PRINTED: 03/27/2024 FORM APPROVED

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COMPL	ETED
		HAL047015	B. WING		R- 03/0	C <b>6/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE CREEKS CROSSING	8398 FAYE	TTEVILLE ROA	AD		
Wickerin	te oneeno onoccino	RAEFORD,	NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 000	Initial Comments		D 000			
	County Department o a follow-up survey an March 5-6, 2024. The	sure Section and Hoke f Social Services conducted d complaint investigation on complaint investigation was County Department of Social 20, 2024.				
D 358	D 358 10A NCAC 13F .1004(a) Medication Administration		D 358			
	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 FOLLOW-UP TO TYPE	•				
	harm, abuse, neglect	esidents placed at eath or serious physical or exploitation will occur.				
	THIS IS A TYPE A2 V	IOLATION				
	reviews, the facility fa were administered as (#2, #8, #9) observed including errors with r prostate (#2), iron def constipation (#2, #8, # blood pressure and/or	ns, interviews, and record iled to ensure medications ordered for 3 of 4 residents during the medication pass medications for enlarged ficiency anemia (#2), #9), acid reflux (#2, #8), high r chest pain (#8), high 8), mood stabilizer (#9),				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING			R-C	
		HAL047015	B. WING			(-C (06/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ΓE, ZIP CODE			
WICKSHII	RE CREEKS CROSSING		ETTEVILLE ROA	AD.			
		RAEFORI	D, NC 28376				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE	
D 358	Continued From page	<del>2</del> 1	D 358				
	medication used to sl kidney function (#8); a residents (#1, #2) incl medications for high bediabetes (#1), urine re (#1), a muscle relaxed allergy symptoms (#1 reflux (#2).  The findings are:  1. The medication error evidenced by 15 error during the 7:00am/8:0	pical pain patch (#8), and a ow the rate of decline in and for 2 of 5 sampled luding errors with blood pressure (#1), etention (#1), a blood thinner r (#1), a nasal spray for ), and a medication for acid					
	a. Review of Resident #2's current FL-2 dated 02/29/24 revealed: -Diagnoses included chronic ischemic heart disease, polyneuropathy, and spinal stenosisThere 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						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED
		HAL047015	B. WING		R-C 03/06/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MICKOLU	DE ODEEKO ODOGONO	8398 FAYE	TTEVILLE ROA	AD	
WICKSHIP	RE CREEKS CROSSING	RAEFORD,	NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 2	D 358		
	esopnagitis (intiamma	ation of the esophagus).			
	03/05/24 revealed: -The medication aide medications for Residerous Sulfate 324mThe MA crushed all concluding the Ferrous applesauce and admiresident at 9:28am.  Observation of Residerand on 03/05/24 at 2-There was a supply tablets, with the president of the bottleThere was a warning not to crush or chew to	ng tablet.  of Resident #2's oral tablets, Sulfate, mixed them in inistered them to the  ent #2's medications on 2:30pm revealed: of Ferrous Sulfate 324mg cription label torn off and e label still attached to the g on the manufacturer's label the medication.			
	Review of Resident # medication administra	2's March 2024 electronic			
	revealed:				
	<del>-</del>				
	administered from 03				
		ation noted on the eMAR to			
		on should not be crushed.			
	and mix with food/be	or may crush medication			
	medication administra	•			
		nt #2 on 03/05/24 at shed all of his medications. to swallow the medications			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		HAL047015	B. WING		R-C 03/06/2024		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE			
WICKSHIE	RE CREEKS CROSSING		ETTEVILLE ROA	AD.			
			D, NC 28376				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMF	5) PLETE TE	
D 358	Continued From page	e 3	D 358				
	-He denied any currel upset or pain.	nt symptoms of stomach					
	revealed:	on 03/05/24 at 2:09pm					
	-She usually crushed all of Resident #2's medicationsShe thought the order to crush medications meant she could crush everythingShe 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 lis medication carts.						
		eMARs or the medication vith medications that could					
	-The MAs knew about refer to it before crush	t the DNC list and should					
		ing any medications.  Is Sulfate should not have					
	4:02pm revealed:	ninistrator on 03/05/24 at					
	<ul> <li>There was a DNC lis in the medication roor</li> </ul>	t on the medication cart and m.					
	-The MAs should refe	rence the DNC list prior to					
	crushing medications -The MAs were traine	ed and knew there was a					
	DNC list available.						
	-Resident #2's Ferrou been crushed.	s Sulfate should not have					
		s DNC medication list fate DR was included on the nat should not be crushed.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDILAN	or dorate of the transfer of t	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:		
		HAL047015	B. WING	B. WING		24
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MICKSHII	RE CREEKS CROSSING	8398 FAYE	TTEVILLE ROA	AD		
RAEFORD			NC 28376			
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D 358	Continued From page	e 4	D 358			
	Attempted telephone	interview with the resident's (PCP) on 03/06/24 at ssful.				
		Ilfate could cause the rointestinal irritation or				
	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.					
	03/05/24 revealed: -The medication aide medications for Resid Finasteride 5mg table	et. of Resident #2's oral tablets, ride, mixed them in				
	hand on 03/05/24 at 2 -There was a supply of dispensed on 10/03/2 -There was no inform indicate the medication	of Finasteride 5mg tablets				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		HAL047015	B. WING		R-C <b>03/06/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE CREEKS CROSSING		ETTEVILLE ROA	AD		
	Г		D, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 5	D 358			
	once time a day for proceed to the second and second an	for Finasteride 5mg 1 tablet rostate scheduled for sumented as administered 03/05/24. ation noted on the eMAR to on should not be crushed. for may crush medication verage to facilitate ation. nentation to indicate if the was being crushed.				
	revealed: -She usually crushed medicationsShe thought the orde meant she could crus	er to crush medications h everything.				
	meant she could crush everythingShe 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 cartsShe did not think the eMARs or the medication					

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labels were marked with medications that could

