STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and Hoke County Department of Social Services conducted a follow-up survey and complaint investigation on March 5-6, 2024. The complaint investigation was initiated by the Hoke County Department of Social Services on February 20, 2024.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Non-compliance continues with increased severity resulting in residents placed at substantial risk that death or serious physical harm, abuse, neglect, or exploitation will occur. THIS IS A TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 4 residents (#2, #8, #9) observed during the medication pass including errors with medications for enlarged prostate (#2), iron deficiency anemia (#2), constipation (#2, #8, #9), acid reflux (#2, #8), high blood pressure and/or chest pain (#8), high phosphorus levels (#8), mood stabilizer (#9),	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

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D 358	Continued From page 1	D 358		

probiotic for gut health (#8), Vitamin B supplement (#8), a topical pain patch (#8), and a medication used to slow the rate of decline in kidney function (#8); and for 2 of 5 sampled residents (#1, #2) including errors with medications for high blood pressure (#1), diabetes (#1), urine retention (#1), a blood thinner (#1), a muscle relaxer (#1), a nasal spray for allergy symptoms (#1), and a medication for acid reflux (#2).

The findings are:

1. The medication error rate was 55% as evidenced by 15 errors out of 27 opportunities during the 7:00am/8:00am medication pass on 03/05/24 and the 8:00am medication pass on 03/06/24.

a. Review of Resident #2's current FL-2 dated 02/29/24 revealed:
-Diagnoses included chronic ischemic heart disease, polyneuropathy, and spinal stenosis.
-There was an order for Ferrous Sulfate Delayed Release (DR) Enteric Coated (EC) 324mg 1 tablet two times a day for iron. (Ferrous Sulfate is an iron supplement used to treat iron deficiency anemia. Ferrous Sulfate is delayed release and has an enteric coating to prevent stomach irritation and upset and reduce the risk of stomach bleeding. Ferrous Sulfate DR should not be crushed or chewed.)
-There was an order for may crush medication and mix with food/beverage to facilitate medication administration.

Review of Resident #2's hospital after visit summary (AVS) dated 02/21/24 - 02/24/24 revealed the resident's diagnoses included hematemesis (vomiting blood) with nausea and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 358	Continued From page 2	D 358		

esophagitis (inflammation of the esophagus).

Observation of the 8:00am medication pass on 03/05/24 revealed:
-The medication aide (MA) prepared morning medications for Resident #2, including one Ferrous Sulfate 324mg tablet.
-The MA crushed all of Resident #2's oral tablets, including the Ferrous Sulfate, mixed them in applesauce and administered them to the resident at 9:28am.

Observation of Resident #2's medications on hand on 03/05/24 at 2:30pm revealed:
-There was a supply of Ferrous Sulfate 324mg tablets, with the prescription label torn off and only about 1/4th of the label still attached to the bottle.
-There was a warning on the manufacturer's label not to crush or chew the medication.

Review of Resident #2's March 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Ferrous Sulfate 324mg give 1 tablet two times a day for iron scheduled for 8:00am and 8:00pm.
-Ferrous Sulfate was documented as administered from 03/01/24 - 03/05/24.
-There was no information noted on the eMAR to indicate the medication should not be crushed.
-There was an entry for may crush medication and mix with food/beverage to facilitate medication administration.

Interview with Resident #2 on 03/05/24 at 10:01am revealed:
-The MAs usually crushed all of his medications.
-It was easier for him to swallow the medications if they were crushed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 358	Continued From page 3 -He denied any current symptoms of stomach upset or pain. Interview with the MA on 03/05/24 at 2:09pm revealed: -She usually crushed all of Resident #2's medications. -She thought the order to crush medications meant she could crush everything. -She did not know if the facility had a Do Not Crush (DNC) list. Interview with the Assistant Resident Care Coordinator (ARCC) on 03/05/24 at 2:42pm revealed: -There was a DNC list in a notebook on all medication carts. -She did not think the eMARs or the medication labels were marked with medications that could not be crushed. -The MAs knew about the DNC list and should refer to it before crushing any medications. -Resident #2's Ferrous Sulfate should not have been crushed. Interview with the Administrator on 03/05/24 at 4:02pm revealed: -There was a DNC list on the medication cart and in the medication room. -The MAs should reference the DNC list prior to crushing medications. -The MAs were trained and knew there was a DNC list available. -Resident #2's Ferrous Sulfate should not have been crushed. Review of the facility's DNC medication list revealed Ferrous Sulfate DR was included on the list as a medication that should not be crushed.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 358	Continued From page 4	D 358		

Attempted telephone interview with the resident's primary care provider (PCP) on 03/06/24 at 4:18pm was unsuccessful.

Telephone interview with the PCP's on call provider on 03/06/24 at 4:29pm revealed:
-Ferrous Sulfate should not be crushed.
-Crushing Ferrous Sulfate could cause the resident to have gastrointestinal irritation or precipitate gastrointestinal bleeding.

b. Review of Resident #2's current FL-2 dated 02/29/24 revealed:
-There was an order for Finasteride 5mg 1 tablet one time a day for prostate. (Finasteride is used to treat urinary retention caused by enlarged prostate. Finasteride is film-coated and should not be crushed.)
-There was an order for may crush medication and mix with food/beverage to facilitate medication administration.

Observation of the 8:00am medication pass on 03/05/24 revealed:
-The medication aide (MA) prepared morning medications for Resident #2, including one Finasteride 5mg tablet.
-The MA crushed all of Resident #2's oral tablets, including the Finasteride, mixed them in applesauce and administered them to the resident at 9:28am.

Observation of Resident #2's medications on hand on 03/05/24 at 2:30pm revealed:
-There was a supply of Finasteride 5mg tablets dispensed on 10/03/23.
-There was no information noted on the label to indicate the medication should not be crushed.

Review of Resident #2's March 2024 electronic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 358	Continued From page 5	D 358		

medication administration record (eMAR) revealed:
-There was an entry for Finasteride 5mg 1 tablet once time a day for prostate scheduled for 8:00am.
-Finasteride was documented as administered daily from 03/01/24 - 03/05/24.
-There was no information noted on the eMAR to indicate the medication should not be crushed.
-There was an entry for may crush medication and mix with food/beverage to facilitate medication administration.
-There was no documentation to indicate if the resident's medication was being crushed.

Interview with Resident #2 on 03/05/24 at 10:01am revealed:
-The MAs usually crushed all of his medications.
-It was easier for him to swallow the medications if they were crushed.
-The medications did not usually hurt his stomach and he was not aware of any side effects from his medications.

Interview with the MA on 03/05/24 at 2:09pm revealed:
-She usually crushed all of Resident #2's medications.
-She thought the order to crush medications meant she could crush everything.
-She did not know if the facility had a Do Not Crush (DNC) list.

Interview with the Assistant Resident Care Coordinator (ARCC) on 03/05/24 at 2:42pm revealed:
-There was a DNC list in a notebook on all medication carts.
-She did not think the eMARs or the medication labels were marked with medications that could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 358	Continued From page 6	D 358		

not be crushed.
-The MAs knew about the DNC list and should refer to it before crushing any medications.
-Resident #2's Finasteride should not have been crushed.

Interview with the Administrator on 03/05/24 at 4:02pm revealed:
-There was a DNC list on the medication cart and in the medication room.
-The MAs should reference the DNC list prior to crushing medications.
-The MAs were trained and knew there was a DNC list available.
-Resident #2's Finasteride should not have been crushed.

Review of the facility's DNC medication list revealed Finasteride was included on the list as a medication that should not be crushed.

Attempted telephone interview with the resident's primary care provider (PCP) on 03/06/24 at 4:18pm was unsuccessful.

Telephone interview with the PCP's on call provider on 03/06/24 at 4:29pm revealed:
-Finasteride should not be crushed.
-She was not aware of any specific concerns for the resident receiving crushed Finasteride.

c. Review of Resident #2's current FL-2 dated 02/29/24 revealed an order for Pantoprazole 40mg 1 tablet two times a day for acid reflux. (Pantoprazole is used to treat gastroesophageal reflux disease.)

Review of Resident #2's primary care provider (PCP) visit noted dated 11/02/23 revealed the resident suffered from persistent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 358	Continued From page 7	D 358		

gastroesophageal reflux.

Review of Resident #2's hospital after visit summary (AVS) dated 02/21/24 - 02/24/24 revealed:
-The resident's diagnoses included hematemesis (vomiting blood) with nausea and esophagitis (inflammation of the esophagus).
-There was an order to start taking Pantoprazole 40mg 1 tablet two times a day.

Observation of the 8:00am medication pass on 03/05/24 revealed:
-The medication aide (MA) prepared and administered oral medications scheduled for 8:00am to Resident #2 at 9:28am.
-The MA did not prepare and administer Pantoprazole to the resident when he received his other morning medications.
-Pantoprazole was not administered as ordered.

Observation of Resident #2's medications on hand on 03/05/24 at 2:31pm revealed there were 60 Pantoprazole 40mg tablets dispensed in a bottle by an outside pharmacy on 02/26/24.

Review of Resident #2's March 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Pantoprazole 40mg 1 tablet two times a day for acid reflux scheduled for 8:00am and 8:00pm.
-Pantoprazole was documented as administered two times a day from 03/01/24 - 03/04/24.
-Pantoprazole was documented as not administered at 8:00am on 03/05/24 with no reason documented.

Interview with Resident #2 on 03/05/24 at 1:05pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 8	D 358		

-He thought he received Pantoprazole every day.
-He was not sure if Pantoprazole was in the medication cup he received that morning.
-He had problems with acid reflux, but he was not having any symptoms of acid reflux today.

Interview with the MA on 03/05/24 at 2:09pm revealed:
-She did not administer Resident #2's Pantoprazole that morning, 03/05/24, because she overlooked it in the medication cart.
-She did not think the resident had any Pantoprazole available to administer.

Interview with the Assistant Resident Care Coordinator (ARCC) on 03/05/24 at 2:42pm revealed:
-The MAs were responsible for ordering medications.
-If a medication was unavailable or on order, the MAs should notify her or the Resident Care Coordinator (RCC).
-The MAs were supposed to double check the medication cart to make sure medications were available when administering medications.

Interview with the Administrator on 03/05/24 at 4:02pm revealed:
-If a medication was not in the medication cart, the MAs should notify the RCC, ARCC, or Memory Care Director (MCD).
-The RCC, ARCC, or MCD would check behind the MAs to see if the medication was in the cart or the back-up supply.
-The ARCC did a weekly cart audit and "9 times out of 10", the medications were available.

Attempted telephone interview with the resident's PCP on 03/06/24 at 4:18pm was unsuccessful.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 9	D 358		

Telephone interview with the PCP's on call provider on 03/06/24 at 4:29pm revealed missing doses of Pantoprazole could increase the resident's risk of gastrointestinal irritation and precipitate the resident's recent gastrointestinal bleed.

d. Review of Resident #2's current FL-2 dated 02/29/24 revealed an order for Miralax give 1 packet (17gm) one time a day for constipation. (Miralax is a laxative used to treat and prevent constipation.)

Observation of the 8:00am medication pass on 03/05/24 revealed:
-The medication aide (MA) prepared 1 packet (17gm) of Miralax powder mixed in water in an 8-ounce styrofoam cup.
-The MA took the styrofoam cup with Miralax to the resident's room and sat it on the bedside table at 9:37am.
-The resident asked if that was Miralax and the MA indicated it was Miralax.
-The MA left the resident's room without observing or asking the resident to take the Miralax.

Review of Resident #2's March 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Miralax give 1 packet (17gm) one time a day for constipation scheduled for 8:00am
-Miralax was documented as administered daily from 03/01/24 - 03/05/24.

Observation of Resident #2's room on 03/05/24 at 10:01am revealed:
-The styrofoam cup with Miralax was still sitting on the corner of the bedside table.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 10 -There were approximately 2 ounces of water with Miralax remaining in the cup. Interview with Resident #2 on 03/05/24 at 10:01am revealed: -He had not finished drinking the water with Miralax. -The MAs usually left the cup with water and Miralax in his room and he usually drank it during the day until it was gone. -He denied any current issues with constipation or diarrhea. Observation of Resident #2's room on 03/05/24 at 1:05pm revealed the styrofoam cup with water and Miralax was no longer sitting on the bedside table. Interview with Resident #2 on 03/05/24 at 1:05pm revealed he thought he had finished drinking the Miralax earlier, but he could not recall a time. Interview with the MA on 03/05/24 at 2:09pm revealed: -There were certain residents she had to observe take their medications and some residents she did not observe because they would take the medications on their own. -She did not usually observe Resident #2 take the Miralax because he would drink it on his own. -She saw a styrofoam cup in Resident #2's trash can today, 03/05/24, around 1:00pm so she thought he drank the Miralax from this morning's medication pass. Interview with the Assistant Resident Care Coordinator (ARCC) on 03/05/24 at 2:42pm revealed: -The MAs were supposed to wait and observe residents take all of their medications.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 11 -The MA should have waited and observed Resident #2 drink all of the Miralax. Interview with the Administrator on 03/05/24 at 4:02pm revealed the MA should have observed Resident #2 take all of his medication, including the Miralax to make sure the resident did not spit it out or pour it out. Attempted telephone interview with the resident's primary care provider (PCP) on 03/06/24 at 4:18pm was unsuccessful. e. Review of Resident #8's current FL-2 dated 02/01/24 revealed: -Diagnoses included essential primary hypertension, stage 4 chronic kidney disease, anemia, weakness, peripheral vascular disease, osteoarthritis, edema, and generalized abdominal pain. -There was an order for Nifedipine ER 30mg 1 tablet 2 times a day for high blood pressure, hold if systolic blood pressure (SBP) is less than (<) 100. (Nifedipine ER is used to treat high blood pressure and chest pain.) Review of Resident #8's physician's order dated 02/23/24 revealed an order to change Nifedipine ER 30mg to once a day, if SBP is less than or equal to 130, then hold the daily dose. Observation of the 8:00am medication pass on 03/05/24 revealed: -The medication aide (MA) took Resident #8's blood pressure. -The resident's blood pressure reading on the monitor was 122/74. -The MA prepared and administered Nifedipine ER 30mg to the resident at 9:54am instead of holding the medication as ordered.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 358	Continued From page 12 Review of Resident #8's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Nifedipine ER 30mg give 1 tablet once time a day for high blood pressure, hold if SBP greater than (>) 130. -Nifedipine ER was scheduled at 8:00am and documented as administered daily from 03/01/24 - 03/05/24. -The resident's blood pressure was checked daily at 8:00am and ranged from 122/74 - 147/62 from 03/01/24 - 03/05/24. Interview with Resident #8 on 03/05/24 at 12:55pm revealed: -She thought her high blood pressure had improved after her primary care provider (PCP) added some medications. -The MAs did not usually hold any of her blood pressure medications; she received them every day. -About 2 weeks ago (could not recall date or time), she was sitting at a table and saw a "white cloud" and her head went down. -She was positive that her blood pressure was low and caused these symptoms. -She did not report the symptoms to anyone because she got better. Interview with the MA on 03/05/24 at 2:09pm revealed: -She was going by the instructions on the eMAR when she administered Resident #8's Nifedipine ER that morning, 03/05/24. -She did not enter the order on the eMAR to hold Nifedipine ER if the SBP was >130. -The MAs did not enter orders on the eMAR and she was not sure who was responsible for entering the orders.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 13 -She was not aware Resident #8's order was to hold the Nifedipine ER if the SBP was less than or equal to 130. Interview with the Assistant Resident Care Coordinator (ARCC) on 03/05/24 at 2:42pm revealed: -The Resident Care Coordinator (RCC), Memory Care Director (MCD), and ARCC were responsible for entering orders into the eMAR system. -She entered Resident #8's Nifedipine ER order into the eMAR system. -She thought the order was to hold the Nifedipine ER if the SBP was greater than 130. -She looked at the order incorrectly and therefore, entered it incorrectly into the eMAR system. -According to the order, Resident #8's Nifedipine ER should have been held that morning, 03/05/24 because her SBP was less than 130. Interview with the Administrator on 03/05/24 at 4:02pm revealed: -The ARCC entered the Nifedipine ER order incorrectly into the eMAR system. -Resident #8's Nifedipine ER should have been held when the SBP was less than or equal to 130 as ordered. Attempted telephone interview with the resident's PCP on 03/06/24 at 4:18pm was unsuccessful. Telephone interview with the PCP's on call provider on 03/06/24 at 4:29pm revealed: -It was especially concerning when the Nifedipine ER was not held as ordered in an elderly resident. -Not holding the Nifedipine ER could cause the resident to have low blood pressure and increase the resident's risk for falls.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

