE DEFICIENCY)	BE C	(X5) COMPLETE DATE
D 453	Continued From page	e 103	D 453			
	Telephone interview of 01/31/24 at 4:20pm re- She worked in the Stand December 2023She and facility staff Maintenance Director other residents"Staff had observed the Director frequently how the back, and would of Maintenance Director #2's bedroom without roomIn early November 2 with concerns for the DirectorIn early November 2 written statements to -She was unaware if	with the former SCC on evealed: CU between October 2023  were concerned the former "favored Resident #2 over the former Maintenance olding hands with Resident in the hallway, and rubbing occasionally observe the walking out of Resident in a maintenance need in the 1023, staff wrote statements former Maintenance 1023, she provided the the Administration.				
	revealed: -He was promoted to December 2023The former SCC had with staff statements former Maintenance I -He did not know wha statementsIn the fall of 2023, so of concerns for witnes Maintenance Director Resident #2, including cheek and foreheadKissing residents in a inappropriate for any	I provided the Administrator related to concerns for the Director. It was written in the staff ome staff had informed him asing the former show affection towards g kissing residents on the sany manner was				

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interview him related to the former Maintenance

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED
			A. BUILDING		
		HAL060166	B. WING		C <b>02/12/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
WICKSHIE	RE STEELE CREEK	13600 S TF			
		CHARLOT	TE, NC 28278		<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 APPROP DEFICIENCY)	BE COMPLETE
D 453	Continued From page	e 104	D 453		
	Director's interactions -In the fall of 2023, th of staff concerns for th Director providing car notified all department to ensure only staff as performed resident car	s with residents. e Administrator was aware he former Maintenance re to residents because she at managers during meetings ssigned to resident care, are needs.			
	Director on 02/01/24 and 07/03/23 and 01/03/2 and 01/03/2 and 01/03/2 and frequently greete with hugs, scratching and kissing foreheads and kissing forehe	ance Director between 4. d residents in the SCU daily their backs over their shirts, s. n one occasion, he was in epairing a telephone and the room while she was in and was defecating on the to the toilet and left the Administrator notified him cern for how he showed			
	him about 'being mind affection towards resi uncomfortable for car.  Telephone interview v Detective on 01/31/22-He interviewed the fa Director in January 20-The Maintenance Diran incident in which hin the hallway without defecating, and assis sought PCAs to assis -A PCA had been interviewed towards.	dful' of how he showed dents could be re staff.  with a Law Enforcement 4 at 4:39pm revealed: acility former Maintenance 024.  rector had stated there was re had observed Resident #2 ther pants on, while she was ted her to the toilet, and the tresident.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE  A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		D WING		С
	HAL060166	B. WING		02/12/2024
NAME OF PROVIDER OR SUPPLIER		DRESS, CITY, STAT	E, ZIP CODE	
WICKSHIRE STEELE CREEK	13600 S T	RYON ST TE, NC 28278		
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PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 453 Continued From page 1	105	D 453		
Resident #2's room and pants on, with no additi about this incident.  -A PCA had been interview Maintenance Director has residents' rooms without services.  -Based on interviews, the Director was overly frient residents without evident and the Director was overly frient residents without evident and the Director.  -He conducted numerous staff after an incident on another resident and the Director.  -He conducted an interviews, because of how the forminteracted with Resident and rubbing her back.  -According to the former on one occasion, he has onto the toilet while she proceeded to clean up floor while a PCA assist bathroom.  Interview with the facility of the former on one occasion.  Interview with the facility of the faci	d Resident #2 did not have onal details provided viewed and felt the had spent too much time in at a need for maintenance the former Maintenance andly towards female noce of criminal acts.  It is a second Law on 02/01/24 at 11:30am the former Maintenance with the former maintenance with the former maintenance with the former maintenance with the former maintenance to assault to a resident, staff disclosed concerns mer Maintenance Director at #2 related to hugging her the maintenance Director, and assisted Resident #2 was defecating and the Resident #2 in the company to the maintenance on the maintenance on the was not aware staff had at the former Maintenance			