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			71. BOILBING.		R-C	
		HAL047015	B. WING		03/06/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIF	RE CREEKS CROSSING	8398 FAYE <sup>*</sup> RAEFORD,	TTEVILLE ROANCE 28376	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPL	ETE
D 358	refer to it before crush-Resident #2's Finastic crushed.  Interview with the Adr 4:02pm revealed: -There was a DNC lisin the medication roor-The MAs should refectushing medications -The MAs were traine DNC list availableResident #2's Finastic crushed.  Review of the facility's revealed Finasteride medication that should Attempted telephone primary care provider 4:18pm was unsuccestill the provider on 03/06/24 -Finasteride should not she was not aware of the resident receiving c. Review of Resident 02/29/24 revealed an 40mg 1 tablet two time (Pantoprazole is used reflux disease.)  Review of Resident #	t the DNC list and should ning any medications. eride should not have been ministrator on 03/05/24 at at on the medication cart and m. erence the DNC list prior to a d and knew there was a eride should not have been s DNC medication list was included on the list as a d not be crushed.  interview with the resident's (PCP) on 03/06/24 at ssful.  with the PCP's on call at 4:29pm revealed: ot be crushed.  of any specific concerns for	D 358			
	(PCP) visit noted date resident suffered from					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
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		HAL047015	B. WING		03/06/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
· ·			TTEVILLE ROA		
WICKSHIE	RE CREEKS CROSSING		, NC 28376		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	V (Y5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 7	D 358		
	gastroesophageal ref	lux.			
	Review of Resident # summary (AVS) dated revealed: -The resident's diagnor (vomiting blood) with (inflammation of the element	2's hospital after visit d 02/21/24 - 02/24/24 coses included hematemesis nausea and esophagitis esophagus). to start taking Pantoprazole les a day.  00am medication pass on  (MA) prepared and dications scheduled for 12 at 9:28am. are and administer esident when he received			
	60 Pantoprazole 40m	g tablets dispensed in a			
	bottle by an outside p	harmacy on 02/26/24.			
	medication administra revealed: -There was an entry f	or Pantoprazole 40mg 1 / for acid reflux scheduled			
	-Pantoprazole was do two times a day from -Pantoprazole was do	ocumented as administered 03/01/24 - 03/04/24.			
	Interview with Reside	nt #2 on 03/05/24 at 1:05pm			

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revealed:

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DIVISION	n nealth Service Negu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
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		HAL047015	B. WING		03/0	6/2024
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
			TTEVILLE RO			
WICKSHIP	RE CREEKS CROSSING			40		
		RAEFURL	), NC 28376			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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				·		
D 358	Continued From page	e 8	D 358			
	l la thairmht ha maasir	red Dentennende errent der				
	•	ved Pantoprazole every day.				
		antoprazole was in the				
	medication cup he red	•				
	•	h acid reflux, but he was not				
	having any symptoms	s of acid reflux today.				
		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 Ass	sistant Resident Care				
	Coordinator (ARCC)	on 03/05/24 at 2:42pm				
	revealed:					
	-The MAs were respo	onsible for ordering				
	medications.					
	-If a medication was u	unavailable or on order, the				
	MAs should notify her	r or the Resident Care				
	Coordinator (RCC).					
		osed to double check the				
		ake sure medications were				
	available when admin					
	Interview with the Adr	ministrator on 03/05/24 at				
	4:02pm revealed:	<del></del>				
	•	not in the medication cart,				
	the MAs should notify	-				
	Memory Care Directo					
		MCD would check behind				
		medication was in the cart				
	or the back-up supply					
		ekly cart audit and "9 times				
	out of 10", the medica	ations were available.				
		interview with the resident's				
	PCP on 03/06/24 at 4	:18pm was unsuccessful.				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	STREETAL	DRESS, CITY, STA	II E, ZIP CODE		
MICKELII	RE CREEKS CROSSING	8398 FAY	ETTEVILLE ROA	AD		
WICKSIII	AL OKLERO OKOSSING	RAEFORI	D, NC 28376			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1 0	K5)
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				DEFICIENCY)		
D 050		_	D 050			
D 358	Continued From page	9	D 358			
	Telephone interview v	with the PCP's on call				
		at 4:29pm revealed missing				
	doses of Pantoprazol					
		rointestinal irritation and				
	precipitate the resider	nt's recent gastrointestinal				
	bleed.					
	d. Review of Residen	t #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					
	,	used to treat and prevent				
	constipation.)					
	0, , , , ,	00 1: 1:				
		00am medication pass on				
	03/05/24 revealed:					
		(MA) prepared 1 packet				
	(17gm) of Miralax pov	wder mixed in water in an				
	8-ounce styrofoam cu	ıp.				
	-The MA took the styr	ofoam cup with Miralax to				
	the resident's room a	nd sat it on the bedside				
	table at 9:37am.					
		f that was Miralax and the				
	MA indicated it was M					
	-The MA left the resid					
		ne resident to take the				
	Miralax.					
	Review of Resident #	2's March 2024 electronic				
	medication administra	ation record (eMAR)				
	revealed:	•				
		or Miralax give 1 packet				
		y for constipation scheduled				
	for 8:00am	,				
		nted as administered daily				
		nted as administered daily				
	from 03/01/24 - 03/05	0/24.				
	05					
	_	ent #2's room on 03/05/24 at				
	10:01am revealed:					
		vith Miralax was still sitting				
	on the corner of the b	edside table.				