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D 358	Continued From page 14 f. Review of Resident #8's current FL-2 dated 02/01/24 revealed an order for Florastor Probiotic 250mg take 2 capsules 2 times a day for gastrointestinal health, take for 12 weeks. (Florastor is a probiotic used to benefit gastrointestinal health.) Observation of the 8:00am medication pass on 03/05/24 revealed the medication aide (MA) prepared and administered 1 Florastor Probiotic 250mg capsule instead of 2 capsules as ordered. Review of Resident #8's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Florastor Probiotic 250mg give 2 capsules 2 times a day for GI health for 12 weeks scheduled for 8:00am and 8:00pm. -Florastor Probiotic capsule was documented as administered from 03/01/24 - 03/05/24. Interview with Resident #8 on 03/05/24 at 12:55pm revealed: -She did not know if she received a Probiotic medication. -She was not currently having any stomach issues other than diarrhea at times. Interview with the MA on 03/05/24 at 2:09pm revealed: -She usually administered 2 Florastor Probiotic capsules to Resident #8. -She overlooked it and made an error that morning, 03/05/24, when she administered 1 capsule instead of 2 capsules. Interview with the Assistant Resident Care Coordinator (ARCC) on 03/05/24 at 2:42pm revealed: -The MAs had been trained to read the eMARs	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 15	D 358		

and administer medications according to the instructions on the eMAR.
-Resident #8 should have received two Florastor Probiotic capsules instead of 1 capsule.

Interview with the Administrator on 03/05/24 at 4:02pm revealed the MA should have read both the eMAR and medication label and administered 2 capsules of Florastor Probiotic instead of 1 capsule.

Attempted telephone interview with the resident's primary care provider (PCP) on 03/06/24 at 4:18pm was unsuccessful.

Telephone interview with the PCP's on call provider on 03/06/24 at 4:29pm revealed only receiving half the dose of Florastor Probiotic could cause the medication not to be as effective in restoring gut flora and preventing diarrhea.

g. Review of Resident #8's current FL-2 dated 02/01/24 revealed an order for Lidocaine Patch 4%, apply 1 patch to the right shoulder and neck topically in the morning for pain, remove at bedtime. (Lidocaine Patch is a topical patch used to treat pain.)

Observation of the 8:00am medication pass on 03/05/24 revealed:
-The medication aide (MA) prepared and administered morning medications to Resident #8 at 9:54am.
-The MA did not apply or offer to apply a Lidocaine Patch to the resident's right shoulder and neck when the resident was administered her other morning medications
-There was no Lidocaine Patch on the resident's right shoulder and neck.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

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WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 358	Continued From page 16	D 358		

Observation of Resident #8 on 03/05/24 at 12:55pm revealed the resident had a Lidocaine Patch on the side of her lower left leg but there was no Lidocaine Patch on her right shoulder and neck.

Interview with Resident #8 on 03/05/24 at 12:55pm revealed:
-The MA put the Lidocaine Patch on her left lower leg sometime later in the morning (could not recall time).
-The MA did not offer to put a Lidocaine Patch on her right shoulder and neck.
-She denied any current pain in her right shoulder and neck.

Review of Resident #8's March 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Lidocaine Patch 4% apply to right shoulder and neck topically in the morning for pain and remove at bedtime scheduled for 8:00am.
-Lidocaine Patch was documented as applied daily from 03/01/24 - 03/05/24.
-The Lidocaine Patch was documented as being applied to the neck and rear left shoulder on 03/01/24; the left leg and both shoulders on 03/02/24; the front left knee on 03/03/24; left front knee on 03/04/24; and the left leg on 03/05/24.

Observation of Resident #8's medications on hand on 03/05/24 at 2:24pm revealed:
-There was a supply of Lidocaine 4% Patches dispensed on 02/27/24.
-The instructions were to apply topically to right shoulder and neck every morning for pain and remove at bedtime per schedule.

Interview with the MA on 03/05/24 at 2:09pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 358	Continued From page 17	D 358		

revealed:
-She usually put Resident #8's Lidocaine Patch on the resident's lower left leg near her knee because that was where the resident usually told her to put it.
-She did not usually put a Lidocaine Patch on the resident's right shoulder and neck.
-She had not notified the PCP to get an order to put the Lidocaine Patch on the resident's leg because she was applying the patch where the resident told her to put it.

Interview with the Assistant Resident Care Coordinator (ARCC) on 03/05/24 at 2:42pm revealed:
-The MA should have applied Resident #8's Lidocaine Patch to her right shoulder and neck as indicated in the order and on the eMAR.
-The MA should have notified her, the Resident Care Coordinator (RCC) or the primary care provider (PCP) that the resident was requesting the patch be applied to a different area and they could have gotten an order.

Interview with the Administrator on 03/05/24 at 4:02pm revealed the MA should have read both the eMAR and medication label and administered the medication as ordered.

Attempted telephone interview with the resident's PCP on 03/06/24 at 4:18pm was unsuccessful.

Telephone interview with the PCP's on call provider on 03/06/24 at 4:29pm revealed not applying the Lidocaine Patch to the area ordered could put the resident at risk of pain in the untreated area.

h. Review of Resident #8's current FL-2 dated 02/01/24 revealed an order for Sevelamer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 358	Continued From page 18	D 358		

Carbonate Oral Packet 0.8grams give 1 packet 3 times a day related to chronic kidney disease. (Sevelamer Carbonate lowers phosphate levels in chronic kidney disease/dialysis patients.)

Review of Resident #8's primary care provider (PCP) visit dated 02/05/24 revealed:
-The resident was admitted to the facility on 01/30/24.
-The resident had end stage renal disease and received dialysis 3 times a week.

Observation of the 8:00am medication pass on 03/05/24 revealed the medication aide (MA) prepared and administered Resident #8's Sevelamer Carbonate at 9:54am, 54 minutes beyond the allowed time frame.

Review of Resident #8's March 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Sevelamer Carbonate Oral Packet 0.8gm give 1 packet 3 times a day related to chronic kidney disease.
-Sevelamer Carbonate was scheduled to be administered at 8:00am, 12:00pm, and 5:00pm.
-Sevelamer Carbonate was documented as administered from 03/01/24 - 03/05/24 except on 03/04/24 at 12:00pm and 5:00pm when the resident was out of the facility.

Interview with Resident #8 on 03/05/24 at 12:55pm revealed:
-She went to dialysis three times a week.
-She sometimes received her morning medications as late as 10:00am.
-She had not noticed any side effects or symptoms when her medications were late.

Interview with the MA on 03/05/24 at 2:09pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 358	Continued From page 19	D 358		

revealed:
-Resident #8's Sevelamer Carbonate was administered late that morning, 03/05/24.
-She was the only MA assigned to administer medications in the assisted living (AL) side of the facility.
-It was a big medication pass and she ran late sometimes because there were so many residents and medications to administer.
-She administered Resident #8's 12:00pm dose of Sevelamer Carbonate at lunch time around 12:30pm (about 2 and ½ hours after the late morning dose).

Interview with the Assistant Resident Care Coordinator (ARCC) on 03/05/24 at 2:42pm revealed:
-She was not aware the MA was running late with the morning medications on 03/05/24 until she noticed the MA was still at the medication cart administering medications (could not recall the time).
-She started helping the MA administer the rest of the morning medications on 03/05/24 once she realized the medication pass was late.

Interview with the Administrator on 03/05/24 at 4:02pm revealed:
-If a MA was running late with a medication pass, the MA should notify the ARCC, Resident Care Coordinator (RCC), or Memory Care Director (MCD) so they could help.
-If a MA was running too far behind on a medication pass, they should let the PCP know and get advisement on what to do.

Attempted telephone interview with the resident's PCP on 03/06/24 at 4:18pm was unsuccessful.

Telephone interview with the PCP's on call

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 358	Continued From page 20	D 358		

provider on 03/06/24 at 4:29pm revealed administering a medication late that was ordered 3 times a day could put the resident at risk of side effects.

i. Review of Resident #8's current FL-2 dated 02/01/24 revealed an order for Hydralazine 100mg 1 tablet 3 times a day for high blood pressure, hold if systolic blood pressure (SBP) is less than (<) 100. (Hydralazine is used to lower blood pressure.)

Observation of the 8:00am medication pass on 03/05/24 revealed:
-The medication aide (MA) checked Resident #8's blood pressure and the reading on the monitor was 122/74.
-The MA prepared and administered Resident #8's Hydralazine 100mg at 9:54am, 54 minutes beyond the allowed time frame.

Review of Resident #8's March 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Hydralazine 100mg 1 tablet 3 times a day for high blood pressure, hold if SBP is less than 100.
-Hydralazine was scheduled to be administered at 8:00am, 2:00pm, and 8:00pm.
-Hydralazine was documented as administered 3 times a day from 03/01/24 - 03/05/24 except on 03/01/24 and 03/04/24 when the resident was documented as out of the facility.
-The resident's blood pressure was checked 3 times a day and ranged from 122/74 - 162/69.

Interview with Resident #8 on 03/05/24 at 12:55pm revealed:
-She sometimes received her morning medications as late as 10:00am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

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WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 358	Continued From page 21 -She had not noticed any side effects or symptoms when her medications were late. -She thought her high blood pressure had improved after her primary care provider (PCP) added some medications. -About 2 weeks ago (could not recall date or time), she was sitting at a table and saw a "white cloud" and her head went down. -She was positive that her blood pressure was low and caused these symptoms. -She did not report the symptoms to anyone because she got better. Interview with the MA on 03/05/24 at 2:09pm revealed: -Resident #8's Hydralazine was administered late that morning, 03/05/24. -She was the only MA assigned to administer medications in the assisted living (AL) side of the facility. -It was a big medication pass and she ran late sometimes because there were so many residents and medications to administer. -She had just administered Resident #8's 2:00pm dose of Hydralazine about a minute ago, around 2:08pm (about 4 hours after the late morning dose). Interview with the Assistant Resident Care Coordinator (ARCC) on 03/05/24 at 2:42pm revealed: -She was not aware the MA was running late with the morning medications on 03/05/24 until she noticed the MA was still at the medication cart administering medications (could not recall the time). -She started helping the MA administer the rest of the morning medications on 03/05/24 once she realized the medication pass was late.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 358	Continued From page 22 Interview with the Administrator on 03/05/24 at 4:02pm revealed: -If a MA was running late with a medication pass, the MA should notify the ARCC, Resident Care Coordinator (RCC), or Memory Care Director (MCD) so they could help. -If a MA was running too far behind on a medication pass, they should let the PCP know and get advisement on what to do. Attempted telephone interview with the resident's PCP on 03/06/24 at 4:18pm was unsuccessful. Telephone interview with the PCP's on call provider on 03/06/24 at 4:29pm revealed receiving Hydralazine doses too close together could cause the resident to have low blood pressure and increase the risk of falls. j. Review of Resident #8's current FL-2 dated 02/01/24 revealed an order for Pantoprazole 40mg 1 tablet 2 times a day for gastroesophageal reflux disease. (Pantoprazole is used to treat acid reflux.) Observation of the 8:00am medication pass on 03/05/24 revealed the medication aide (MA) prepared and administered Resident #8's Pantoprazole scheduled for 7:00am at 9:54am, 1 hour and 54 minutes beyond the allowed time frame. Review of Resident #8's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Pantoprazole 40mg 1 tablet 2 times a day for GERD scheduled for 7:00am and 4:00pm. -Pantoprazole was documented as administered from 03/01/24 - 03/05/24 except on 03/04/24 at	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 358	Continued From page 23 4:00pm when the resident was out of the facility. Interview with Resident #8 on 03/05/24 at 12:55pm revealed: -She sometimes received her morning medications as late at 10:00am. -She had not noticed any side effects or symptoms when her medications were late. Interview with the MA on 03/05/24 at 2:09pm revealed: -She usually administered Resident #8's Pantoprazole scheduled for 7:00am with the 8:00am medications to save time. -Resident #8's Pantoprazole was administered late that morning, 03/05/24. -She was the only MA assigned to administer medications in the assisted living (AL) side of the facility. -It was a big medication pass and she ran late sometimes because there were so many residents and medications to administer. Interview with the Assistant Resident Care Coordinator (ARCC) on 03/05/24 at 2:42pm revealed: -She was not aware the MA was running late with the morning medications on 03/05/24 until she noticed the MA was still at the medication cart administering medications (could not recall the time). -She started helping the MA administer the rest of the morning medications on 03/05/24 once she realized the medication pass was late. Interview with the Administrator on 03/05/24 at 4:02pm revealed: -If a MA was running late with a medication pass, the MA should notify the ARCC, Resident Care Coordinator (RCC), or Memory Care Director	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 24	D 358		

(MCD) so they could help.
-If a MA was running too far behind on a medication pass, they should let the primary care provider (PCP) know and get advisement on what to do.