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	or riealin Service Regu				1
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
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		HAL060166	B. WING		02/12/2024
		TIALOGOTOG			1 02/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
WIOKOLUI	DE OTEEL E ODEEK	13600 S	TRYON ST		
WICKSHIP	RE STEELE CREEK	CHARLO	TTE, NC 28278		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE
				DEFICIENCY)	
D 453	Continued From page	e 106	D 453		
	care.				
	-The former Maintena				
	responsible for provid	ling resident care.			
	I	vith Resident #2's former			
	_	rse Practitioner on 02/02/24			
	at 10:18am revealed:				
		2's healthcare provider			
	between 2022 throug				
		of any allegations of abuse,			
	neglect, or exploitatio	n of Resident #2 by facility			
	staff.				
	-If facility staff had ob	served a concern for			
	Resident #2 and poss	sible abuse by a facility			
	employee, she expec	ted to be notified			
	immediately.				
		ministrator on 02/02/24 at			
	2:55pm revealed:				
	· · · · · · · · · · · · · · · · · · ·	for reporting any concerns			
	1	eglect, or exploitation to local			
		partment of social services,			
		alth service regulations.			
	-On 10/19/23, a dinin	g staff had her of a concern			
	for the former Mainter				
		ing staff notified her that she			
	felt uncomfortable wit	h the former Maintenance			
		providing hugs to residents,			
	and kissing residents				
		itional staff and was told the			
		Director was often observed			
	giving hugs to Reside				
	-She determined the				
	Director's hugging of				
		Resident #2 frequently			
	having episodes of cr	ying where she sought out			
	staff for hugs.				
	-She did not documer	nt the staff concerns or			
	interviews.				
	-She did not initiate a	NC Healthcare Personnel			

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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: _		COMPLETED
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		HAL060166	B. WING		02/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		13600 S T	RYON ST		
WICKSHIE	RE STEELE CREEK		TTE, NC 28278		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
D 453	Continued From page	e 107	D 453		
	Initial or Investigation Maintenance Director -On 10/20/24, she me Maintenance Director uncomfortable with hi affection towards staf careful how he interac -On 10/20/24, she no Maintenance Director was not permitted "ev mean any harm." -Between 10/19/23 at provided any written s Maintenance Director -She was unaware of provided by staff cone Maintenance Director -Between 10/19/23 at notified of any additio	Report related to the former and notified him staff felt sphysical expressions of and residents and to be cted with staff and residents. It tified the former that kissing of residents are though I know you don't and 01/02/24, staff had not estatements related to the start and written statements cerning the former			
	Telephone interview of Officer (COO) on 02/0-She was at the facilities. Staff did not report of Maintenance Director residentsShe was not aware of statements about communication Maintenance Directors. She stated, "from my a resident does not complete to each of the stated it was inapped Maintenance Directors. She stated if signed, from staff after 10/19/10 Administrator should	oncerns about the former kissing or hugging of any signed staff written acerns of the former 's behavior after 10/19/23. 'y perspective, staff hugging constitute an allegation of exploitation." or opriate for the former to kiss Resident #2. dated, written statements '/23 existed, the			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A RUIL DING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		C	
		HAL060166	B. WING		02/12/	2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHII	RE STEELE CREEK	13600 S TF	RYON ST			
	(2 0 · 2 2 2 2 0 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1	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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
D 453	Continued From page	e 108	D 453			
	departmentIf a staff statement d inappropriate touching staff should have been and a report made to Health Service Regulti-On 01/02/24 at approate telephone call with instructed the Administructed the	ocumented concerns for g of a resident, the accused in immediately suspended the NC Department of ations and law enforcement. Eximately 10:30am, she had the Administrator, and she strator to call law Iministrator to immediately on 01/02/24. Intil late January 2024, that waited till after 5:00pm on enforcement of an ssault by the former				
	The facility failed to ensure law enforcement and the county DSS was contacted when they were made aware of abuse and exploitation by a male staff who hugged, kissed and inappropriately touched two cognitively impaired female residents (#2 and #3) related to staff reporting the male was discovered in the resident's rooms applying lotion under her cover when her genitalia and her low extremities were exposed, staff reporting the male kissing the resident in the mouth (#3) and staff reporting inappropriate kissing and hugging of a resident multiple times (#2). The facility's failure resulted in delayed reporting and investigation of potential cause and prevention of further abuse or exploitation and delayed protection and prevention from staff in care facilities. The facility's failure resulted in serious neglect and exploitation and constitutes a Type A1 Violation.  The facility provided a plan of protection on January 30, 2024, and on February 12, 2024, in					