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STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION  (IDENTIFICATION NUMBER: HALD47015   NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, JIP CODE  SAMP FATTEVILLE ROAD  RAFFOR, NO. 2376  PROVIDER'S RATHOR OF DEFICIENCES  (EACH CORRECTIVE ACTION SHOULD BE  (EACH CORRECTIVE ACTION SHOULD BE	Division o	of Health Service Regu	liation					
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY. STATE, 2IP CODE  3398 FAYETTEVILLE ROAD  RAFFORD, NC 28376  SUMMARY STATEMENT OF DEPTICIENCES  100 PROVIDER STATEM (FACE DESCRIPTION MUST BE PRECEDED BY PLILL PRETEX (FACE DESCRIPTION MUST BE PRECEDED BY PLILL PRETEX (FACE DESCRIPTION MUST BE PRECEDED BY PLILL PRETEX TAG.)  100 Tam revealed:  100 Tam revealed:  110 There were approximately 2 ounces of water with Miralax remaining in the cup.  110 Interview with Resident #2 on 03/05/24 at 1:05pm revealed by the foliage of the bedside table.  110 Dispm revealed the styrofoam cup with water and Miralax was no longer sitting on the bedside table.  110 Interview with Resident #2 on 03/05/24 at 1:05pm revealed the thought he had finished drinking the miral manual man			(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION			
NAME OF PROVIDER OR SUPPLIER  TREETADDRESS, CITY, STITLE, ZIP CODE  338 FAYETTEVILLE ROAD  RAFFORD, NC 2876  SUMMANS STATEMENT OF DESIGNATION SHOULD BE PRICED BY TULL PRICE COORDING (EACH CORPORATION MUST are prescoord by TULL PRICE COORDING (EACH CORPORATION MUST are prescoord by TULL PRICE COORDING (EACH CORPORATION MUST are prescoord by TULL PRICE COORDING (EACH CORPORATION MUST are prescoord by TULL PRICE COORDING (EACH CORPORATION MUST are prescoord by TULL PRICE COORDING COORDIN	AND PLAN (	)F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		COMPLETED	
NAME OF PROVIDER OR SUPPLIER  TREETADDRESS, CITY, STITLE, ZIP CODE  338 FAYETTEVILLE ROAD  RAFFORD, NC 2876  SUMMANS STATEMENT OF DESIGNATION SHOULD BE PRICED BY TULL PRICE COORDING (EACH CORPORATION MUST are prescoord by TULL PRICE COORDING (EACH CORPORATION MUST are prescoord by TULL PRICE COORDING (EACH CORPORATION MUST are prescoord by TULL PRICE COORDING (EACH CORPORATION MUST are prescoord by TULL PRICE COORDING (EACH CORPORATION MUST are prescoord by TULL PRICE COORDING COORDIN							0	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, JIP CODE  8398 FAYETTEVILLE ROAD  RAEFORD, NC 28376   (EXCHIEVE CRESKS CROSSING  SUMMARY STATEMENT OF DEFICIENCIES  (EXCHIEVE CRESK) Was 18 EMASCRED BY MULL PREFIX  (EXCHIEVE CRESKS WAS 18 EMASCRED BY MULL PREFIX  REGULATORY or Las CINCHIP THIS MYGRIMMON  TAS  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 1.00 fam 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 goneHe denied any current issues with constipation or diarrhea.  Observation of Resident #2's room on 03/05/24 at 1.05pm revealed the thought he had finished drinking the Miralax wan to longer sitting on the bedside table.  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 miralax because he would drink it on his ownShe saw a styrotoam cup in Resident #2's trash can today, 03/05/24, at 2.42pm revealed: -The MAS were supposed to wait and observe  Interview with the Assistant Resident Care Coordinator (ARCC) on 03/05/24 at 2.42pm revealed: -The MAS were supposed to wait and observe			1141 047045	B WING		1		
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Coordinator (ARCC) on 03/05/24 at 2:42pm revealed: -The MAs were supposed to wait and observe		 						
Coordinator (ARCC) on 03/05/24 at 2:42pm revealed: -The MAs were supposed to wait and observe		Interview with the Ass	sistant Resident Care					
revealed: -The MAs were supposed to wait and observe								
-The MAs were supposed to wait and observe		, , ,	on 00,00,2 i at 2. i2piii					
			osed to wait and observe					
		_ · · · · · · · · · · · · · · · · · · ·						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED
		HAL047015	B. WING		R-C 03/06/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MICKEHIE	RE CREEKS CROSSING	8398 FAYE	TTEVILLE ROA	AD	
WICKSHIP	NE CREEKS CROSSING	RAEFORD,	NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 11	D 358		
		waited and observed			
	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 painThere 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.)				
	02/23/24 revealed an	8's physician's order dated order to change Nifedipine ay, if SBP is less than or ld the daily dose.			
	03/05/24 revealed: -The medication aide blood pressureThe resident's blood monitor was 122/74The MA prepared an	00am medication pass on  (MA) took Resident #8's  pressure reading on the  d administered Nifedipine ent at 9:54am instead of n as ordered.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
			A. BOILDING		D.C.	
		HAL047015	B. WING		R-C <b>03/06/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MICKSHIE	RE CREEKS CROSSING	8398 FAYE	TTEVILLE ROA	AD		
WICKSIIII	NE OREERO CROSSINO	RAEFORE	), NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	e 12	D 358			
	medication administrative revealed: -There was an entry for 1 tablet once time and hold if SBP greater the Nifedipine ER was sedocumented as adminious - 03/05/24The resident's blood at 8:00am and range 03/01/24 - 03/05/24.  Interview with Reside	for Nifedipine ER 30mg give lay for high blood pressure, an (>) 130. cheduled at 8:00am and histered daily from 03/01/24 pressure was checked daily d from 122/74 - 147/62 from				
	added some medicati -The MAs did not usu pressure medications dayAbout 2 weeks ago (	mary care provider (PCP)				
	cloud" and her head was positive that low and caused these	went down. It her blood pressure was E symptoms. E symptoms to anyone				
	revealed: -She was going by the when she administers ER that morning, 03/0-She did not enter the Nifedipine ER if the S	e order on the eMAR to hold BP was >130. er orders on the eMAR and				

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entering the orders.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				R-0		
		HAL047015	D. WING		03/0	6/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE CREEKS CROSSING		TTEVILLE ROA	AD		
		RAEFORD	), NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	<del>2</del> 13	D 358			
		Resident #8's order was to R if the SBP was less than				
	Interview with the Ass Coordinator (ARCC) of revealed:	sistant Resident Care on 03/05/24 at 2:42pm				
	-The Resident Care Coordinator (RCC), Memory Care Director (MCD), and ARCC were responsible for entering orders into the eMAR					
	systemShe entered Resider into the eMAR system	nt #8's Nifedipine ER order n.				
	-She thought the order ER if the SBP was gre	er was to hold the Nifedipine				
		nto the eMAR system.				
		er, Resident #8's Nifedipine held that morning, 03/05/24 s less than 130.				
	4:02pm revealed:	ministrator on 03/05/24 at				
	incorrectly into the eM	he Nifedipine ER order IAR system. pine ER should have been				
		as less than or equal to 130				
	-	interview with the resident's :18pm was unsuccessful.				
	ER was not held as o -Not holding the Nifed	at 4:29pm revealed: cerning when the Nifedipine rdered in an elderly resident. lipine ER could cause the blood pressure and increase				

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STATE FORM 6899 ERJT11 If continuation sheet 14 of 96

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
74101 2741	or connection	IDENTIFICATION NOMBERS	A. BUILDING: _	A. BUILDING:		R-C	
		HAL047015	B. WING	B. WING		024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE			
WICKSHIE	RE CREEKS CROSSING		TTEVILLE ROA	AD			
		RAEFORD	, NC 28376				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 358	Continued From page	e 14	D 358				
		n, take for 12 weeks. ic used to benefit					
	03/05/24 revealed the prepared and adminis	O0am medication pass on medication aide (MA) stered 1 Florastor Probiotic ad of 2 capsules as ordered.					
	Review of Resident # medication administrate revealed:	8's March 2024 electronic ation 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 8:00pmFlorastor Probiotic capsule was documented as administered from 03/01/24 - 03/05/24.						
	medication.	the received a Probiotic y having any stomach					
	revealed: -She usually administ capsules to Resident -She overlooked it an	d made an error that hen she administered 1					
	revealed:	sistant Resident Care on 03/05/24 at 2:42pm rained to read the eMARs					

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PRINTED: 03/27/2024 FORM APPROVED