Attempted telephone interview with the resident's PCP on 03/06/24 at 4:18pm was unsuccessful.

Telephone interview with the PCP's on call provider on 03/06/24 at 4:29pm revealed receiving Pantoprazole late could cause the medication to be less effective and increase the resident's acid reflux symptoms.

k. Review of Resident #8's current FL-2 dated 02/01/24 revealed an order for Senna Plus 8.6/50mg take 1 tablet 2 times a day for constipation. (Senna Plus is a laxative and stool softener used to treat and prevent constipation.)

Observation of the 8:00am medication pass on 03/05/24 revealed:
-The medication aide (MA) prepared and administered oral medications scheduled for 8:00am to Resident #8 at 9:54am.
-The MA did not prepare and administer Senna Plus to the resident when she received her other morning medications.
-Senna Plus was not administered as ordered.

Observation of Resident #8's medications on hand on 03/05/24 at 2:11pm revealed there was no Senna Plus available for administration.

Review of Resident #8's March 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Senna Plus 8.6/50mg 1 tablet 2 times a day scheduled for 8:00am and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 25	D 358		

8:00pm.
-Senna Plus was documented as administered twice a day from 03/01/24 - 03/04/24.
-Senna Plus was documented as not being administered at 8:00am on 03/05/24 due to "ordering medication".

Interview with Resident #8 on 03/05/24 at 12:55pm revealed:
-She was supposed to receive Senna Plus every day.
-At one time, she was having problems with constipation but it was better now.

Interview with the MA on 03/05/24 at 2:09pm revealed:
-She did not administer Resident #8's Senna Plus that morning, 03/05/24, because it was not in the medication cart.
-The MAs were responsible for ordering medications when there were 7 pills remaining in the supply.
-She was not sure if Resident #8's Senna Plus had been ordered.
-She had not had time to check the back-up supply of medications in the medication room to see if there was any available.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/06/24 at 3:26pm revealed:
-Resident #8 was a new admission to the facility on 01/30/24.
-The pharmacy had not been requested to dispense any Senna Plus for the resident until 03/05/24.
-The pharmacy dispensed 60 Senna Plus tablets on 03/05/24.

Interview with the Assistant Resident Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 26	D 358		

Coordinator (ARCC) on 03/05/24 at 2:42pm revealed:
-The MAs were responsible for ordering medications.
-She checked the medications on hand with the eMARs each week to make sure medications were available for administration.
-If medications were not in the medication cart, the MAs should check the back up supply in the medication room.
-Resident #8's Senna Plus should have been available for administration.

Interview with the Administrator on 03/05/24 at 4:02pm revealed:
-If a medication was unavailable during a medication pass, the MA should notify the ARCC, Resident Care Coordinator (RCC), or the Memory Care Director (MCD).
-The MA should immediately check the back-up supply of medications during the medication pass to see if the medication was available in the medication room.

Attempted telephone interview with the resident's primary care provider (PCP) on 03/06/24 at 4:18pm was unsuccessful.

Telephone interview with the PCP's on call provider on 03/06/24 at 4:29pm revealed if the resident was supposed to receive Senna Plus as a scheduled dose, not receiving the Senna Plus could cause the resident to have constipation and more likely to have an impaction.

I. Review of Resident #8's current FL-2 dated 02/01/24 revealed an order for Virt-Caps softgel give 1 capsule every day for supplement. (Virt-Caps softgel is a prescription Vitamin B supplement for conditions which may require

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 27	D 358		

increased amounts of Vitamin B supplements, such as kidney disease.)

Review of Resident #8's primary care provider (PCP) visit dated 02/05/24 revealed:
-The resident was admitted to the facility on 01/30/24.
-The resident had end stage renal disease and received dialysis 3 times a week.

Observation of the 8:00am medication pass on 03/05/24 revealed:
-The medication aide (MA) prepared and administered oral medications scheduled for 8:00am to Resident #8 at 9:54am.
-The MA did not prepare and administer Virt-Caps to the resident when she received her other morning medications.
-Virt-Caps were not administered as ordered.

Observation of Resident #8's medications on hand on 03/05/24 at 2:11pm revealed there were no Virt-Caps available for administration.

Review of Resident #8's March 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Virt-Caps softgel give 1 capsule every day for supplement scheduled for 8:00am.
-Virt-Caps softgel was not documented as administered from 03/01/24 - 03/05/24 due to "needs to be ordered" and "on order".

Interview with Resident #8 on 03/05/24 at 12:55pm revealed:
-She went to dialysis three times a week.
-She was not sure if she received Virt-Caps or if she had missed any doses.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 358	Continued From page 28 Interview with the MA on 03/05/24 at 2:09pm revealed: -She did not administer Resident #8's Virt-Caps that morning, 03/05/24, because it was not in the medication cart. -The MAs were responsible for ordering medications when there were 7 pills remaining in the supply. -She was not sure if Resident #8's Virt-Caps had been ordered. -She had not had time to check the back-up supply of medications in the medication room to see if there was any available. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/06/24 at 3:26pm revealed: -Resident #8 was a new admission to the facility on 01/30/24. -The pharmacy had not been requested to dispense any Virt-Caps until 02/26/24. -Virt-Caps was a non-covered medication by the resident's insurance. -The pharmacy faxed the facility to notify them of the non-coverage for Virt-Caps on 02/26/24. -The pharmacy did not hear back from the facility about Virt-Caps until 03/05/24. -The facility requested a 15-day supply of Virt-Caps be dispensed on 03/05/24 and the facility was going to pay out-of-pocket for the Virt-Caps. Interview with the Assistant Resident Care Coordinator (ARCC) on 03/05/24 at 2:42pm revealed: -The MAs were responsible for ordering medications. -She checked the medications on hand with the eMARs each week to make sure medications were available for administration.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 358	Continued From page 29	D 358		

-If medications were not in the medication cart, the MAs should check the back-up supply in the medication room.
-She was not aware Resident #8's Virt-Caps were not available for administration until today, 03/05/24
-She contacted the facility's contracted pharmacy today, 03/05/24, about Resident #8's Virt-Caps.
-The resident's insurance would not pay for the Virt-Caps.
-They would notify the resident's provider about Virt-Caps.

Interview with the Administrator on 03/05/24 at 4:02pm revealed:
-If a medication was unavailable during a medication pass, the MA should notify the ARCC, Resident Care Coordinator (RCC), or the Memory Care Director (MCD).
-The MA should immediately check the back-up supply of medications during the medication pass to see if the medication was available in the medication room.

Attempted telephone interview with the resident's PCP on 03/06/24 at 4:18pm was unsuccessful.

Telephone interview with the PCP's on call provider on 03/06/24 at 4:29pm revealed not receiving Virt-Caps as ordered could cause the resident to have vitamin deficiencies.

m. Review of Resident #8's current FL-2 dated 02/01/24 revealed an order for Sodium Bicarbonate 650mg take 1 tablet 3 times a day. (Sodium Bicarbonate is a supplement that may slow the rate of decline of kidney disease.)

Review of Resident #8's primary care provider (PCP) visit dated 02/05/24 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 30	D 358		

-The resident was admitted to the facility on 01/30/24.
-The resident had end stage renal disease and received dialysis 3 times a week.

Observation of the 8:00am medication pass on 03/05/24 revealed:
-The medication aide (MA) prepared and administered oral medications scheduled for 8:00am to Resident #8 at 9:54am.
-The MA did not prepare and administer Sodium Bicarbonate to the resident when she received her other morning medications.
-Sodium Bicarbonate was not administered as ordered.

Review of Resident #8's March 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Sodium Bicarbonate 650mg 1 tablet 3 times a day for supplement scheduled for 8:00am, 2:00pm, and 8:00pm.
-Sodium Bicarbonate was documented as administered from 03/01/24 - 03/04/24 except on 03/01/24 and 03/04/24 at 2:00pm when the resident was out of the facility.
-Sodium Bicarbonate was documented as not administered at 8:00am on 03/04/24 and 03/05/24 due to "ordering the medication".

Interview with Resident #8 on 03/05/24 at 12:55pm revealed:
-She went to dialysis three times a week.
-She was not sure if she received Sodium Bicarbonate or if she had missed any doses.

Interview with the MA on 03/05/24 at 2:09pm revealed:
-She did not administer Resident #8's Sodium Bicarbonate that morning, 03/05/24, because it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 31	D 358		

was not in the medication cart.
-The MAs were responsible for ordering medications when there were 7 pills remaining in the supply.
-She was not sure if Resident #8's Sodium Bicarbonate had been ordered.
-She had not had time to check the back-up supply of medications in the medication room to see if there was any available.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/06/24 at 3:26pm revealed:
-Resident #8 was a new admission to the facility on 01/30/24.
-The pharmacy dispensed 90 Sodium Bicarbonate tablets (one month supply) on 02/27/24 and they were delivered to the facility on 02/27/24.
-There should still be some Sodium Bicarbonate tablets available for administration in the facility.

Interview with the Assistant Resident Care Coordinator (ARCC) on 03/05/24 at 2:42pm revealed:
-The MAs were responsible for ordering medications.
-She checked the medications on hand with the eMARs each week to make sure medications were available for administration.
-If medications were not in the medication cart, the MAs should check the back up supply in the medication room.
-Resident #8's had a supply of Sodium Bicarbonate in the back up supply in the medication room.
-The MA should have checked the back up supply during the morning medication pass and administered the Sodium Bicarbonate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 358	Continued From page 32 Interview with the Administrator on 03/05/24 at 4:02pm revealed: -If a medication was unavailable during a medication pass, the MA should notify the ARCC, Resident Care Coordinator (RCC), or the Memory Care Director (MCD). -The MA should immediately check the back-up supply of medications during the medication pass to see if the medication was available in the medication room. Attempted telephone interview with the resident's PCP on 03/06/24 at 4:18pm was unsuccessful. Telephone interview with the PCP's on call provider on 03/06/24 at 4:29pm revealed not receiving Sodium Bicarbonate as ordered could cause the resident to have acid-base issues with balancing bicarbonate and carbon dioxide. n. Review of Resident #9's current FL-2 dated 01/07/24 revealed: -Diagnoses included frontotemporal neurocognitive disorder, essential hypertension, and hyperlipidemia. -There was an order for Depakote DR 250mg 1 tablet twice a day. (Depakote DR is a delayed-release medication that can be used to treat mood disorders.) Observation of the 8:00am medication pass on 03/06/24 revealed: -The medication aide (MA) prepared morning medications for Resident #9, including one Depakote DR 250mg tablet. -The MA crushed all of Resident #9's oral tablets, including the Depakote DR, mixed them in a whole cup of yogurt and administered one spoonful from the top of the yogurt cup to the resident at 8:34am.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 33 -There were pieces of crushed pills left around the rim of the yogurt cup and in the yogurt inside the cup. -The MA sat the yogurt cup on the table beside the resident's breakfast plate and walked out of the dining room. -At 9:04am, a second MA assisted Resident #9 with her breakfast including feeding the yogurt with crushed medications to the resident. Observation of Resident #9's medications on hand on 03/06/24 at 12:33pm revealed: -There was a supply of Depakote DR 250mg tablets dispensed on 02/06/24. -There was a warning on the label not to crush or chew the medication, swallow whole. Review of Resident #9's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Depakote DR 250mg 1 tablet two times a day for mood stabilization scheduled for 8:00am and 4:00pm. -Depakote DR was documented as administered from 03/01/24 - 03/05/24. -There was no information noted on the eMAR to indicate the medication should not be crushed. -There was an entry for may crush appropriate medications/open capsules if not contraindicated every shift for swallowing. -Staff documented the entry for crushing medications for day shift, evening shift, and night shift from 03/01/24 - 03/05/24 (day shift). Interview with the MA on 03/06/24 at 12:32pm revealed: -She usually crushed all of Resident #9's tablets and opened any capsules. -She was not aware of a Do Not Crush (DNC) list and had not been trained to use a DNC list before	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 34	D 358		

crushing medications.
-She did not notice the warning label on the Depakote DR packaging that indicated the medication should not be crushed.

Review of the facility's DNC medication list revealed Depakote DR was included on the list as a medication that should not be crushed.

Interview with the Memory Care Director (MCD) on 03/06/24 at 12:57pm revealed:
-There was a DNC list in each notebook on each medication cart.
-The MAs were trained to check the DNC list prior to crushing medications.
-Resident #9's Depakote DR should not be crushed.
-If medications were crushed, the MAs were supposed to mix the crushed medications in a small amount of applesauce or yogurt in the plastic medication cup to make sure all of the crushed medications were administered.
-Once the MAs administered crushed medications from the small plastic medication cup to a resident, the MAs were supposed to dispose of it in the trash can on the medication cart.
-All residents in the SCU were confused so medications should not be left unattended with any resident.

Interview with the Administrator on 03/06/24 at 1:09pm revealed:
-There was a DNC list on each medication cart.
-The MAs should check the DNC list prior to crushing medications.
-The MAs should observe each resident take their medication.

Attempted telephone interview with the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 358	Continued From page 35	D 358		

primary care provider (PCP) on 03/06/24 at 4:18pm was unsuccessful.

Telephone interview with the PCP's on call provider on 03/06/24 at 4:29pm revealed:
-Depakote DR should not be crushed.
-Crushing Depakote DR would cause the medication to be released immediately so the medication would not last as long in the resident's system which could cause the resident to have increased agitation.