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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		
			_		С	
		HAL060166	B. WING		02/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIP	RE STEELE CREEK	13600 S TI CHARLOT	RYON ST TE, NC 28278			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE COMPLETE	
				DEFICIENCY)		
D 453	Continued From page	e 109	D 453			
	accordance with G.S.	131D-34 for this violation.				
	CORRECTION DATE VIOLATION SHALL N 2024.	FOR THE TYPE A1 IOT EXCEED MARCH 13,				
D980	G.S. § 131D-25 Imple	ementation	D980			
	G.S. 131D-25 Implem	nentation				
	Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21.					
	This Rule is not met a					
	and operation of the f the facility's policies to rules and statutes reg Resident Rights, Med	o ensure the management acility and implementation of o ensure compliance with parding Health Care, lication Administration, el Registry, and Reporting of				
	The findings are:					
	01/01/24 revealed the capacity of 90 beds in	s current license effective facility was licensed for a acluding 42 Assisted Living Care Unit (SCU) beds.				
	Review of the facility's 01/30/24 was 58 resid					

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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		C 02/12/2024	Į.
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MICKSHIE	RE STEELE CREEK	13600 S TF	RYON ST			
Wickerin	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 APPROP DEFICIENCY)	BE COMP	
D980	Continued From page	e 110	D980			
D980	11:46am revealed: -In regard to the incid and Resident #3She reported to the pend of October that sithe former maintenant kissing a female resident a female resident and the former maintenant along with witnessed the former inappropriate behavior about it.  Telephone interview with the Coordinator (SCO revealed: -In regard to the incident and Resident #3She worked in the Stand December 2023.	ents related to Resident #2  previous SCC towards the he was uncomfortable with ce director hugging and lent who resided in the SCU. ked her to provide a written other staff who had Maintenance Director's or but nothing was done  with the former Special Care C) on 01/31/24 at 4:20pm  ents related to Resident #2  CU between October 2023	D980			
	Maintenance Director kissing, and hugging -In early November 20 written statements to -She did not know if the staff related to the written Maintenance Did the facility when the ATT Telephone interview with detective on 01/31/24 -In regard to incidents Resident #3.	023, she provided the the Administrator. he Administrator interviewed litten statements. rector was still working at administrator resigned. with a law enforcement at 4:39pm revealed: s related to Resident #2 and				
	Director was overly fr residents without evic	the former Maintenance iendly towards female lence of criminal acts. ility Administrator waited iness hours, between				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	,
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COWFLETED	
			D WING		С	
		HAL060166	B. WING	<del></del>	02/12/202	4
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHII	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE CON	(X5) MPLETE MATE
D980	Continued From page	e 111	D980			
2000	5:30pm and 6:00pm, a possible sexual assobserved by staff on 9:00am and immedia AdministratorHe would have experimmediately notify law to reduce opportunities contaminated or discartication of the incident and Resident #3She was never intervor management staff statement dated 11/0	to notify law enforcement of sault crime which was 01/02/24 between 8:30 and tely reported to the cted the Administrator to w enforcement on 01/02/24 es of any evidence to be arded.  with a former MA on revealed: lents related to Resident #2				
	2:55pm revealed: -In regard to the incid and Resident #3She was responsible for resident abuse, ne law enforcement, Dep (DSS), and HCPROn 10/19/23, a dinin felt uncomfortable wit Director providing hug residents on their fore-She interviewed add former Maintenance I giving hugsShe determined the Director's hugging resinappropriate.	itional staff and was told the Director was often observed former Maintenance				

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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		C <b>02/12/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHII	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 COMPLETE	
D980	Continued From page	: 112	D980			
	-She did not initiate the related to the former I behaviorsOn 10/20/24, she mediantenance Director uncomfortable with his affection towards staff careful how he interact Interview with the Research (RCC) on 02/05/24 at -In regard to medicatide -She was not aware contracted in the receiving their mediantenance of the receiving the re	the HCPR investigation Maintenance Director's  Let with the former and notified him staff felt as physical expressions of and residents and to be cted with staff and residents.  Let with the former and notified him staff felt and residents and to be cted with staff and residents.  Let with staff and residents.  Let with staff and residents and health care.  Let is issues with the residents and physician and the control of				
	Interview with the facility Compliance Nurse on 02/12/24 at 3:18pm revealed: -In regard to medications and health careShe was hired as the facility Compliance Nurse in October 2023She had not audited all of the residents' records since she began working at the facility because the Administrator never told her to do soShe just learned there were errors with how staff entered orders into the electronic Medication Administration Record (eMAR)The results and any issues of the audits completed by the RCC and SCC were supposed be given to the Administrator and discussed in the morning meetingsThe Administrator was responsible for following up on the missed medicationsIt became her responsibility in January 2024 because it was not always being done.					