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED
	HAL047015	B. WING		R-C <b>03/06/2024</b>
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
WICKSHIRE CREEKS CROSSING		TTEVILLE ROA , NC 28376	AD	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
instructions on the eM-Resident #8 should in Probiotic capsules insulative with the Adia 4:02pm revealed the the eMAR and medic 2 capsules of Florastic capsule.  Attempted telephone primary care provider 4:18pm was unsucced.  Telephone interview with provider on 03/06/24 receiving half the dost could cause the media in restoring gut flora at 1.02/01/24 revealed an 1.02/01/24 revealed:  The medication of the 8:03/05/24 revealed:  The medication aide administered morning at 9:54am.  The MA did not apply Lidocaine Patch to the and neck when the resother morning medical	cations according to the MAR. have received two Florastor stead of 1 capsule.  ministrator on 03/05/24 at MA should have read both ation label and administered or Probiotic instead of 1  interview with the resident's r (PCP) on 03/06/24 at ssful.  with the PCP's on call at 4:29pm revealed only se of Florastor Probiotic ication not to be as effective and preventing diarrhea.  at #8's current FL-2 dated order for Lidocaine Patch the right shoulder and neck and for pain, remove at Patch is a topical patch used  00am medication pass on  (MA) prepared and generalized medications to Resident #8  y or offer to apply a ge resident's right shoulder estident was administered her actions aine Patch on the resident's	D 358		

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R-C	
		HAL047015	B. WING		03/06/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE CREEKS CROSSING		ETTEVILLE ROAD, NC 28376	AD		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	e 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.					
	leg sometime later in recall time)The MA did not offer her right shoulder and	caine Patch on her left lower the morning (could not to put a Lidocaine Patch on				
	Interview with the MA	on 03/05/24 at 2:09pm				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
		HAL047015	B. WING		R-C 03/06/2024	.
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE. ZIP CODE	1 00/00/2021	
MICKEHIE	RE CREEKS CROSSING		TTEVILLE ROA			
WICKSHIP	CREEKS CROSSING	RAEFORD	, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	BE COMP	LETE
D 358	Continued From page	e 17	D 358			
	revealed: -She usually put Resion the resident's lowe because that was when to put itShe did not usually president's right should. She had not notified put the Lidocaine Pat because she was appresident told her to put the Lidocaine Pat because she was appresident told her to put the Lidocaine Patch to he indicated in the order. The MA should have Lidocaine Patch to he indicated in the order. The MA should have Care Coordinator (RC provider (PCP) that the patch be applied to could have gotten and Interview with the Adra 4:02pm revealed the the eMAR and medicated the medication as order. Attempted telephone PCP on 03/06/24 at 4	dent #8's Lidocaine Patch er left leg near her knee ere the resident usually told but a Lidocaine Patch on the der and neck. the PCP to get an order to ch on the resident's leg blying the patch where the ut it.  sistant Resident Care on 03/05/24 at 2:42pm  applied Resident #8's er right shoulder and neck as and on the eMAR. notified her, the Resident CC) or the primary care he resident was requesting to a different area and they order.  ministrator on 03/05/24 at MA should have read both ation label and administered lered.  interview with the resident's e:18pm was unsuccessful.				
	applying the Lidocain could put the resident untreated area.	e Patch to the area ordered				

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02/01/24 revealed an order for Sevelamer

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
744012744	or contraction	IDENTIFICATION NOMBERS	A. BUILDING: _	A. BUILDING:		
		HAL047015	B. WING	B. WING		4
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MICKSHIE	RE CREEKS CROSSING	8398 FAYE	TTEVILLE ROA	AD		
WIOKOIIII	NE OREERO OROGONIO	RAEFORD	, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COM	K5) PLETE ATE
D 358	Continued From page	e 18	D 358			
	Carbonate Oral Packetimes a day related to	et 0.8grams give 1 packet 3 chronic kidney disease. e lowers phosphate levels in				
	(PCP) visit dated 02/0 -The resident was add 01/30/24.	mitted to the facility on d stage renal disease and				
	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.					
	medication administrative revealed: -There was an entry foral Packet 0.8gm givelated to chronic kidruseled to chronic kidruseled at 8:00a administered at 8:00a -Sevelamer Carbonat administered from 03.	for Sevelamer Carbonate ve 1 packet 3 times a day ney disease. The was scheduled to be sum, 12:00pm, and 5:00pm, are was documented as 1/01/24 - 03/05/24 except on and 5:00pm when the				
		three times a week. ived her morning s 10:00am.				

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	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				R-0	
	HAL047015	B. WING		03/0	6/2024
NAME OF PROVIDER OR SUPPLIER	STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIRE CREEKS CROSSING		TEVILLE ROA	AD		
	RAEFORD,	NC 28376			
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358 Continued From page 19		D 358			
revealed: -Resident #8's Sevelamer administered late that more she was the only MA assist medications in the assisted facilityIt was a big medication passometimes because there residents and medications. She administered Resider of Sevelamer Carbonate as 12:30pm (about 2 and ½ horning dose).  Interview with the Assistant Coordinator (ARCC) on 03 revealed: -She was not aware the Mathematications on the morning medications on the morning medications on the morning medications on the morning medications or realized the medication passisted	rning, 03/05/24. signed to administer and living (AL) side of the ass and she ran late awere so many as to administer. Ent #8's 12:00pm dose at lunch time around anours after the late  At Resident Care 3/05/24 at 2:42pm  At was running late with on 03/05/24 until she at the medication cart as (could not recall the ass was late.  At administer the rest of on 03/05/24 once she ass was late.  Strator on 03/05/24 at with a medication pass, arcc, Resident Care amony Care Director ar behind on a build let the PCP known at to do.				

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Telephone interview with the PCP's on call

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-C	
		HAL047015	B. WING		03/06/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE CREEKS CROSSING		TTEVILLE ROA	AD		
		RAEFORD	, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	20	D 358			
	provider on 03/06/24 administering a medic					
	02/01/24 revealed an 100mg 1 tablet 3 time pressure, hold if systo	#8's current FL-2 dated order for Hydralazine as a day for high blood blic blood pressure (SBP) is ydralazine is used to lower				
	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 122/74The MA prepared and administered Resident #8's Hydralazine 100mg at 9:54am, 54 minutes beyond the allowed time frame.					
	medication administrative revealed: -There was an entry for tablet 3 times a day for if SBP is less than 10 and -Hydralazine was school 8:00am, 2:00pm, and -Hydralazine was door times a day from 03/03/01/24 and 03/04/2 documented as out of -The resident's blood	or Hydralazine 100mg 1 or high blood pressure, hold 0. eduled to be administered at 8:00pm. eumented as administered 3 1/24 - 03/05/24 except on 4 when the resident was f the facility. pressure was checked 3 ed from 122/74 - 162/69.				
	12:55pm revealed: -She sometimes rece					