Based on observations, interviews, and record review, it was determined that Resident #9 was not interviewable.

o. Review of Resident #9's current FL-2 dated 01/07/24 revealed an order for Miralax 17gm (1 scoop) once daily. (Miralax is a laxative used to treat and prevent constipation. Miralax is a powder and the inside of the cap on the bottle has a marking for 17g that should be used to measure the dosage at the top of the white section of the inner cap.)

Observation of the 8:00am medication pass on 03/06/24 revealed:
-There was a white section lining the inside of the purple cap on the Miralax bottle.
-There was "17g" imprinted near the top of the white section with an arrow pointing up to indicate the measurement for 17g was at the top of the white section inside the cap.
-The medication aide (MA) poured the Miralax powder halfway below the marking for the 17g dose.
-The MA did not measure the Miralax correctly and the full dosage was not mixed in the cup of water.
-The MA mixed the Miralax powder in water and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 36	D 358		

administered it to Resident #9 at 8:34am.
-The resident drank all of the water with Miralax.

Review of Resident #9's March 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Miralax give 17gm (1 scoop) one time a day for constipation scheduled for 8:00am.
-Miralax was documented as administered daily from 03/01/24 - 03/05/24.

Interview with the MA on 03/06/24 at 12:32pm revealed:
-She thought the marking to measure the Miralax was the bottom of the "17" imprinted on the inside of the cap.
-She had not seen the arrow pointing to the top of the white inner lining as the mark for 17gm.
-She did not realize she had been measuring the Miralax incorrectly.
-The resident had not complained of any constipation issues to her.

Interview with the Memory Care Director (MCD) on 03/06/24 at 12:57pm revealed:
-The MAs should use the cap of the Miralax bottle to measure the correct dosage.
-She had not received any reports of Resident #9 having any current issues with constipation.

Interview with the Administrator on 03/06/24 at 1:09pm revealed the MAs had been trained to use the lid on the Miralax bottle to measure the Miralax Powder.

Attempted telephone interview with the resident's primary care provider (PCP) on 03/06/24 at 4:18pm was unsuccessful.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 37	D 358		

Telephone interview with the PCP's on call provider on 03/06/24 at 4:29pm revealed if the resident did not get the full dose of Miralax, it would be less effective in treating the resident's constipation.

Based on observations, interviews, and record review, it was determined that Resident #9 was not interviewable.

2. Review of Resident #2's current FL-2 dated 02/29/24 revealed diagnoses included chronic ischemic heart disease, polyneuropathy, and spinal stenosis.

Review of Resident #2's physician's order dated 01/18/24 revealed an order for Omeprazole 20mg every morning. (Omeprazole is used to treat gastroesophageal reflux disease.)

Review of Resident #2's physician's orders dated 02/12/24 revealed:
-There was an order to discontinue Omeprazole 20mg every morning.
-There was an order to start taking Omeprazole 10mg 1 capsule every morning starting on 02/13/24

Review of Resident #2's March 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Omeprazole 20mg 1 capsule in the morning for acid reflux scheduled at 8:00am.
-Omeprazole 20mg was documented as administered daily from 02/01/24 - 02/14/24.
-There was an entry for Omeprazole 10mg 1 capsule one time a day for gastroesophageal reflux disease with a start date documented as 02/15/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 38	D 358		

-Omeprazole 10mg was documented as not administered at 8:00am from 02/15/24 - 02/20/24 and 02/22/24 due to "not on the cart" and "on order".

Attempted telephone interview with the resident's outside pharmacy provider on 03/06/24 at 3:50pm was unsuccessful.

Review of Resident #2's hospital after visit summary (AVS) dated 02/21/24 - 02/24/24 revealed:
-The resident's diagnoses included hematemesis (vomiting blood) with nausea and esophagitis (inflammation of the esophagus).
-There was an order to start taking Pantoprazole 40mg 1 tablet two times a day. (Pantoprazole is used to treat gastroesophageal reflux disease.)

Interview with Resident #2 on 03/05/24 at 1:05pm revealed:
-He thought he received a medication for acid reflux every day.
-He was not sure if he had missed any doses of acid reflux medication.
-He had problems with acid reflux, but he was not having any symptoms of acid reflux today.
-He denied any current symptoms of vomiting blood.

Interview with the Assistant Resident Care Coordinator (ARCC) on 03/05/24 at 2:42pm revealed:
-The MAs were responsible for ordering medications.
-If a medication was unavailable or on order, the MAs should notify her or the Resident Care Coordinator (RCC).
-The MAs were supposed to double check the medication cart to make sure medications were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 39	D 358		

available when administering medications.

Interview with the Administrator on 03/05/24 at 4:02pm revealed:
-If a medication was not in the medication cart, the MAs should notify the RCC, ARCC, or Memory Care Director (MCD).
-The RCC, ARCC, or MCD would check behind the MAs to see if the medication was in the cart or the back-up supply.
-The ARCC did a weekly cart audit and "9 times out of 10", the medications were available.

Attempted telephone interview with the resident's primary care provider (PCP) on 03/06/24 at 4:18pm was unsuccessful.

Telephone interview with the PCP's on call provider on 03/06/24 at 4:29pm revealed in general missing doses of medications for acid reflux could increase the resident's risk of gastrointestinal irritation and precipitate the resident's recent gastrointestinal bleed.

3. Review of Resident #1's current FL-2 dated 11/16/23 revealed diagnoses included progressive supranuclear ophthalmoplegia, secondary Parkinsonism and spinal stenosis.

a. Review of Resident #1's physician's orders dated 01/11/24 revealed there was an order for Apixaban oral tablet 2.5mg 1 tablet 2 times a day (used to treat blood clots).

Review of Resident #1's February 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Apixaban oral tablet 2.5mg 1 tablet 2 times a day scheduled for administration at 9:00am and 9:00pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 40	D 358		

-There was an entry of 09 for Apixaban oral tablet 2.5mg at 9:00am on 02/05/24, 02/06/24 and 02/13/24. ("09" on the chart code says "Other/See Nurse Notes").

Review of Resident #1's February 2024 facility exception report revealed:
-The exception for the 09 entry for Apixaban oral tablet 2.5mg at 9:00am on 02/05/24 and 02/06/24 was "on order".
-There was no exception listed for the 09 entry for Apixaban oral tablet 2.5mg on 02/13/24 for the 9:00am dose.

Observation of Resident #1's medications on hand on 03/06/24 at 9:22am revealed there was a bottle of Apixaban oral tablet 2.5mg give 1 tablet 2 times a day, dispensed with 180 tablets on 01/14/24.

Interview with Resident #1 on 03/06/24 at 9:40am, 10:50am and 5:10pm revealed:
-He got his medications on time.
-He had not missed any medications.

Interview with the Resident Care Coordinator (RCC) on 03/06/24 at 11:30am revealed:
-The medication aide (MA) was responsible for ordering medications.
-The Assistant Resident Care Coordinator (ARCC) did cart audits weekly.
-Medications were to be ordered when they were down to a 7 to 10 day supply.
-If family provided the medications, they tried to give 14 days notice of the need for a refill to the family.
-The MA was supposed to follow up with the pharmacy if the medication was not received within two days.
-If family did not provide the medication on time,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 41 they got the medication from the facility's contracted pharmacy and paid for it. -"On order" meant the medication had been ordered, they were awaiting arrival and it had not been administered for that day. -There should have been an explanation for any entry that was documented as "09". -No one checked behind the MA on a daily basis. -She was not aware Resident #1 was not administered Apixaban on 02/05/24, 02/06/24 and 02/13/24. -Resident #1 was never out of his medications. -She did not know why the medication was not administered. -The Apixaban was listed as Eliquis on the bottle so the MA may not have known they were the same. -Resident #1's family member was supposed to bring all his medications but was having difficulty with the outside pharmacy. -When family was unable to obtain the medication, the facility could obtain the medication from their contracted pharmacy and the facility would pay for it. -Resident #1's family agreed to allow the facility to order the medication from the facility's contracted pharmacy and she would pay. Interview with the ARCC on 03/06/24 at 11:30am revealed: -The MA was responsible for ordering medications. -She did cart audits weekly. -No one checked behind the MA on a daily basis. -The resident was never out of his medications. -She was not aware Resident #1 was not administered Apixaban on 02/05/24, 02/06/24 and 02/13/24. -She did not know why the medication was not administered.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 358	Continued From page 42 -The Apixaban was listed as Eliquis on the bottle so the MA may not have known they were the same. -On 02/07/24, she sent Resident #1's family a text message that included all of the prescription numbers to show what medications needed to be refilled. -On 02/08/24, Resident #1's family responded stating she was unable to obtain 2 of the medications. -On 02/08/24, she asked Resident #1's family the name of the medications she was unable to obtain so that she could get the primary care provider (PCP) to write a prescription that would allow the facility to obtain the medication from their contracted pharmacy. (The medication names were not listed in the message.) Interview with the Administrator on 03/06/24 at 1:00pm revealed: -The MA was responsible for ordering medications once the medication reached a 7 to 10 day supply. -The ARCC was expected to check the medication supply when she did the cart audit weekly. -If family provided the medication, they should have been notified when there was a 7 to 10 day supply left. -"On order" probably meant the medication had been ordered and was not administered. -The MA should have been documenting whatever the exception was if they used the code of "09". -It was the expectation that the MA checked the cart thoroughly as well as the overstock medications and talked to the RCC and ARCC regarding unavailable medications. -When a medication ran out, the MA was to call the pharmacy to get the medication refilled, report	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 43	D 358		

to a supervisor (RCC and ARCC) and document their efforts to get the medication.
-The MA was to follow up daily with the pharmacy until the medication was obtained
-If family did not provide the medication in a timely manner, they would order from the facility's contracted pharmacy and the facility would pay for the medication.
-The RCC and the ARCC were responsible for contacting the facility's contracted pharmacy within 24 hours of the family not providing the medication.
-She was not aware Resident #1 was not administered Apixaban on 02/05/24, 02/06/24 and 02/13/24.
-She did not know why Resident #1's medication was not administered
-Checking behind the MA was the function of the medication audit which would now be conducted twice a week.

Telephone interview with the on-call provider for the PCP on 03/06/24 at 4:16pm revealed missed doses of Apixaban increased the resident's risk of blood clots.

b. Review of Resident #1's physician's orders dated 01/11/24 revealed there was an order for Dulaglutide subcutaneously solution pen-injector 1.5mg/0.5ml inject 1.5mg subcutaneously 1 time a day every Wednesday (used to treat diabetes).

Review of Resident #1's February 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Dulaglutide subcutaneously solution pen-injector 1.5mg/0.5ml inject 1.5mg subcutaneously 1 time a day scheduled for administration every Wednesday at 8:00am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 44 -There was an entry of 09 for Dulaglutide subcutaneously solution pen-injector 1.5mg/0.5ml on 02/21/24 and 02/28/24. Review of Resident #1's February 2024 facility exception report revealed: -There was no exception listed for the 09 entry for Dulaglutide subcutaneously solution pen-injector 1.5mg/0.5ml on 02/21/24. -The exception for the 09 entry for Dulaglutide subcutaneously solution pen-injector 1.5mg/0.5ml on 02/28/24 was "on order". Observation of Resident #1's medications on hand on 03/06/24 at 9:22am revealed there were 2 boxes of Dulaglutide subcutaneously solution pen-injector 1.5mg/0.5ml dispensed on 02/23/24 with (4 pens each box dispensed) with 7 pens left. Interview with Resident #1 on 03/06/24 at 9:40am, 10:50am and 5:10pm revealed: -He got his medications on time. -He had not missed any medications. -He knew he took Trulicity (brand name for Dulaglutide) but was unsure of what other medications he took. -He had never experienced high blood sugar or low blood sugar so he did not know what that felt like. Telephone interview with Resident #1's contact person on 03/05/24 at 4:10pm revealed: -She picked Resident #1's medication up from an outside pharmacy. -There was a distribution problem on behalf of Resident #1's pharmacy in February 2024. -She was not aware of Resident #1 running out of any medications. -Resident #1 should not have run out of any	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 45	D 358		

medications.
-The facility was supposed to inform her 2 weeks in advance of Resident #1 needing medication refills.

Interview with a medication aide (MA) on 03/06/24 at 9:40am revealed:
-She went to the Resident Care Coordinator (RCC) to request insulin when there were 4 insulin pens left.
-She requested an insulin refill once for Resident #1 when she noticed it was not available in February 2024 but did not recall whether or not she noticed any other medications being unavailable.

Interview with the RCC on 03/06/24 at 11:30am revealed:
-The MA was responsible for ordering medications.
-The Assistant Resident Care Coordinator (ARCC) did cart audits weekly.
-Medications were to be ordered when they were down to a 7 to 10 day supply.
-If family provided the medications, they tried to give 14 days notice of the need for a refill to the family.
-The MA was supposed to follow up with the pharmacy if the medication was not received within two days.
-If family did not provide the medication on time, they got the medication from the facility's contracted pharmacy and paid for it.
-"On order" meant the medication had been ordered, they were awaiting arrival and it had not been administered for that day.
-There should have been an explanation for any entry that was documented as "09".
-No one checked behind the MA on a daily basis.
-She was not aware Resident #1 was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 46 administered Dulaglutide on 02/21/24 and 02/28/24. -Resident #1 was never out of his medications. -She did not know why the medication was not administered. -Resident #1's family member was supposed to bring all his medications but was having difficulty with the outside pharmacy. -The missed Dulaglutide doses could have possibly been due to Resident #1's family member not being able to obtain the medication. -When family was unable to obtain the medication, the facility could obtain the medication from their contracted pharmacy and the facility would pay for it. -Resident #1's family agreed to allow the facility to order the medication from the facility's contracted pharmacy and she would pay. Interview with the ARCC on 03/06/24 at 11:30am revealed: -The MA was responsible for ordering medications. -She did cart audits weekly. -No one checked behind the MA on a daily basis. -The resident was never out of his medications. -She was not aware Resident #1 was not administered Dulaglutide on 02/21/24 and 02/28/24. -She did not know why the medication was not administered. -On 02/07/24, she sent Resident #1's family a text message that included all of the prescription numbers to show what medications needed to be refilled. -On 02/08/24, Resident #1's family responded stating she was unable to obtain 2 of the medications. -On 02/08/24, she asked Resident #1's family the name of the medications she was unable to	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 47	D 358		

obtain so that she could get the primary care provider (PCP) to write a prescription that would allow the facility to obtain the medication from their contracted pharmacy. (The medications were not identified.)