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DIVISION	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING:		COMPLETED	
			A. BUILDING:			
					C	
		HAL060166	B. WING		02/1	2/2024
			•		-	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MICKELIE	RE STEELE CREEK	13600 S T	RYON ST			
WICKSHIP	RE STEELE GREEK	CHARLO	TTE, NC 28278			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N.	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		DATE
				DEFICIENCY)		
D980	Continued From page	e 113	D980			
	Telephone interview v	vith a first and second shift				
	I					
	PCA on 02/07/24 at 1					
		ber 2023, she had to begin				
		care supplies for residents,				
	which included wet w	• •				
	incontinence bed pad	s, towels, and soap for				
	residents because the	e facility stopped purchasing				
	the items.					
	-Between September	2023 and December 2023,				
		d the Administrator of the				
		supplies and was told the				
	Administrator would in					
		<del>-</del>				
		ember 2023, the facility				
		ersonal care items, which				
		o, gloves, and incontinence				
	briefs for residents.					
	Telephone interview	with a second shift MA on				
	02/07/24 at 11:55am	revealed:				
	-She had concerns fo	r the management of the				
	facility by the Adminis	strator because the				
	Administrator was rar					
	September 2023 and	-				
		2023 and December 2023,				
		incontinence supplies,				
		s, and towels for residents				
	_	maintaining a stock of				
	supplies.	0000 15 1 0000				
		2023 and December 2023,				
		nistrator of concerns for a				
	<del>-</del>	nal needs supplies and staff				
		their own was told to "keep				
	up the good work."					
	Non-compliance was	identified at violation levels				
	in the following rule a					
	1 Based on interview	s and record reviews the				
		e physician's orders were				
	implemented for 2 of	5 sampled residents (#1 and				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	SI CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		GOWII ELTED
		HAL060166	B. WING		C <b>02/12/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
WICKSHIE	RE STEELE CREEK	13600 S T	RYON ST		
Wickerin	NE OTELLE ONLEN	CHARLO	TTE, NC 28278		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOLE CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	LD BE COMPLETE
D980	Continued From page	e 114	D980		
	#5) related to taking I (#1) and taking finger	blood pressures twice daily stick blood sugars (FSBS) er to tag 0276, 10A NCAC			
	facility failed to ensur (Resident #2 and #3) abuse and exploitation male staff member in hugging, and kissing behaviors and did no residents. [Refer to ta	vs and record reviews, the e 2 of 5 sampled residents were free from neglect, on related to reports of a appropriately touching, while staff observed the t intervene to protect the eg 0338, 10A NCAC 13F s (Type A1 Violation)].			
	reviews, the facility farwere administered as residents (#1, #2, #4 medication to lower be medication to treat armedication to treat varmedication to treat do to treat Alzheimer's deprevent blood clots (#10 to control high blood 0358, 10A NCAC 13F Administration (Type	epression (#2), a medication isease (#2), a medication to #4), and a medication used sugars (#5).[Refer to tag10004(a) Medication A1 Violation)].			
	facility failed to ensur Administration Recor 2 of 5 residents (#1 a documentation of a n hypertension (#1, #4) vaginal dryness (#1), blood clots (#4). [Refe	e the Medication ds (MAR) were accurate for nd #4) including inaccurate			