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medications as late as 10:00am.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
					R-C	
		HAL047015	B. WING		03/06/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE CREEKS CROSSING		ETTEVILLE RO	AD		
	CLIMMADY CT		), NC 28376	DROVIDEDIC DI AN OF CORDECTIO		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	21	D 358			
	-She had not noticed symptoms when her reshe thought her high improved after her privaded some medication. About 2 weeks ago (time), she was sitting cloud" and her head vershe was positive that low and caused these. She did not report the because she got better that morning, 03/05/2. She was the only Mamedications in the ast facility. It was a big medications and medications of Hydralazine as the symptomic sympto	any side effects or medications were late. In blood pressure had mary care provider (PCP) ons.  could not recall date or at a table and saw a "white went down. It her blood pressure was e symptoms. It is esymptoms to anyone er.  I on 03/05/24 at 2:09pm  dazine was administered late 4.  A assigned to administer sisted living (AL) side of the on pass and she ran late here were so many				
	revealed: -She was not aware t	on 03/05/24 at 2:42pm he MA was running late with				
	noticed the MA was s administering medica time). -She started helping t	ons on 03/05/24 until she till at the medication cart tions (could not recall the the MA administer the rest of ons on 03/05/24 once she				
	realized the medication					

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STATE FORM 6899 ERJT11 If continuation sheet 22 of 96

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
A. BOLDING.	R-C
HAL047015 B. WING	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 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOW CORRECT TO THE APPROVIDER'S PLAN OF CORRECT TO THE AP	DULD BE COMPLETE
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 helpIf a MA was running loo 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 4:00pmPantoprazole was documented as administered	

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:	
		HAL047015	B. WING		03/06/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
WICKSHIE	RE CREEKS CROSSING	8398 FAY	ETTEVILLE RO	AD	
WICKSHIP	LE CREEKS CROSSING	RAEFORI	D, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 358	Continued From page	23	D 358		
	4:00pm when the resi	dent was out of the facility.			
	Interview with Reside 12:55pm revealed:				
	-She sometimes rece medications as late a	•			
	-She had not noticed				
		medications were late.			
	Interview with the MA revealed:	on 03/05/24 at 2:09pm			
	-She usually administ	ered Resident #8's			
	•	led for 7:00am with the			
	8:00am medications t				
	•	orazole was administered			
	late that morning, 03/	assigned to administer			
	<u>-</u>	sisted living (AL) side of the			
	~	on pass and she ran late			
	sometimes because t residents and medica				
	Interview with the Ass	istant Resident Care			
		on 03/05/24 at 2:42pm			
	-She was not aware t	he MA was running late with			
	_	ons on 03/05/24 until she			
		till at the medication cart			
		tions (could not recall the			
	time)She started helping t	he MA administer the rest of			
		ons on 03/05/24 once she			
	realized the medication				
	Interview with the Adr 4:02pm revealed:	ninistrator on 03/05/24 at			
	-If a MA was running	late with a medication pass, he ARCC, Resident Care			

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Coordinator (RCC), or Memory Care Director

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
74101 2741	or contraction.	BERTIN IS WISH NOMBER	A. BUILDING: _	A. BUILDING:		
		HAL047015	B. WING		l l	R-C <b>(06/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
WICKSHIE	RE CREEKS CROSSING		ETTEVILLE ROA D, NC 28376	D		
()(1) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	E COPPECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 24	D 358			
	I	interview with the resident's I:18pm was unsuccessful.				
	provider on 03/06/24 receiving Pantoprazo	le late could cause the effective and increase the				
	02/01/24 revealed an 8.6/50mg take 1 table constipation. (Senna	t #8's current FL-2 dated order for Senna Plus et 2 times a day for Plus is a laxative and stool t and prevent constipation.)				
	03/05/24 revealed: -The medication aide administered oral me 8:00am to Resident # -The MA did not prep Plus to the resident w morning medications.	dications scheduled for t8 at 9:54am. are and administer Senna when she received her other				
	Observation of Resid hand on 03/05/24 at 2 no Senna Plus availa Review of Resident # medication administrative revealed: -There was an entry for the series of the series	administered as ordered.  ent #8's medications on 2:11pm revealed there was ble for administration.  8's March 2024 electronic ation record (eMAR)  for Senna Plus 8.6/50mg 1 scheduled for 8:00am and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		I \ /	(X3) DATE SURVEY COMPLETED	
		HAL047015	B. WING			R-C 8 <b>/06/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	-	
MICKEHII	RE CREEKS CROSSING	8398 FAY	ETTEVILLE ROA	AD		
WICKSHIP	RE CREEKS CROSSING	RAEFOR	D, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETE DATE
D 358	twice a day from 03/0 -Senna Plus was doct administered at 8:00a "ordering medication"  Interview with Reside 12:55pm revealed: -She was supposed to dayAt one time, she was constipation but it was  Interview with the MA revealed: -She did not administe that morning, 03/05/2 medication cartThe MAs were respo medications when the the supplyShe was not sure if F had been orderedShe had not had time supply of medications see if there was any a  Telephone interview w at the facility's contract at 3:26pm revealed: -Resident #8 was a no 01/30/24The pharmacy had n dispense any Senna I 03/05/24The pharmacy disper on 03/05/24.	umented as administered 1/24 - 03/04/24. umented as not being im on 03/05/24 due to  Int #8 on 03/05/24 at Direceive Senna Plus every In having problems with It better now.  Int #8's Senna Plus It because it was not in the Insible for ordering It were 7 pills remaining in It rewere 7 pills remaining in It resident #8's Senna Plus It to check the back-up It in the medication room to the facility of the medicatio	D 358			
	Interview with the Ass	istant Resident Care				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			_		l R-	c
		HAL047015	B. WING			6/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE CREEKS CROSSING		TTEVILLE ROA	AD		
	Т	RAEFORD,	NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 26	D 358			
	revealed: -The MAs were responsed in the MAs were responsed in the MARS each week to were available for adriff medications were in the MAs should check medication roomResident #8's Sennation available for administ interview with the Adriff a medication was used in the MARS with the MARS and the MARS with the MARS with the MARS and the MARS with the MARS and the MARS with the MARS and the MARS with the	dications on hand with the make sure medications ministration.  not in the medication cart, the back up supply in the Plus should have been ration.  ministrator on 03/05/24 at unavailable during a MA should notify the ARCC, inator (RCC), or the Memory				
		interview with the resident's (PCP) on 03/06/24 at ssful.				
	resident was suppose a scheduled dose, no could cause the resid more likely to have ar  I. Review of Resident 02/01/24 revealed an give 1 capsule every (Virt-Caps softgel is a	at 4:29pm revealed if the ed to receive Senna Plus as it receiving the Senna Plus ent to have constipation and in impaction.  #8's current FL-2 dated order for Virt-Caps softgel				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	32.2.23		A. BUILDING: _			
		HAL047015	B. WING		R- 03/0	C <b>6/2024</b>
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
MICKELIE	DE CREEKS CROSSING	8398 FAYE	TTEVILLE ROA	AD		
WICKSHIP	RE CREEKS CROSSING	RAEFORD	, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	27	D 358			
	increased amounts of such as kidney diseas	f Vitamin B supplements, se.)				
	(PCP) visit dated 02/0	8's primary care provider 05/24 revealed: mitted to the facility on				
	o1/30/24.  -The resident was admitted to the facility off o1/30/24.  -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:					
	8:00am to Resident #	dications scheduled for 8 at 9:54am.				
	to the resident when s morning medications.					
	-Virt-Caps were not a	dministered as ordered.				
		ent #8's medications on 2:11pm revealed there were e for administration.				
	Review of Resident # medication administrative revealed:	8's March 2024 electronic ation record (eMAR)				
	capsule every day for 8:00am.	or Virt-Caps softgel give 1 supplement scheduled for				
	-Virt-Caps softgel was administered from 03, "needs to be ordered"	/01/24 - 03/05/24 due to				
	Interview with Reside 12:55pm revealed: -She went to dialysis -She was not sure if s she had missed any o	three times a week. she received Virt-Caps or if				