Interview with the Administrator on 03/06/24 at 1:00pm revealed:
-The MA was responsible for ordering medications once the medication reached a 7 to 10 day supply.
-It was also the expectation that the ARCC checked the medication supply when she did the cart audit weekly.
-If family provided the medication, they should have been notified when there was a 7 to 10 day supply left.
-"On order" probably meant the medication had been ordered and was not administered.
-The MA should have been documenting whatever the exception was if they used the code of "09".
-The MA was expected to check the cart thoroughly as well as the overstock medications and talk to the RCC and ARCC regarding unavailable medications.
-When a medication ran out, the MA was to call the pharmacy to get the medication refilled, report to a supervisor (RCC and ARCC) and document their efforts to get the medication.
-The MA was to follow up daily with the pharmacy until the medication was obtained
-If family did not provide the medication in a timely manner, they would order from the facility's contracted pharmacy and the facility would pay for the medication.
-The RCC and the ARCC were responsible for contacting the facility's contracted pharmacy within 24 hours of the family not providing the medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 48	D 358		

-She was not aware Resident #1 was not administered Dulaglutide on 02/21/24 and 02/28/24.
-She did not know why Resident #1's medication was not administered
-Checking behind the MA was the function of the medication audit which would now be conducted twice a week.

Telephone interview with the on-call provider for the PCP on 03/06/24 at 4:16pm revealed missed doses of Dulaglutide affected the weekly blood sugar and increased the Hemoglobin A1C (test that measures average blood sugar levels over past 3 months).

c. Review of Resident #1's physician's orders dated 01/11/24 revealed there was an order for Losartan potassium oral tablet 100mg 1 tablet 1 time a day (used to treat hypertension).

Review of Resident #1's February 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Losartan potassium oral tablet 100mg 1 tablet 1 time a day scheduled for administration at 8:00am.
-There was an entry of 09 for Losartan potassium oral tablet 100mg on 02/06/24 and 02/24/24.

Review of Resident #1's February 2024 facility exception report revealed:
-The exception for the 09 entry for Losartan potassium oral tablet 100mg on 02/06/24 was "on order".
-There was no exception listed for the 09 entry for Losartan potassium oral tablet 100mg on 02/24/24.

Observation of Resident #1's medications on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 49	D 358		

hand on 03/06/24 at 9:22am revealed there was a bottle of Losartan potassium oral tablet 100mg dispensed with 90 tablets on 01/17/24.

Interview with Resident #1 on 03/06/24 at 9:40am, 10:50am and 5:10pm revealed:
-He got his medications on time.
-He had not missed any medications.
-He knew what it felt like to have high blood pressure and had not experienced high blood pressure since being at the facility.

Telephone interview with Resident #1's contact person on 03/05/24 at 4:10pm revealed:
-She picked Resident #1's medication up from an outside pharmacy.
-There was a distribution problem on behalf of Resident #1's pharmacy in February 2024.
-She was not aware of Resident #1 running out of any medications.
-Resident #1 should not have run out of any medications.
-The facility was supposed to inform her 2 weeks in advance of Resident #1 needing medication refills.

Interview with the Resident Care Coordinator (RCC) on 03/06/24 at 11:30am revealed:
-The medication aide (MA) was responsible for ordering medications.
-The Assistant Resident Care Coordinator (ARCC) did cart audits weekly.
-Medications were to be ordered when they were down to a 7 to 10 day supply.
-If family provided the medications, they tried to give 14 days notice of the need for a refill to the family.
-The MA was supposed to follow up with the pharmacy if the medication was not received within two days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 50 -If family did not provide the medication on time, they got the medication from the facility's contracted pharmacy and paid for it. -"On order" meant the medication had been ordered, they were awaiting arrival and it had not been administered for that day. -There should have been an explanation for any entry that was documented as "09". -No one checked behind the MA on a daily basis. -She was not aware Resident #1 was not administered Losartan on 02/06/24 and 02/24/24. -Resident #1 was never out of his medications. -She did not know why the medication was not administered. -Resident #1's family member was supposed to bring all his medications but was having difficulty with the outside pharmacy. -When family was unable to obtain the medication, the facility could obtain the medication from their contracted pharmacy and the facility would pay for it. -Resident #1's family agreed to allow the facility to order the medication from the facility's contracted pharmacy and she would pay. Interview with the ARCC on 03/06/24 at 11:30am revealed: -The MA was responsible for ordering medications. -She did cart audits weekly. -No one checked behind the MA on a daily basis. -The resident was never out of his medications. -She was not aware Resident #1 was not administered Losartan on 02/06/24 and 02/24/24. -She did not know why the medication was not administered. -On 02/07/24, she sent Resident #1's family a text message that included all of the prescription numbers to show what medications needed to be	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 51	D 358		

refilled.
-On 02/08/24, Resident #1's family responded stating she was unable to obtain 2 of the medications.
-On 02/08/24, she asked Resident #1's family the name of the medications she was unable to obtain so that she could get the primary care provider (PCP) to write a prescription that would allow the facility to obtain the medication from their contracted pharmacy. (The medications were not identified.)

Interview with the Administrator on 03/06/24 at 1:00pm revealed:
-The MA was responsible for ordering medications once the medication reached a 7 to 10 day supply.
-It was also the expectation that the ARCC checked the medication supply when she did the cart audit weekly.
-If family provided the medication, they should have been notified when there was a 7 to 10 day supply left.
-"On order" probably meant the medication had been ordered and was not administered.
-The MA should have been documenting whatever the exception was if they used the code of "09".
-The MA was expected to check the cart thoroughly as well as the overstock medications and talk to the RCC and ARCC regarding unavailable medications.
-When a medication ran out, the MA was to call the pharmacy to get the medication refilled, report to a supervisor (RCC and ARCC) and document their efforts to get the medication.
-The MA was to follow up daily with the pharmacy until the medication was obtained
-If family did not provide the medication in a timely manner, they would order from the facility's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 52	D 358		

contracted pharmacy and the facility would pay for the medication.
-The RCC and the ARCC were responsible for contacting the facility's contracted pharmacy within 24 hours of the family not providing the medication.
-She was not aware Resident #1 was not administered Losartan on 02/06/24 and 02/24/24.
-She did not know why Resident #1's medication was not administered
-Checking behind the MA was the function of the medication audit which would now be conducted twice a week.

Telephone interview with the on-call provider for the PCP on 03/06/24 at 4:16pm revealed missed doses of Losartan increased the risk of hypertension which could lead to organ failure.

d. Review of Resident #1's physician's orders dated 01/11/24 revealed there was an order for Metformin HCl oral tablet 500mg 2 times a day (used to treat diabetes).

Review of Resident #1's February 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Metformin HCl oral tablet 500mg 2 times a day scheduled for administration at 8:00am and 8:00pm.
-There was an entry of 09 for Metformin HCl oral tablet 500mg on 02/17/24 and 02/18/24 for the 8:00am dose and on 02/17/24 for the 8:00pm dose.

Review of Resident #1's February 2024 facility exception report revealed:
-The exception for the 09 entry for Metformin HCl oral tablet 500mg on 02/17/24 at 8:00am and 8:00pm was "not on the cart".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 53 -The exception for the 09 entry for Metformin HCl oral tablet 500mg at 8:00am on 02/18/24 was "on order". Observation of Resident #1's medications on hand on 03/06/24 at 9:22am revealed there was a bottle of Metformin HCl oral tablet 500mg 2 packs dispensed with 30 tablets on 02/19/24 with 49 left and 1 bottle dispensed with 180 tablets on 02/23/24. Interview with Resident #1 on 03/06/24 at 9:40am, 10:50am and 5:10pm revealed: -He got his medications on time. -He had not missed any medications. -He had never experienced high blood sugar or low blood sugar so he did not know what that felt like. Telephone interview with Resident #1's contact person on 03/05/24 at 4:10pm revealed: -She had no medication concerns on the facility's behalf. -She picked Resident #1's medication up from an outside pharmacy. -There was a distribution problem on behalf of Resident #1's pharmacy in February 2024. -She was not aware of Resident #1 running out of any medications. -Resident #1 should not have run out of any medications. -The facility was supposed to inform her 2 weeks in advance of Resident #1 needing medication refills. Interview with the Resident Care Coordinator (RCC) on 03/06/24 at 11:30am revealed: -The medication aide (MA) was responsible for ordering medications. -The Assistant Resident Care Coordinator	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 358	Continued From page 54 (ARCC) did cart audits weekly. -Medications were to be ordered when they were down to a 7 to 10 day supply. -If family provided the medications, they tried to give 14 days notice of the need for a refill to the family. -The MA was supposed to follow up with the pharmacy if the medication was not received within two days. -If family did not provide the medication on time, they got the medication from the facility's contracted pharmacy and paid for it. -"On order" meant the medication had been ordered, they were awaiting arrival and it had not been administered for that day. -"Not on the cart" meant the medication was not on the cart, had been ordered, they were awaiting arrival and it had not been administered for that day. -If the medication was not on the cart, the MA should have requested a refill and documented that they called the pharmacy or documented that they borrowed the medication instead of saying that it was not on the cart. -No one checked behind the MA on a daily basis. -She was not aware Resident #1 was not administered Metformin HCl on 02/17/24 and 02/18/24. -Resident #1 was never out of his medications. -She did not know why the medication was not administered. -When family was unable to obtain the medication, the facility could obtain the medication from their contracted pharmacy and the facility would pay for it. -Resident #1's family agreed to allow the facility to order the medication from the facility's contracted pharmacy and she would pay. Interview with the ARCC on 03/06/24 at 11:30am	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 55	D 358		

revealed:
-The MA was responsible for ordering medications.
-She did cart audits weekly.
-No one checked behind the MA on a daily basis.
-The resident was never out of his medications.
-She was not aware Resident #1 was not administered Metformin HCl on 02/17/24 and 02/18/24.
-She did not know why the medication was not administered.
-On 02/07/24, she sent Resident #1's family a text message that included all of the prescription numbers to show what medications needed to be refilled.
-On 02/08/24, Resident #1's family responded stating she was unable to obtain 2 of the medications.
-On 02/08/24, she asked Resident #1's family the name of the medications she was unable to obtain so that she could get the primary care provider (PCP) to write a prescription that would allow the facility to obtain the medication from their contracted pharmacy. (The medications were not identified.)

Interview with the Administrator on 03/06/24 at 1:00pm revealed:
-The MA was responsible for ordering medications once the medication reached a 7 to 10 day supply.
-It was also the expectation that the ARCC checked the medication supply when she did the cart audit weekly.
-If family provided the medication, they should have been notified when there was a 7 to 10 day supply left.
-"On order" probably meant the medication had been ordered and was not administered.
-"Not on the cart" meant the medication was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 56	D 358		

on the cart but could have been in the backup medications or overstock medications.
-The MA should have been documenting whatever the exception was if they used the code of "09".
-The MA was expected to check the cart thoroughly as well as the overstock medications and talk to the RCC and ARCC regarding unavailable medications.
-When a medication ran out, the MA was to call the pharmacy to get the medication refilled, report to a supervisor (RCC and ARCC) and document their efforts to get the medication.
-The MA was to follow up daily with the pharmacy until the medication was obtained
-If family did not provide the medication in a timely manner, they would order from the facility's contracted pharmacy and the facility would pay for the medication.
-The RCC and the ARCC were responsible for contacting the facility's contracted pharmacy within 24 hours of the family not providing the medication.
-She was not aware Resident #1 was not administered Metformin HCl on 02/17/24 and 02/18/24.
-She did not know why Resident #1's medication was not administered
-Checking behind the MA was the function of the medication audit which would now be conducted twice a week.

Telephone interview with the on-call provider for the PCP on 03/06/24 at 4:16pm revealed missed doses of Metformin HCl increased the Hemoglobin A1C (test used to measure average blood sugar levels over the past 3 months) and decreased the control of diabetes.

e. Review of Resident #1's physician's orders

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 57	D 358		

dated 01/11/24 revealed there was an order for Tamsulosin HCl oral capsule 0.4mg 1 time a day (used to treat urine retention).

Review of Resident #1's February 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Tamsulosin HCl oral capsule 0.4mg 1 time a day scheduled for administration at 8:00am.
-There was an entry of 09 for Tamsulosin HCl oral capsule 0.4mg on 02/22/24, 02/23/24, 02/24/24, 02/25/24, 02/26/24, 02/27/24, 02/28/24 and 02/29/24.

Review of Resident #1's February 2024 facility exception report revealed:
-The exception for the 09 entry for Tamsulosin HCl oral capsule 0.4mg on 02/22/24. 02/26/27 and 02/27/24 was "on order".
-There was no exception listed for the 09 entry for Tamsulosin HCl oral capsule 0.4mg on 02/23/24, 02/24/24, 02/25/24 and 02/29/24.
-The exception for the 09 entry for Tamsulosin HCl oral capsule 0.4mg on 02/28/24 was "not on the cart; on order".

Observation of Resident #1's medications on hand on 03/06/24 at 9:22am revealed there was a pack of Tamsulosin HCl oral capsule 0.4mg 30 tablets dispensed on 03/05/24 with 29 left.

Interview with Resident #1 on 03/06/24 at 9:40am, 10:50am and 5:10pm revealed:
-He got his medications on time.
-He had not missed any medications.
-He had not had any difficulty urinating and had been going to the bathroom the same; there had been no increased urination needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 58 Interview with the Resident Care Coordinator (RCC) on 03/06/24 at 11:30am revealed: -The medication aide (MA) was responsible for ordering medications. -The Assistant Resident Care Coordinator (ARCC) did cart audits weekly. -Medications were to be ordered when they were down to a 7 to 10 day supply. -If family provided the medications, they tried to give 14 days notice of the need for a refill to the family. -The MA was supposed to follow up with the pharmacy if the medication was not received within two days. -If family did not provide the medication on time, they got the medication from the facility's contracted pharmacy and paid for it. -"On order" meant the medication had been ordered, they were awaiting arrival and it had not been administered for that day. -"Not on the cart" meant the medication was not on the cart, had been ordered, they were awaiting arrival and it had not been administered for that day. -If the medication was not on the cart, the MA should have requested a refill and documented that they called the pharmacy or documented that they borrowed the medication instead of saying that it was not on the cart. -There should have been an explanation for any entry that was documented as "09". -No one checked behind the MA on a daily basis. -She was not aware Resident #1 was not administered Tamsulosin HCl on 02/22/24-02/29/24. -Resident #1 was never out of his medications. -She did not know why the medication was not administered. -Resident #1's family member was supposed to bring all his medications but was having difficulty	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 59	D 358		

with the outside pharmacy.
-The missed Tamsolusin HCl doses could have possibly been due to Resident #1's family member not being able to obtain the medication.
-When family was unable to obtain the medication, the facility could obtain the medication from their contracted pharmacy and the facility would pay for it.
-Resident #1's family agreed to allow the facility to order the medication from the facility's contracted pharmacy and she would pay.