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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	
		7.1. 20.22.1.10.			0	
	HAL060166	B. WING		02	C 2/ <b>12/2024</b>	
OVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE			
OTES E ODESK	13600 S	TRYON ST				
STEELE CREEK	CHARLO	TTE, NC 28278				
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
Continued From page	e 115	D980				
facility failed to report by a staff member re- couching, hugging, are residents (#2 and #3; Personnel Registry (I 10A NCAC 13F .120; Registry (Type A1 Viol 3. Based on interview facility failed to imme Department of Social aw enforcement about exploitation of 2 of 2 (#3) who were inapprostaff member. [Refer	t allegations of alleged abuse lated to him inappropriately and kissing 2 of 2 sampled ) to the Health Care HCPR). [Refer to tag 0438, 5 Health Care Personnel colation)].  It is and record reviews, the diately notify the county I Services (DSS) and local ut potential abuse and sampled residents (#2 and copriately touched by a male to tag 0453, 10A NCAC 13F					
management, operate policies of the facility compliance with the redult care homes as implementation of oreo keeping residents administration, medical accidents to law enforceporting staff with all The Administrator's factor the overall operatemanagement, and suppossible to the seconstitutes a Type Administrator and suppossible to the overall operatemanagement, and suppossible to the overall operatemanagement and the overall operatemanagemen	ions and implementation of and maintain substantial rules and statutes governing related to health care ders, residents rights related safe from abuse, medication eation administration related ectronic medication is, reporting of incidents and ercement and DSS, and not degations of abuse to HCPR. Failure to ensure responsibility ion, administration, repervision of the facility eglect of the residents which it Violation.					
	SUMMARY ST (EACH DEFICIENC REGULATORY OR  Continued From page  5. Based on interview acility failed to report oy a staff member resouching, hugging, an esidents (#2 and #3) Personnel Registry (I IOA NCAC 13F .1209 Registry (Type A1 Violation) From page  5. Based on interview acility failed to immediate the properties of the facility failed to immediate the properties of the facility failed to immediate the properties of the facility compliance with the resource of the facility compliance with the resource of the facility compliance with the resource of the decident of the electron of	ALLOGOTEC SUPPLIER  STEELE CREEK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 115  Description of the decition of the decidity failed to report allegations of alleged abuse by a staff member related to him inappropriately ouching, hugging, and kissing 2 of 2 sampled esidents (#2 and #3) to the Health Care Personnel Registry (HCPR). [Refer to tag 0438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type A1 Violation)].  Department of Social Services (DSS) and local aw enforcement about potential abuse and exploitation of 2 of 2 sampled residents (#2 and #3) who were inappropriately touched by a male staff member. [Refer to tag 0453, 10A NCAC 13F 1212d Reporting Incidents and Accidents (Type A1 Violation)].  The Administrator failed to ensure the overall management, operations and implementation of colicies of the facility and maintain substantial compliance with the rules and statutes governing adult care homes as related to health care mplementation of orders, residents rights related to accurate of the electronic medication administration, medication administration related to accurate of the electronic medication administration records, reporting of incidents and accidents to law enforcement and DSS, and not eporting staff with allegations of abuse to HCPR. The Administrator's failure to ensure responsibility or the overall operation, administration, management, and supervision of the facility esulted in serious neglect of the residents which constitutes a Type A1 Violation.  The facility failed to provide an acceptable Plan of	MIDER OR SUPPLIER  STEELE CREEK  STEELE CREEK  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D980  Continued From page 115  D980  D980	WIDER OR SUPPLIER  STEELE CREEK  13600 S TRYON ST CHARLOTTE, NC 28278  SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 115  5. Based on interviews and record reviews, the acility failed to report allegations of alleged abuse by a staff member related to him inappropriately ouching, hugging, and kissing 2 of 2 sampled esidents (#2 and #3) to the Health Care Personnel Registry (HCPR). [Refer to tag 0438, 10A NCAC 13F - 1205 Health Care Personnel Registry (Type A1 Violation)].  5. Based on interviews and record reviews, the acility failed to immediately notify the county Department of Social Services (DSS) and local ave nofrocement about potential abuse and exploitation of 2 of 2 sampled residents (#2 and 83) who were inappropriately bounched by a male staff member. (Refer to tag 0453, 10A NCAC 13F 1212d Reporting Incidents and Accidents (Type A1 Violation)].  The Administrator failed to ensure the overall management, operations and implementation of olicies of the facility and maintain substantial compliance with the rules and statutes governing adult care homes as related to health care mplementation of orders, residents rights related to keeping residents safe from abuse, medication administration, medication administration, medication administration related o accurate of the electronic medication administration, medication administration records, reporting of incidents and cocidents to law enforcement and DSS, and not eporting staff with allegations of abuse to HCPR. The Administrator's failure to ensure responsibility or the overall operation, administration, management, and s	MIDER OR SUPPLER  STREET ADDRESS, CITY, STATE, ZIP CODE  13600 S TRYON ST  CHARLOTTE, NC 28278  SUMMARY STATEMENT OF DEFICIENCIS (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECULATORY OR LSC (DENTIFYING INFORMATION)  D980  Continued From page 115  D980  D980 D	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE  A. BUILDING:		SURVEY PLETED		
		HAL060166	B. WING			C / <b>12/2024</b>
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	ΓΕ, ZIP CODE	, v=	
WICKSHIE	RE STEELE CREEK		TRYON ST OTTE, NC 28278			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
D980	Continued From page	e 116	D980			
		and operations of the facility fety and respect to the				
		DATE FOR THIS TYPE A1 NOT EXCEED MARCH 13,				

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