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AND PLAN OF CORRECTION	) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
, and i contact on the contact of th	DERTII TOTATON NOMBER.	A. BUILDING: _			
	HAL047015	B. WING		R-C <b>03/06/2024</b>	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIRE CREEKS CROSSING	8398 FAYE	TTEVILLE ROA	AD		
WICKSTINE CKEEKS CKCSSING	RAEFORE	), NC 28376		1	
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
D 358 Continued From page 28		D 358			
Interview with the MA on revealed: -She did not administer Fithat morning, 03/05/24, b medication cartThe MAs were responsit medications when there with the supplyShe was not sure if Resibeen orderedShe had not had time to supply of medications in the see if there was any avail.  Telephone interview with at the facility's contracted at 3:26pm revealed: -Resident #8 was a new son 01/30/24The pharmacy had not be dispense any Virt-Caps was a non-coversident's insuranceThe pharmacy faxed the the non-coverage for Virt-The pharmacy did not he about Virt-Caps until 03/01The facility requested at Virt-Caps be dispensed of facility was going to pay of Virt-Caps.  Interview with the Assistat Coordinator (ARCC) on 01 revealed: -The MAs were responsite medicationsShe checked the medical	Resident #8's Virt-Caps recause it was not in the cole for ordering were 7 pills remaining in dent #8's Virt-Caps had check the back-up the medication room to lable.  a pharmacy technician I pharmacy on 03/06/24 admission to the facility been requested to intil 02/26/24. Wered medication by the efacility to notify them of -Caps on 02/26/24. Part back from the facility 05/24. To-day supply of on 03/05/24 and the out-of-pocket for the out-of-pocket for the one of the ordering one of the ordering one of the ordering of the	D 336			

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were available for administration.

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL047015	B. WING		R-C 03/06	) 6/2024
WICKSHIRE CREEKS CROSSING 8398 FAYE			DRESS, CITY, STA	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	the MAs should check medication room.  -She was not aware Food not available for admit 03/05/24  -She contacted the fat today, 03/05/24, about -The resident's insural virt-Caps.  -They would notify the Virt-Caps.  Interview with the Adrit-Caps and to a condition of the virt-Caps and to a condition of the virt-Caps are sident Care Coord Care Director (MCD).  -The MA should immedication was used in the medication room.  Attempted telephone PCP on 03/06/24 at 4  Telephone interview with the virting virt-Caps are sident to have vitant m. Review of Resider 02/01/24 revealed an Bicarbonate 650mg to Godium Bicarbonate slow the rate of declired in the virting vi	Resident #8's Virt-Caps were nistration until today, cility's contracted pharmacy at Resident #8's Virt-Caps. Ince would not pay for the resident's provider about ministrator on 03/05/24 at anavailable during a MA should notify the ARCC, inator (RCC), or the Memory ediately check the back-up and during the medication pass on was available in the interview with the resident's :18pm was unsuccessful.  With the PCP's on call at 4:29pm revealed not a ordered could cause the nin deficiencies.  In #8's current FL-2 dated order for Sodium ake 1 tablet 3 times a day, is a supplement that may	D 358			

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(PCP) visit dated 02/05/24 revealed:

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STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL047015	B. WING		R-C 03/06/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE CREEKS CROSSING		ETTEVILLE ROA	AD		
		RAEFOR	D, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	Ξ
D 358	Continued From page	e 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					
	-Sodium Bicarbonate administered from 03 03/01/24 and 03/04/2 resident was out of th -Sodium Bicarbonate administered at 8:00a 03/05/24 due to "orde	/01/24 - 03/04/24 except on 4 at 2:00pm when the le facility. was documented as not am on 03/04/24 and ering the medication".				
	Interview with the MA revealed:	three times a week.				

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Bicarbonate that morning, 03/05/24, because it

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	
			A. BOILDING	<del></del>	D.0
		HAL047015	B. WING		R-C <b>03/06/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
MICKELII	RE CREEKS CROSSING	8398 FAY	ETTEVILLE ROA	AD	
WICKSHII	NE CREEKS CROSSING	RAEFOR	D, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	31	D 358		
	was not in the medical-The MAs were responsed in the supply.  She was not sure if Figure Bicarbonate had been supply of medications see if there was any at the facility's contral at 3:26pm revealed:  Resident #8 was a non 01/30/24.  The pharmacy disperbication bicarbonate tablets (002/27/24 and they we 02/27/24.  There should still be	ation cart. Insible for ordering Fre were 7 pills remaining in Resident #8's Sodium In ordered. In the medication room to available.  With a pharmacy technician cted pharmacy on 03/06/24  The wew admission to the facility Inseed 90 Sodium			
	revealed: -The MAs were responsed in the MAs were responsed in the MAR each week to were available for adulif medications were the MAs should check medication roomResident #8's had a Bicarbonate in the barmedication room.	on 03/05/24 at 2:42pm onsible for ordering dications on hand with the make sure medications ministration. not in the medication cart, at the back up supply in the supply of Sodium ck up supply in the checked the back up supply edication pass and			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or Connection	IDENTIFICATION NOWIDEN.	A. BUILDING: _		OOMII LETED
		HAL047015	B. WING		R-C 03/06/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MICKSHIE	RE CREEKS CROSSING	8398 FAYE	TTEVILLE ROA	AD	
WICKSHII	NE CREEKS CROSSING	RAEFORD,	NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 32	D 358		
D 358	4:02pm revealed: -If a medication was a medication pass, the Resident Care Coord Care Director (MCD)The MA should immedication to see if the medication room.  Attempted telephone PCP on 03/06/24 at 4  Telephone interview a provider on 03/06/24 receiving Sodium Bicacause the resident to balancing bicarbonate on Review of Residen 01/07/24 revealed: -Diagnoses included in neurocognitive disord and hyperlipidemiaThere was an order a tablet twice a day. (Diagnose medication of the 8:03/06/24 revealed: -The medication aide medications for Residen Depakote DR 250mgThe MA crushed all of the control of the o	unavailable during a MA should notify the ARCC, inator (RCC), or the Memory ediately check the back-up and during the medication pass on was available in the interview with the resident's with the PCP's on call at 4:29pm revealed not arbonate as ordered could have acid-base issues with and carbon dioxide.  It #9's current FL-2 dated frontotemporal ler, essential hypertension, for Depakote DR 250mg 1 Depakote DR is a dication that can be used to  000am medication pass on  (MA) prepared morning dent #9, including one	D 358		
	whole cup of yogurt a spoonful from the top resident at 8:34am.	nd administered one of the yogurt cup to the			