Interview with the ARCC on 03/06/24 at 11:30am revealed:
-The MA was responsible for ordering medications.
-She did cart audits weekly.
-No one checked behind the MA on a daily basis.
-The resident was never out of his medications.
-She was not aware Resident #1 was not administered Tamsulosin HCl on 02/22/24-02/29/24.
-She did not know why the medication was not administered.
-On 02/07/24, she sent Resident #1's family a text message that included all of the prescription numbers to show what medications needed to be refilled.
-On 02/08/24, Resident #1's family responded stating she was unable to obtain 2 of the medications.
-On 02/08/24, she asked Resident #1's family the name of the medications she was unable to obtain so that she could get the PCP to write a prescription that would allow the facility to obtain the medication from their contracted pharmacy. (The medications were not identified.)

Interview with the Administrator on 03/06/24 at 1:00pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 60 -The MA was responsible for ordering medications once the medication reached a 7 to 10 day supply. -It was also the expectation that the ARCC checked the medication supply when she did the cart audit weekly. -If family provided the medication, they should have been notified when there was a 7 to 10 day supply left. -"On order" probably meant the medication had been ordered and was not administered. -"Not on the cart" meant the medication was not on the cart but could have been in the backup medications or overstock medications. -The MA should have been documenting whatever the exception was if they used the code of "09". -It was the expectation that the MA checked the cart thoroughly as well as the overstock medications and talked to the RCC and ARCC regarding unavailable medications. -When a medication ran out, the MA was to call the pharmacy to get the medication refilled, report to a supervisor (RCC and ARCC) and document their efforts to get the medication. -The MA was to follow up daily with the pharmacy until the medication was obtained -If family did not provide the medication in a timely manner, they would order from the facility's contracted pharmacy and the facility would pay for the medication. -The RCC and the ARCC were responsible for contacting the facility's contracted pharmacy within 24 hours of the family not providing the medication. -She was not aware Resident #1 was not administered Tamsulosin HCl on 02/22/24-02/29/24. -She did not know why Resident #1's medication was not administered	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 61	D 358		

-Checking behind the MA was the function of the medication audit which would now be conducted twice a week.

Telephone interview with the on-call provider for the PCP on 03/06/24 at 4:16pm revealed missed doses of Tamsulosin HCl increased urinary urgency.

f. Review of Resident #1's physician's orders dated 01/11/24 revealed there was an order for Tizanidine HCl oral tablet 2mg 2mg 3 times a day (used to treat pain).

Review of Resident #1's February 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Tizanidine HCl oral tablet 2mg 3 times a day scheduled for administration at 8:00am, 2:00pm and 8:00pm.
-There was an entry of 09 for Tizanidine HCl 2mg at 8:00am on 02/05/24, 02/06/24, and 02/17/24 at 2:00pm on 02/05/24 and 02/17/24, and at 8:00pm on 02/17/24.

Review of Resident #1's February 2024 facility exception report revealed:
-The exception for the 09 entry for Tizanidine HCl oral tablet 2mg at 8:00am and 2:00pm on 02/05/24 and 02/06/24 for the 8:00am dose was "on order."
- The exception for the 09 entry for Tizanidine HCl oral tablet 2mg at 8:00am, 2:00pm and 8:00pm on 02/17/24 was "not on the cart".
-The exception for the 09 entry for Tizanidine HCl oral tablet 2mg at 8:00am and 2:00pm on 02/18/24 for the 8:00am was "not on the cart".

Observation of Resident #1's medications on hand on 03/06/24 at 9:22am revealed there were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 62 3 packs of Tizanidine HCl oral tablet 2mg 30 tablets dispensed in each pack on 02/19/24 with 56 left. Interview with Resident #1 on 03/06/24 at 9:40am, 10:50am and 5:10pm revealed: -He got his medications on time. -He had not missed any medications. -He had not had any pain other than pain in his heel; no increased pain. Interview with the Resident Care Coordinator (RCC) on 03/06/24 at 11:30am revealed: -The medication aide (MA) was responsible for ordering medications. -The Assistant Resident Care Coordinator (ARCC) did cart audits weekly. -Medications were to be ordered when they were down to a 7 to 10 day supply. -If family provided the medications, they tried to give 14 days notice of the need for a refill to the family. -The MA was supposed to follow up with the pharmacy if the medication was not received within two days. -If family did not provide the medication on time, they got the medication from the facility's contracted pharmacy and paid for it. -"On order" meant the medication had been ordered, they were awaiting arrival and it had not been administered for that day. -"Not on the cart" meant the medication was not on the cart, had been ordered, they were awaiting arrival and it had not been administered for that day. -If the medication was not on the cart, the MA should have requested a refill and documented that they called the pharmacy or documented that they borrowed the medication instead of saying that it was not on the cart.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 63 -No one checked behind the MA on a daily basis. -She was not aware Resident #1 was not administered Tizanidine HCl on 02/05/24, 02/06/24, 02/17/24 and 02/18/24. -Resident #1 was never out of his medications. -She did not know why the medication was not administered. -Resident #1's family member was supposed to bring all his medications but was having difficulty with the outside pharmacy. -When family was unable to obtain the medication, the facility could obtain the medication from their contracted pharmacy and the facility would pay for it. -Resident #1's family agreed to allow the facility to order the medication from the facility's contracted pharmacy and she would pay. Interview with the ARCC on 03/06/24 at 11:30am revealed: -The MA was responsible for ordering medications. -She did cart audits weekly. -No one checked behind the MA on a daily basis. -The resident was never out of his medications. -She was not aware Resident #1 was not administered Tizanidine HCl on 02/05/24, 02/06/24, 02/17/24 and 02/18/24. -She did not know why the medication was not administered. -On 02/07/24, she sent Resident #1's family a text message that included all of the prescription numbers to show what medications needed to be refilled. -On 02/08/24, Resident #1's family responded stating she was unable to obtain 2 of the medications. -On 02/08/24, she asked Resident #1's family the name of the medications she was unable to obtain so that she could get the primary care	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 64 provider (PCP) to write a prescription that would allow the facility to obtain the medication from their contracted pharmacy. (The medications were not listed in the message.) Interview with the Administrator on 03/06/24 at 1:00pm revealed: -The MA was responsible for ordering medications once the medication reached a 7 to 10 day supply. -It was also the expectation that the ARCC checked the medication supply when she did the cart audit weekly. -If family provided the medication, they should have been notified when there was a 7 to 10 day supply left. -"On order" probably meant the medication had been ordered and was not administered. -"Not on the cart" meant the medication was not on the cart but could have been in the backup medications or overstock medications. -It was the expectation that the MA checked the cart thoroughly as well as the overstock medications and talked to the RCC and ARCC regarding unavailable medications. -When a medication ran out, the MA was to call the pharmacy to get the medication refilled, report to a supervisor (RCC and ARCC) and document their efforts to get the medication. -The MA was to follow up daily with the pharmacy until the medication was obtained -If family did not provide the medication in a timely manner, they would order from the facility's contracted pharmacy and the facility would pay for the medication. -The RCC and the ARCC were responsible for contacting the facility's contracted pharmacy within 24 hours of the family not providing the medication. -The PCP was supposed to be notified of any	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 65	D 358		

missed medication.
-She was not aware Resident #1 was not administered Tizanidine HCl on 02/05/24, 02/06/24, 02/17/24 and 02/18/24.
-She did not know why Resident #1's medication was not administered
-Checking behind the MA was the function of the medication audit which would now be conducted twice a week.

Telephone interview with the on-call provider for the PCP on 03/06/24 at 4:16pm revealed missed doses of Tizanidine HCl increased the risk of muscle spasm and pain.

g. Review of Resident #1's physician's orders dated 01/11/24 revealed there was an order for Flonase nasal spray 2 sprays in each nostril daily (used to treat allergy symptoms).

Review of Resident #1's February 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Flonase nasal spray 2 sprays in each nostril scheduled for administration in the morning at 8:00am.
-There was an entry of 09 for Flonase nasal spray on 02/05/24 and on 02/14/24.

Review of Resident #1's February 2024 facility exception report revealed the exception for the 09 entry for Flonase nasal spray on 02/05/24 and 02/14/24 was "on order".

Observation of Resident #1's medications on hand on 03/06/24 at 9:22am revealed there was a bottle of Flonase nasal spray with an expiration date of 04/2026. (There was no dispense date.)

Interview with Resident #1 on 03/06/24 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 358	Continued From page 66 9:40am, 10:50am and 5:10pm revealed: -He got his medications on time. -He had not missed any medications. -He had not had any allergy symptoms. Interview with the Resident Care Coordinator (RCC) on 03/06/24 at 11:30am revealed: -The medication aide (MA) was responsible for ordering medications. -The Assistant Resident Care Coordinator (ARCC) did cart audits weekly. -Medications were to be ordered when they were down to a 7 to 10 day supply. -If family provided the medications, they tried to give 14 days notice of the need for a refill to the family. -The MA was supposed to follow up with the pharmacy if the medication was not received within two days. -If family did not provide the medication on time, they got the medication from the facility's contracted pharmacy and paid for it. -"On order" meant the medication had been ordered, they were awaiting arrival and it had not been administered for that day. -No one checked behind the MA on a daily basis. -She was not aware Resident #1 was not administered Flonase on 02/05/24 an 02/14/24. -Resident #1 was never out of his medications. -She did not know why the medication was not administered. -Resident #1's family member was supposed to bring all his medications but was having difficulty with the outside pharmacy. -When family was unable to obtain the medication, the facility could obtain the medication from their contracted pharmacy and the facility would pay for it. -Resident #1's family agreed to allow the facility to order the medication from the facility's contracted	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 358	Continued From page 67 pharmacy and she would pay. Interview with the ARCC on 03/06/24 at 11:30am revealed: -The MA was responsible for ordering medications. -She did cart audits weekly. -No one checked behind the MA on a daily basis. -The resident was never out of his medications. -She was not aware Resident #1 was not administered Flonase on 02/05/24 an 02/14/24. -She did not know why the medication was not administered. -On 02/07/24, she sent Resident #1's family a text message that included all of the prescription numbers to show what medications needed to be refilled. -On 02/08/24, Resident #1's family responded stating she was unable to obtain 2 of the medications. -On 02/08/24, she asked Resident #1's family the name of the medications she was unable to obtain so that she could get the primary care provider (PCP) to write a prescription that would allow the facility to obtain the medication from their contracted pharmacy. (The medications were not listed in the message.) Interview with the Administrator on 03/06/24 at 1:00pm revealed: -The MA was responsible for ordering medications once the medication reached a 7 to 10 day supply. -It was also the expectation that the ARCC checked the medication supply when she did the cart audit weekly. -If family provided the medication, they should have been notified when there was a 7 to 10 day supply left. -"On order" probably meant the medication had	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 358	Continued From page 68	D 358		

been ordered and was not administered.
-It was the expectation that the MA checked the cart thoroughly as well as the overstock medications and talked to the RCC and ARCC regarding unavailable medications.
-When a medication ran out, the MA was to call the pharmacy to get the medication refilled, report to a supervisor (RCC and ARCC) and document their efforts to get the medication.
-The MA was to follow up daily with the pharmacy until the medication was obtained
-If family did not provide the medication in a timely manner, they would order from the facility's contracted pharmacy and the facility would pay for the medication.
-The RCC and the ARCC were responsible for contacting the facility's contracted pharmacy within 24 hours of the family not providing the medication.
-She was not aware Resident #1 was not administered Flonase on 02/05/24 an 02/14/24.
-She did not know why Resident #1's medication was not administered
-Checking behind the MA was the function of the medication audit which would now be conducted twice a week.

Telephone interview with the on-call provider for the PCP on 03/06/24 at 4:16pm revealed missed doses of Flonase caused congestion and increased allergies.

Telephone interview with Resident #1's responsible person on 03/05/24 at 4:10pm revealed:
-She picked Resident #1's medication up from an outside pharmacy.
-There was a distribution problem on behalf of Resident #1's pharmacy in February 2024.
-She was not aware of Resident #1 running out of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 358	Continued From page 69 any medications. -Resident #1 should not have run out of any medications. -The facility was supposed to inform her 2 weeks in advance of Resident #1 needing medication refills. Interview with a MA on 03/06/24 at 9:40am revealed: -The MA was responsible for ordering medications. -Medication was supposed to be ordered when there were 7 to 10 pills left. -If family provided the medication, the MA was supposed to inform the family that the medication was running low when there were 7 to 10 pills left. -Carts were audited every couple of weeks by the RCC and the ARCC to make sure they had enough medication. -"On order" on the eMAR meant a request for a refill had been faxed to the pharmacy and the medication was not on the cart or in overstock and was not administered. -She was unsure why Resident #1 had several medications that were "on order". -If a medication was not available, the MA was supposed to select "09" and write a progress note as to why the medication was not available. -She was not aware of any policies regarding getting a resident's medication when it ran out and family had not provided a refill. -She was not aware of the use of a back up pharmacy. -She did not recall reporting any medications not available or not being administered to anyone. Attempted interview with Resident #1's pharmacy on 03/06/24 at 3:20pm was unsuccessful. The facility failed to administer medications as	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 358	Continued From page 70 ordered to 3 of 4 residents observed during the medication passes on 03/05/24 and 03/06/24 resulting in a 55% medication error rate. Resident #2 missed at least 7 doses of a medication for acid reflux and had a hospital visit after missing the doses and was diagnosed with gastrointestinal bleed and esophagitis. Resident #2 was administered a crushed Ferrous Sulfate tablet and did not receive a new medication for acid reflux on 03/05/24 putting the resident at increased risk for gastrointestinal irritation and precipitating a gastrointestinal bleed. Resident #8's blood pressure medication was not held for a systolic blood pressure less than 130 on 03/05/24 putting the resident at risk of low blood pressure and increased falls. Resident #1 missed multiple doses of several medications due to the medications being unavailable including a blood thinner, medications for diabetes, high blood pressure, and a muscle relaxer putting the resident at increased risk of blood clots, decreased blood sugar control, increase risk of high blood pressure, muscles spasms and pain. The failure of the facility to administer medications as ordered placed the residents at substantial risk of serious physical harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/05/24 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 5, 2024.	D 358		
D 364	10A NCAC 13F .1004(g) Medication Administration	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 364	Continued From page 71 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered within one hour before or after the scheduled times for 3 of 5 residents observed (#11, #13, #14) in the assisted living (AL) side of the facility on 3/05/24 resulting in medications ordered multiple times a day being administered too close to the next scheduled administration time and medications not being administered at consistent time intervals to ensure therapeutic effectiveness. The findings are: Review of the facility's Medication Administration Policies and Procedures with effective date of 10/01/20 revealed the facility would ensure that medications were administered to the residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. Review of the facility's census report dated 03/05/24 revealed: -The facility's current in-house census was 66 residents. -There were 40 residents currently residing in the assisted living (AL) side of the facility. -There were 26 residents currently residing in the special care unit (SCU). Observation of the assisted living (AL) side of the facility on 03/05/24 at 9:55am revealed a	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 364	Continued From page 72 medication aide (MA) was administering medications on 100 hall. Interview with the MA on 03/05/24 at 9:55am revealed: -She was still administering the 8:00am medications to the residents on the 100 hall in the AL -There was usually one MA assigned to administer medications to all residents in the AL on first shift. -She usually started administering medications at 7:00am and she usually finished around 10:00am. -She had finished administering medications to the residents who lived on the 200 hall in the AL but she still have 5 more residents to administer 8:00am medications on the 100 hall in the AL. -There had not been any emergencies that morning that slowed down her medication pass. Observation of the AL on 03/05/24 at 10:05am revealed the Assistant Resident Care Coordinator (ARCC) went to the 100 hall medication cart with a second laptop computer and started helping the MA administer medications to the residents on the 100 hall. Observation of the AL on 03/05/24 at 10:32am revealed the MA and ARCC finished administering medications in the AL side of the facility. Interview with the ARCC MA on 03/05/24 at 10:32am revealed she had just finished administering morning medications to the last resident in the AL side of the facility. A second interview with the MA on 03/05/24 at 2:09pm revealed:	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 364	Continued From page 73 -She was the only MA assigned to administer medications in the AL side of the facility. -She was responsible for administering medications to residents on the 100 hall and 200 hall. -It was a big medication pass and she ran late sometimes because there were so many residents and medications to administer. -She started working as a MA independently about the second week of February 2024. -She started with the fingerstick blood sugars, then went to 200 hall and then to 100 hall. -She had told the ARCC in the past that it was a big medication pass and they needed more MAs. -The ARCC would sometimes help her administer medications when the ARCC was not busy. -The ARCC helped her finish administering medications that morning, 03/05/24. Interview with the ARCC on 03/05/24 at 2:42pm revealed: -She was not aware the MA was running late with the morning medications on 03/05/24 until she noticed the MA was still at the medication cart administering medications (could not recall the time). -She started helping the MA administer the rest of the morning medications on 03/05/24 once she realized the medication pass was late. -The first shift MAs were responsible for administering medications scheduled between 7:00am - 9:00am. -There was usually 1 MA in the AL side of the facility and 1 MA in the special care unit (SCU) during first shift. -The first shift MAs were also responsible for administering treatments such as topical medications that were scheduled between 7:30am - 11:30am. -Today, 03/05/24, was not a good day and the	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 364	Continued From page 74	D 364		

medication pass in the AL side of the facility was running late.
-If a MA was running late with a medication pass, the MA was supposed to notify her or the RCC and they would help or get help.

Interview with the Administrator on 03/05/24 at 4:02pm revealed:
-There was usually 1 MA in the AI and 1 in the SCU.
-Some of the early medications (6:00am and 7:00am) were administered by third shift to help decrease the amount of morning medications for first shift.
-The MAs should let the ARCC, Resident Care Coordinator (RCC), or Memory Care Director (MCD) know if they were running late with the medication pass so they could get help for them.

Review of the March 2024 electronic medication administration records (eMARs) for the 3 residents in the AL who received late medications ordered more than once daily on 03/05/24 revealed all 3 residents had medications ordered twice a day and/or 3 times a day. [For medications with multiple administrations, consistent time intervals are necessary to prevent side effects and adverse reactions.]

a. Review of Resident #11's current FL-2 dated 09/18/23 revealed diagnoses included essential hypertension, constipation, hypothyroidism, seizures, Parkinson's disease, and cerebrovascular disease.

Observation of the medication aide (MA) in the assisted living (AL) side of the facility administering morning medications on 03/05/24 revealed the MA administered Resident #11's medications scheduled for 8:00am at 10:30am, 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 364	Continued From page 75	D 364		

hour and 30 minutes beyond the allowed time frame.

Review of Resident #11's March 2024 electronic medication administration record (eMAR) revealed Sinemet (for Parkinson's disease) was scheduled 3 times a day at 8:00am, 2:00pm, and 8:00pm.

Telephone interview with Resident #11's primary care provider (PCP) on 03/06/24 at 3:52pm revealed:
-Resident #11's medications should be administered on time to ensure therapeutic effectiveness.
-Receiving Sinemet late could cause the resident to have more tremors and stiffness which could put the resident at risk for falls.

b. Review of Resident #13's current FL-2 dated 12/05/23 revealed diagnoses included hemiplegia, insomnia, hypertension, bipolar disorder, gastroesophageal reflux disease, polyneuropathy, restless leg syndrome, retention of urine, and constipation.

Observation of the medication aide (MA) in the assisted living (AL) side of the facility administering morning medications on 03/05/24 revealed the MA administered Resident #13's medications scheduled for 8:00am at 10:18am, 1 hour and 18 minutes beyond the allowed time frame.

Review of Resident #13's March 2024 electronic medication administration record (eMAR) revealed:
-There were 5 medications, Famotidine (for acid reflux), Keppra (for seizures or mood disorders), Olanzapine (antipsychotic), Senna-S (for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 364	Continued From page 76	D 364		

constipation), and Trileptal (for seizures) scheduled twice a day at 8:00am and 8:00pm.
-Tylenol Arthritis (for pain) was scheduled twice a day for 8:00am and 4:00pm.
-Ferrous Gluconate (iron supplement) was scheduled 3 times a day at 8:00am, 2:00pm, and 5:00pm.

Telephone interview with Resident #13's primary care provider (PCP) on 03/05/24 at 3:52pm revealed:
-Resident #13's medications should be administered on time to ensure therapeutic effectiveness.
-Administering medications used to treat seizures late, could lower the seizure threshold and put the resident at risk of having seizures.
-Administering medications used to treat mood disorders late, could cause the resident to have increased behaviors.
-A delay in getting pain medication could cause the resident to have breath through pain.

c. Review of Resident #14's current FL-2 dated 108/31/23 revealed diagnoses included metabolic encephalopathy, overactive bladder, insomnia, traumatic brain injury, constipation, and hyperlipidemia.

Observation of the medication aide (MA) in the assisted living (AL) side of the facility administering morning medications on 03/05/24 revealed the MA administered Resident #14's medications scheduled for 8:00am at 10:07am, 1 hour and 7 minutes beyond the allowed time frame.

Review of Resident #14's March 2024 electronic medication administration record (eMAR) revealed there were 2 medications, Zonisamide

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 364	Continued From page 77 (for seizures) and Senna-S (for constipation) were scheduled twice a day at 8:00am and 8:00pm. Telephone interview with Resident #14's primary care provider (PCP) on 03/05/24 at 3:52pm revealed: -Resident #14's medications should be administered on time to ensure therapeutic effectiveness. -Administering medications used to treat seizures late, could lower the seizure threshold and put the resident at risk of having seizures.	D 364		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medication staff who administered medications actually observed 2 of 4 residents (#2, #9) taking their medications during the morning medication passes observed on 03/05/24 and 03/06/24. The findings are: Review of the facility's Medication Administration	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 366	Continued From page 78 Policies and Procedures with effective date of 10/01/20 revealed the recording of the administration on the medication administration record (MAR) shall be by the staff person who administered the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication prior to the administration of another resident's medication. 1. Review of Resident #9's current FL-2 dated 01/07/24 revealed: -Diagnoses included frontotemporal neurocognitive disorder, essential hypertension, and hyperlipidemia. -There was an order for Norvasc 5mg 1 tablet daily. (Norvasc is used to lower blood pressure.) -There was an order for Depakote DR 250mg 1 tablet twice a day. (Depakote DR is a delayed-release medication that can be used to treat mood disorders.) Review of Resident #9's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Norvasc 5mg 1 tablet once daily scheduled at 8:00am. -Norvasc was documented as administered from 03/01/24 - 03/06/24. -There was an entry for Depakote DR 250mg 1 tablet two times a day for mood stabilization scheduled for 8:00am and 4:00pm. -Depakote DR was documented as administered from 03/01/24 - 03/06/24 (8:00am). Observation of the 8:00am medication pass in the special care unit (SCU) on 03/06/24 revealed: -Resident #9 was sitting alone at the bar attached to the serving station in the SCU dining room eating breakfast.	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

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D 366	Continued From page 79 -There were 23 other SCU residents sitting at multiple tables throughout the dining room eating breakfast. -The medication aide (MA) prepared morning medications for Resident #9, including one Depakote DR 250mg tablet and one Norvasc 5mg tablet. -The MA crushed both tablets and mixed them in a whole cup of yogurt and administered one spoonful from the top of the yogurt cup to the resident at 8:34am. -There were pieces of crushed pills left around the rim of the yogurt cup and in the yogurt inside the cup. -The MA did not attempt to have the resident eat anymore yogurt with the crushed pieces of medication. -The MA sat the yogurt cup on the table beside the resident's breakfast plate and walked out of the SCU dining room. -The MA did not stay in the dining room to observe the resident. -The MA went to the nurses' station outside of the dining room and worked sitting at the desk. -The MA did not attempt to go back to Resident #9's table to see if she had eaten the yogurt. -At 8:57am, the resident picked up the cup of yogurt and ate a few spoonfuls but there was still crushed medication particles in the yogurt. -At 8:59am, a personal care aide (PCA) stopped at Resident #9's table and provided feeding assistance with some of her breakfast, including 2 spoonfuls of yogurt. -At 9:02am, the resident started eating some of the yogurt again but did not finish it. -At 9:04am, a second MA was walking by and stopped to assist Resident #9 with eating her breakfast including feeding the remainder of the yogurt with crushed medications to the resident.	D 366		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 366	Continued From page 80 Interview with the MA on 03/06/24 at 12:32pm revealed: -She usually crushed all of Resident #9's tablets and opened any capsules and mixed in applesauce. -She usually handed the resident a spoon and let the resident take the crushed medication in applesauce herself. -That morning on 03/06/24, she mixed the crushed medications in the whole cup of yogurt and tried to keep all of the crushed medications at the top of the yogurt cup. -She gave the resident one spoonful of yogurt with crushed medications, but she was not sure if the resident received all of the crushed medications because she forgot to check. -She did not think about it until "after the fact". Interview with the Memory Care Director (MCD) on 03/06/24 at 12:57pm revealed: -If medications were crushed, the MAs were supposed to mix the crushed medications in a small amount of applesauce or yogurt in the small plastic medication cup, not the whole cup of yogurt, to make sure all of the crushed medications were administered. -Once the MAs administered crushed medications from the small plastic medication cup to a resident, the MAs were supposed to dispose of it in the trash can on the medication cart. -All residents in the SCU were confused so medications should not be left unattended with any resident. -The MAs were supposed to observe all residents take all their medications. Interview with the Administrator on 03/06/24 at 1:09pm revealed: -The MAs had been trained and should observe	D 366		

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	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 366	Continued From page 81 each resident take their medications. -Resident #9 was in the SCU and the MA should have observed the resident take all the yogurt with crushed medications. Based on observations, interviews, and record review, it was determined that Resident #9 was not interviewable. 2. Review of Resident #2's current FL-2 dated 02/29/24 revealed: -Diagnoses included chronic ischemic heart disease, polyneuropathy, and spinal stenosis. -There was an order for Miralax give 1 packet (17gm) one time a day for constipation. (Miralax is a laxative used to treat and prevent constipation.) Observation of the 8:00am medication pass in the assisted living (AL) side of the facility on 03/05/24 revealed: -The medication aide (MA) prepared 1 packet (17gm) of Miralax powder mixed in water in an 8-ounce styrofoam cup. -The MA took the styrofoam cup with Miralax to the resident's room and sat it on the bedside table at 9:37am. -The resident asked if that was Miralax and the MA indicated it was Miralax. -The MA left the resident's room without observing or asking the resident to take the Miralax. Review of Resident #2's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Miralax give 1 packet (17gm) one time a day for constipation scheduled for 8:00am -Miralax was documented as administered daily	D 366		

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	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 366	Continued From page 82 from 03/01/24 - 03/05/24. Observation of Resident #2's room on 03/05/24 at 10:01am revealed: -The styrofoam cup with Miralax was still sitting on the corner of the bedside table. -There were approximately 2 ounces of water with Miralax remaining in the cup. Interview with Resident #2 on 03/05/24 at 10:01am revealed: -He had not finished drinking the water with Miralax. -The MAs usually left the cup with water and Miralax in his room and he usually drank it during the day until it was gone. Observation of Resident #2's room on 03/05/24 at 1:05pm revealed the styrofoam cup with water and Miralax was no longer sitting on the bedside table. Interview with Resident #2 on 03/05/24 at 1:05pm revealed he thought he had finished drinking the Miralax earlier, but he could not recall a time. Interview with the MA on 03/05/24 at 2:09pm revealed: -There were certain residents she had to observe take their medications and some residents she did not observe because they would take the medications on their own. -She did not usually observe Resident #2 take the Miralax because he would drink it on his own. -She saw a styrofoam cup in Resident #2's trash can today, 03/05/24, around 1:00pm so she thought he drank the Miralax from this morning's medication pass. -There was one resident in the AL side of the facility who was confused and had wandering	D 366		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 366	Continued From page 83 behaviors but that resident was currently in the hospital. Interview with the Assistant Resident Care Coordinator (ARCC) on 03/05/24 at 2:42pm revealed: -The MAs were supposed to wait and observe residents take all of their medications. -The MA should have waited and observed Resident #2 drink all of the Miralax. Interview with the Administrator on 03/05/24 at 4:02pm revealed the MA should have observed Resident #2 take all of his medication, including the Miralax to make sure the resident did not spit it out or pour it out.	D 366		
D 377	10A NCAC 13F .1006(a) Medication Storage 10A NCAC 13F .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were stored in a safe and secure manner in accordance with the facility's policies and procedures for 1 of 1 resident (#2) sampled who self-administered medications including a lubricant eye drop, a topical pain relief spray, and a foam for relief of muscle cramps. The findings are: Review of the facility's Medication Storage	D 377		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

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D 377	Continued From page 84	D 377		

Policies and Procedures with effective date of 10/01/20 revealed:
-Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner.
-Medications must be stored behind lock and key within the resident's room.