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STATE FORM 6899 ERJT11 If continuation sheet 33 of 96

Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
			_			_
					R-	
		HAL047015	B. WING	<del></del>	03/0	6/2024
	20,4252 02 0422452	070557.0	DD500 01TV 074	TE 710 0005		
NAME OF P	ROVIDER OR SUPPLIER	STREETAD	DRESS, CITY, STA	ALE, ZIP CODE		
MICKSHIE	RE CREEKS CROSSING	8398 FAYE	TTEVILLE RO	AD		
WICKSIIII	NE ONLENS ONOSSING	RAEFORE	), NC 28376			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
D 050	0 :	00	D 050			
D 358	Continued From page	33	D 358			
	-There were nieces o	f crushed pills left around				
	•	cup and in the yogurt inside				
		sup and in the yogurt inside				
	the cup.					
	, ,	rt cup on the table beside				
	the resident's breakfa	st plate and walked out of				
	the dining room.					
	-At 9:04am, a second	MA assisted Resident #9				
	with her breakfast inc	luding feeding the yogurt				
	with crushed medicat	ions to the resident.				
	Observation of Residen	ent #9's medications on				
	hand on 03/06/24 at 1					
		of Depakote DR 250mg				
	tablets dispensed on					
	_	on the label not to crush or				
	chew the medication,	swallow whole.				
		9's March 2024 electronic				
	medication administra	ation record (eMAR)				
	revealed:					
	-There was an entry f	or Depakote DR 250mg 1				
	tablet two times a day	/ for mood stabilization				
	scheduled for 8:00am	and 4:00pm.				
		ocumented as administered				
	from 03/01/24 - 03/05					
		ation noted on the eMAR to				
		on should not be crushed.				
		or may crush appropriate				
		osules if not contraindicated				
	every shift for swallov	•				
	-Staff documented the					
		hift, evening shift, and night				
	shift from 03/01/24 - 0	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 caps					
		of a Do Not Crush (DNC) list				
		ned to use a DNC list before				
	and had not been trai	HEA TO USE A DIMO HELLING	1			1

Division of Health Service Regulation

STATE FORM 6899 ERJT11 If continuation sheet 34 of 96

DIVISION	n Health Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
					5	
		1141 047045	B. WING		R-C	
		HAL047015			03/06	5/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		8398 FAYF	TTEVILLE ROA	ΔD		
WICKSHIP	RE CREEKS CROSSING	RAEFORD		_		
			110 20070			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	•	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 050	0 " 15	0.4	D 050			
D 358	Continued From page	÷ 34	D 358			
	crushing medications					
	•	e warning label on the				
	Depakote DR packag					
	medication should no	_				
	medication should no	t be crushed.				
	Review of the facility's	s DNC medication list				
	-	R was included on the list as				
	a medication that sho					
	a medication that sho	uid flot be crusiled.				
	Interview with the Me	mory Care Director (MCD)				
	on 03/06/24 at 12:57p					
		t in each notebook on each				
	medication cart.					
		d to check the DNC list prior				
	to crushing medicatio					
	-Resident #9's Depak	ote DR should not be				
	crushed.					
		crushed, the MAs were				
	supposed to mix the	crushed medications in a				
	small amount of apple	esauce or yogurt in the				
	plastic medication cup	o to make sure all of the				
	crushed medications	were administered.				
	-Once the MAs admir	nistered crushed				
	medications from the	small plastic medication				
		MAs were supposed to				
	•	sh can on the medication				
	cart.	on dan on the medication				
		CU were confused so				
		ot be left unattended with				
		ot be left unattended with				
	any resident.					
	Interview with the Adr	ninistrator on 03/06/24 at				
		ninistrator on 03/06/24 at				
	1:09pm revealed:	4				
		t on each medication cart.				
		ck the DNC list prior to				
	crushing medications					
		erve each resident take				
	their medication.					
			I			

Division of Health Service Regulation

Attempted telephone interview with the resident's

STATE FORM 6899 ERJT11 If continuation sheet 35 of 96

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7.1.12 . 2.1.1		.52	A. BUILDING: _		
		HAL047015	B. WING		R-C 03/06/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
MICKELL	RE CREEKS CROSSING	8398 FAYE	ETTEVILLE ROA	AD	
WICKSHIP	RE CREEKS CROSSING	RAEFORE	), NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 35	D 358		
	primary care provider 4:18pm was unsucce	(PCP) on 03/06/24 at ssful.			
	Telephone interview v provider on 03/06/24				
	-Depakote DR should				
	-Crushing Depakote [				
		ased immediately so the			
	medication would not last as long in the resident's system which could cause the resident to have increased agitation.				
		ns, interviews, and record ined that Resident #9 was			
	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.)				
	03/06/24 revealed:	00am medication pass on			
	purple cap on the Mira				
	• .	rinted near the top of the arrow pointing up to indicate			
		17g was at the top of the			
	white section inside the	ne cap.			
		(MA) poured the Miralax			
	powder halfway below dose.	v the marking for the 17g			
		sure the Miralax correctly			
		as not mixed in the cup of			
	water.				
	-The MA mixed the M	iralax powder in water and			