Review of Resident #2's current FL-2 dated 02/29/24 revealed:
-Diagnoses included chronic ischemic heart disease, polyneuropathy, and spinal stenosis.
-There was an order for Aspercreme Maximum Strength Pain Relief Spray apply topically at bedtime for foot and leg pain; may self-administer unsupervised. (Aspercreme is used to treat minor aches and pains.)
-There was an order for Theraworx apply topically at bedtime to legs and feet for pain; may self-administer unsupervised. (Theraworx is a topical foam used to treat muscle cramps.)
-There was an order for Refresh Plus eye drops instill 2 drops in each eye every 4 hours as needed for dry eyes. (Refresh Plus is a lubricant eye drop used to treat dry eyes.)

Observation of Resident #2's room in the assisted living (AL) side of the facility on 03/05/24 at 9:28am revealed:
-The resident lived in a private room with no roommate.
-There were 3 medications sitting on top of the resident's bedside table.
-There was a can of Aspercreme Maximum Strength Pain Relief Spray with the resident's name written on the can; a bottle of Theraworx Foam Pump; and a supply of Refresh Plus unit dose eye drops.

A second observation of Resident #2's room on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 377	Continued From page 85 03/05/24 at 10:01am revealed: -Resident #2 was in his room. -The Aspercreme, Theraworx, and Refresh Plus were sitting on top of the resident's bedside table. A third observation of Resident #2's room on 03/05/24 at 1:05pm revealed: -Resident #2 was in his room. -The Aspercreme, Theraworx, and Refresh Plus were sitting on top of the resident's bedside table. Interview with Resident #2 on 03/06/04 at 4:56pm revealed: -He self-administered the 3 medications he kept on his bedside table. -He did not usually lock the door to his room when he left the room. -He had not been instructed to put the medications in a locked area. Interview with a medication aide (MA) on 03/05/24 at 2:09pm revealed: -She was not sure how medications were to be stored when a resident self-administered medications. -There was one resident in the AL side of the facility who was confused and had wandering behaviors but that resident was currently in the hospital. Interview with the Resident Care Coordinator (RCC) on 03/06/24 at 5:52pm revealed: -She thought the facility's policy allowed residents to store self-administered medications at bedside. -The residents did not have a locked drawer to store the medications in their rooms. -The facility did not usually have residents with wandering behaviors living in the AL side of the facility. -There were no current residents with wandering	D 377		

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	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 377	Continued From page 86 behaviors in the AL to her knowledge. Interview with the Administrator on 03/06/24 at 6:11pm revealed: -The facility's policy for storage of self-administered medications was those medications should be stored in a locked area in the resident's room. -The self-administered medications should not be accessible to other residents or staff. -Resident #2's self-administered medications should be stored in a locked area in his room.	D 377		
D 611	10A NCAC 13F .1801(b) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (b) The facility's infection and control policies and procedures shall be implemented by the facility and shall address the following: (1) Standard and transmission-based precautions, including: (A) respiratory hygiene and cough etiquette; (B) environmental cleaning and disinfection; (C) reprocessing and disinfection of reusable resident medical equipment; (D) hand hygiene; (E) accessibility and proper use of personal protective equipment (PPE); and (F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions; (2) When and how to report to the local health department when there is a suspected or	D 611		

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	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 611	Continued From page 87 confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1802 of this Section; (3) Measures for the facility to consider taking in the event of a communicable disease outbreak to prevent the spread of illness, such as isolating infected residents; limiting or stopping group activities and communal dining; limiting or restricting outside visitation to the facility; screening staff, residents, and visitors for signs of illness; and use of source control as tolerated by the residents; and (4) Strategies for addressing potential staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure recommendations and guidance established by the federal Centers for Disease Control and Prevention (CDC) and guidelines established in the facility's infection control policies and procedures were followed for 2 of 2 sampled residents with a positive COVID-19 diagnosis. The findings are: Review of the federal Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic dated 05/08/23 revealed: -Facilities should ensure that everyone is aware of recommended infection prevention and control	D 611		

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	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 611	Continued From page 88	D 611		

practices in the facility.
-Facilities should post visual alerts to include current infection prevention and control practices at the entrance and other strategic areas such as waiting areas or dining rooms. The posted visual alerts should be dated to ensure that visitors, staff, and residents are aware that the posted alerts reflect current infection prevention and control recommendations.
-Healthcare personnel who enter the room of a patient with suspected or confirmed COVID-19 infection should use a National Institute for Occupational Safety and Health (NIOSH) approved particulate respirator with N95 filter or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).

Review of the facility's COVID-19 Preparedness Manual dated 09/26/22 revealed:
-The Administrator and Health and Wellness Director were responsible for directing staff members on current federal CDC guidelines related to infection control.
-An outbreak exists in the facility with two or more positive cases of COVID-19.
-When a COVID-19 outbreak is identified among residents or staff, any vendors, families, visitors, and prospective residents, etc. should be made aware that the facility is experiencing an outbreak at the current time.
-COVID-19 is considered an airborne disease and precautions for airborne disease include keeping the resident's room door closed and wearing a special respiratory mask.
-Surgical masks should not be used as personal protective equipment (PPE) when caring for residents who have tested positive for COVID-19, only approved N95 masks should be worn. If only surgical masks are available, a full-face shield

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 611	Continued From page 89 should be worn with the surgical mask. -Staff providing care to residents with COVID-19 (both symptomatic and asymptomatic) must be in all recommended COVID-19 PPE (N95, eye protection, gown, gloves). -If caring for COVID-19 positive and symptomatic residents as well as non-COVID-19 positive residents in other areas of the building, staff need to wear at minimum, a procedure mask in non-COVID-19 positive resident rooms only in the event of an outbreak (2 or more individuals positive for COVID-19). -Staff members should clean hands often, after removing gloves and after contact with an ill person, by washing hands with soap and water for 20 seconds. If soap and water are not available and hands are not visibly dirty, an alcohol-based hand sanitizer containing at least 60% alcohol may be used. -In the event of a confirmed positive COVID-19 case with a resident or associate, the Administrator and Health and Wellness Director should contact the local health department and follow the local health department's recommendations. Observation of the entrance of the facility on 03/05/24 at 8:45am revealed: -There were two undated signs posted on either side of the front entrance door that read "please wear a facemask". -There was no signage which indicated there were current positive COVID-19 cases in the building. Observation of the reception area at the front entrance of the facility on 03/05/24 at 8:46am revealed: -There was a box of disposable surgical masks and a hand sanitizer station.	D 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 611	Continued From page 90 -The concierge did not inform the survey team of positive COVID-19 cases at the time of entrance to the facility. Interview with the concierge on 03/05/24 at 8:48am revealed there were two residents with COVID-19 in the assisted living (AL) section of the facility. 1. Review of Resident #13's current FL-2 dated 12/05/23 revealed diagnoses included hypertension, polyneuropathy, hemiplegia, and bipolar disorder. Review of Resident #13's history and physical from a local hospital dated 03/04/24 revealed: -Resident #13 was sent to the hospital from the facility on 03/02/24 for having syncope and shortness of breath (Syncope is a medical term for a brief loss of consciousness or fainting). -Resident #13's COVID-19 test at the hospital was positive. Review of Resident #13's discharge summary from a local hospital dated 03/04/24 revealed that Resident #13 was discharged back to the facility on 03/04/24. 2. Review of Resident #15's current FL-2 dated 03/04/24 revealed diagnoses included suprapubic catheter, Type 2 diabetes mellitus, chronic heart failure with preserved ejection fraction, chronic kidney disease stage 4 due to Type 2 diabetes mellitus, coronary artery disease, carotid atherosclerosis, carotid artery disorder, and benign essential hypertension. Review of Resident #15's discharge summary from a local hospital dated 03/04/24 revealed: -Resident #15 went to the emergency room on	D 611		

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	HAL047015	A. BUILDING: _____ B. WING _____	R-C 03/06/2024

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D 611	Continued From page 91 03/01/24 due to having blood in his catheter drainage bag. -Resident #15 tested positive for COVID-19. -Resident #15 was admitted to the hospital and treated for a urinary tract infection and elevated creatinine and potassium levels. -Resident #15 was discharged from the hospital and returned to the facility on 03/04/24. Observation of the 100 hall on the AL side of the facility from 9:28am - 9:55am revealed: -Resident #13 and Resident #15 resided on the 100 hall. -There was no signage to alert staff or visitors that the residents were on isolation/quarantine. -There were no PPE carts/supplies outside of their rooms for use by staff. Interview with a medication aide (MA) on 03/05/24 at 9:38am revealed: -She was not aware Resident #15 was positive for COVID-19. -She had not administered medications to Resident #15 that morning yet. -She was aware Resident #13 was positive for COVID-19 so she planned to administer medications to Resident #13 last. Second observation of the AL 100 hall of the facility on 03/05/24 from 10:17am to 10:22am revealed: -The Assistant Resident Care Coordinator (ARCC) was working as a medication aide (MA). -There was no isolation cart with PPE outside of Resident #13's room. -There was no isolation cart with PPE outside of Resident #15's room. -The ARCC pushed the medication cart outside of Resident #13's room and began preparing medications.	D 611		

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D 611	Continued From page 92 -A personal care aide (PCA) wearing a surgical mask and no other PPE exited Resident #13's room. -The ARCC entered Resident #13's room without putting on any PPE before entering the room. -The ARCC exited Resident #13's room and left the door open approximately 6-8 inches. -The ARCC did not wash or sanitize her hands immediately after exiting the room. -The ARCC used her bare hands to use the touch screen on the computer to enter information into the electronic medication administration record (eMAR) system. -The ARCC used her bare hands to unlock the medication cart and open the drawer to put a medication card in the cart. -The ARCC began pushing the medication cart down the hallway. -The ARCC parked the medication cart at the end of the hallway and applied hand sanitizer. Interview with the ARCC on 03/05/24 at 10:23am revealed: -Staff members were required to wear a mask and gloves when entering a resident's room with COVID-19. -She was aware Resident #13 was positive for COVID-19. -She forgot to wear PPE when she entered Resident #13's room to administer Resident #13's medications. -The staff relied on "word of mouth" to know which residents were positive for COVID-19. Interview with the Administrator on 03/05/24 at 10:40am revealed: -There were currently 2 residents in the facility who had tested positive for COVID-19. -Resident #13 and Resident #15 had both returned to the facility from the hospital yesterday,	D 611		

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D 611	Continued From page 93 03/04/24. -Both residents tested positive for COVID-19 while they were in the hospital emergency room. -Both residents were asymptomatic. -Both residents resided on the AL side of the facility and were on isolation/quarantine. -They were trying to get the residents to wear a mask or stay in their rooms. -The facility did not do mass testing for COVID-19; they only tested if someone was symptomatic. -She recently (could not give a specific date) saw where the CDC guidelines now indicated if someone with COVID-19 was without a fever or symptoms for at least 24 hours, they did not have to quarantine but wear a mask. -When facility staff was caring for COVID-19 positive residents, staff should wear a mask and gloves and wash their hands after providing care to the resident. -Prior to the 2 residents currently with COVID-19, there were several residents and staff who tested positive for COVID-19 a couple of weeks ago. -There was no official signage or list to indicate which residents were positive for COVID-19. -Facility staff usually communicated this information by word of mouth during shift changes and rounds and when a resident returned from the hospital. -She did not usually post signage indicating there were COVID-19 positive individuals in the facility; the concierge usually notified visitors as they entered the facility. Second interview with the Administrator on 03/05/24 at 7:50pm revealed: -The facility did not have any recent updates to their infection control policies. -The facility's corporate office was responsible for updating all policies.	D 611		

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D 611	Continued From page 94 -The Administrator and Environmental Services Director were responsible for ensuring that all team members followed infection control policies and procedures. -The facility no longer restricted visitors during COVID-19 outbreaks. -Visitors should be informed that there were positive cases of COVID-19 in the facility and asked to wear masks. -She was not aware that the receptionist did not immediately inform surveyors of COVID-19 cases upon entrance to the facility on 03/05/24. -Staff members should always wear a mask in a resident's room when the resident had tested positive for COVID-19. -The facility had a COVID-19 outbreak on 02/16/24 and she contacted the local health department and left a message on a nurse's voicemail but did not receive a return call with any instructions or guidance. -The COVID-19 outbreak at the facility that started on 02/16/24 lasted approximately 10-14 days. -She did not attempt to call the health department again during that time. -The two residents who were currently positive for COVID-19 returned from the hospital on 03/04/24. -She had not called the local health department with the current outbreak of COVID-19 because she had been too busy to call. -Staff should at least wear a mask and gloves in a resident's room that had COVID-19, but many chose not to wear full personal protective equipment (PPE). Attempted interviews with the the local health department contact on 03/06/24 at 11:40am and 3:48pm were unsuccessful. _____	D 611		

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D 611	Continued From page 95 The facility failed to ensure the recommendations established by the federal Centers for Disease Control and Prevention (CDC) and the facility's established infection control policies and procedures were being followed by allowing staff members to enter two COVID-19 positive residents' rooms without the recommended personal protective equipment and failing to inform visitors of COVID-19 positive cases with signage indicating a COVID-19 outbreak, which could increase the risk of transmission and spread of COVID-19 to other residents in the facility. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/07/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 20, 2024.	D 611		