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Division	of Health Service Regu	lation r			T	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R-C	
		HAL047015	B. WING		03/06/2024	
					1 00.00.00	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	•		
WICKSHIE	RE CREEKS CROSSING		ETTEVILLE ROA	AD		
		RAEFOR	D, NC 28376		<u>.                                      </u>	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	()	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		
IAG			IAG	DEFICIENCY)		
	–		B 050			
D 358	8 Continued From page 36		D 358			
	administered it to Res	sident #9 at 8:34am.				
	-The resident drank a	ıll of the water with Miralax.				
		9's March 2024 electronic				
	medication administra	ation record (eMAR)				
	revealed:					
	_	for Miralax give 17gm (1				
		y for constipation scheduled				
	for 8:00am.					
		nted as administered daily				
	from 03/01/24 - 03/05	0/24.				
	Interview with the MA	on 03/06/24 at 12:32pm				
	revealed:	τοπ 05/00/24 at 12.52μm				
		king to measure the Miralax				
	_	e "17" imprinted on the inside				
	of the cap.					
	•	e arrow pointing to the top of				
		as the mark for 17gm.				
	-She did not realize s	he had been measuring the				
	Miralax incorrectly.					
	-The resident had not	t complained of any				
	constipation issues to	her.				
		0 5: ( (2.25)				
		mory Care Director (MCD)				
	on 03/06/24 at 12:57					
	to measure the correct	the cap of the Miralax bottle				
		ct dosage. d any reports of Resident #9				
		sues with constipation.				
		Table Mar Corresponding				
	Interview with the Adr	ministrator on 03/06/24 at				
		MAs had been trained to				
	•	alax bottle to measure the				
	Miralax Powder.					
	Attempted telephone	interview with the resident's				
		(PCP) on 03/06/24 at				
	4:18pm was unsucce	ssful.				

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STATE FORM 6899 ERJT11 If continuation sheet 37 of 96

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R-C
		HAL047015	B. WING		03/06/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
WICKSHIE	RE CREEKS CROSSING	8398 FAYE	ETTEVILLE ROA	AD	
RAEFORI			), 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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 37	D 358		
	resident did not get th	vith the PCP's on call at 4:29pm revealed if the ne full dose of Miralax, it ne in treating the resident's			
	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.				
	01/18/24 revealed an	2's physician's order dated order for Omeprazole 20mg prazole is used to treat lux disease.)			
	Review of Resident # 02/12/24 revealed:	2's physician's orders dated			
	02/12/24 revealed: -There was an order to discontinue Omeprazole 20mg every morningThere was an order to start taking Omeprazole 10mg 1 capsule every morning starting on 02/13/24				
	medication administrative revealed: -There was an entry for capsule in the morning at 8:00amOmeprazole 20mg wadministered daily frought -There was an entry for capsule one time a data	for Omeprazole 20mg 1 g for acid reflux scheduled ras documented as m 02/01/24 - 02/14/24. for Omeprazole 10mg 1 ay for gastroesophageal			
	reflux disease with a s	start date documented as			

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STATE FORM 6899 ERJT11 If continuation sheet 38 of 96

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7.1. 20.25.1.to.			R-C
		HAL047015	B. WING		l	8/06/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MICKELIII	DE COEEKS COOSSING	8398 FAY	ETTEVILLE ROAD	)		
WICKSHII	RE CREEKS CROSSING	RAEFOR	D, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 38	D 358			
	administered at 8:00a	vas documented as not am from 02/15/24 - 02/20/24 'not on the cart" and "on				
		interview with the resident's ovider on 03/06/24 at 3:50pm				
	summary (AVS) dated 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					
		sophageal reflux disease.)				
	revealed:	nt #2 on 03/05/24 at 1:05pm  ved a medication for acid				
	reflux every day.	e had missed any doses of				
	acid reflux medication					
	having any symptoms					
	Interview with the Ass Coordinator (ARCC)	sistant Resident Care on 03/05/24 at 2:42pm				
	revealed: -The MAs were respo	onsible for ordering				
	MAs should notify her Coordinator (RCC).	unavailable or on order, the r or the Resident Care				
		osed to double check the lke sure medications were				

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STATE FORM 6899 ERJT11 If continuation sheet 39 of 96

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING			
		HAL047015	B. WING		l l	R-C <b>06/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
WICKSHII	RE CREEKS CROSSING		ETTEVILLE RO	AD		
	QUILLEN/ QT		D, NC 28376	DD0//DEDIG D/ AV	05.00005071011	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	39	D 358			
	available when admir	istering medications.				
	4:02pm revealed: -If a medication was r the MAs should notify Memory Care Directo -The RCC, ARCC, or the MAs to see if the or the back-up supply -The ARCC did a wee out of 10", the medica  Attempted telephone primary care provider 4:18pm was unsucce  Telephone interview w provider on 03/06/24 general missing dose reflux could increase gastrointestinal irritati	r (MCD). MCD would check behind medication was in the cart checkly cart audit and "9 times ations were available.  interview with the resident's (PCP) on 03/06/24 at ssful.  with the PCP's on call at 4:29pm revealed in s of medications for acid the resident's risk of on and precipitate the				
	11/16/23 revealed dia progressive supranuo secondary Parkinsonia. Review of Residen dated 01/11/24 revea Apixaban oral tablet 2 (used to treat blood concept of Review of Resident # medication administrative revealed:	t #1's current FL-2 dated gnoses included clear ophthalmoplegia, sm and spinal stenosis.  t #1's physician's orders led there was an order for 2.5mg 1 tablet 2 times a day lots).  1's February 2024 electronic ation record (eMAR)  or Apixaban oral tablet is a day scheduled for				

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STATE FORM 6899 ERJT11 If continuation sheet 40 of 96

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3			
			A. BUILDING:			
		HAL047015	B. WING			R-C 3/06/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
		8398 FAY	ETTEVILLE ROAD	1		
WICKSHII	RE CREEKS CROSSING		D, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 40	D 358			
		-				
	exception report reve -The exception for the tablet 2.5mg at 9:00a was "on order"There was no exception	1's February 2024 facility aled: 9 09 entry for Apixaban oral m on 02/05/24 and 02/06/24 tion listed for the 09 entry for 2.5mg on 02/13/24 for the				
	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 timeHe had not missed any medications.					
	(RCC) on 03/06/24 at -The medication aide ordering medicationsThe Assistant Reside (ARCC) did cart audit -Medications were to down to a 7 to 10 day -If family provided the give 14 days notice of familyThe MA was suppose pharmacy if the medication aide within two days.	(MA) was responsible for ent Care Coordinator s weekly. be ordered when they were				

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Division o	Division of Health Service Regulation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	≣TED
						0
			B. WING		R-C	
		HAL047015	B. WING		03/0	6/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE. ZIP CODE		
			, ,	,		
WICKSHIF	RE CREEKS CROSSING		TTEVILLE ROA	AD		
		RAEFORD	), NC 28376			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	JAIE	DAIL
D 358	Continued From page	e 41	D 358			ı
						ı
	they got the medication	on from the facility's				ı
	contracted pharmacy	and paid for it.				ı .
	-"On order" meant the	e medication had been				ı
	ordered, they were a	waiting arrival and it had not				ı .
	been administered for	•				ı
		een an explanation for any				ı
	entry that was docum					ı
		nind the MA on a daily basis.			ļ	ı
	-She was not aware F	•				ı
		an on 02/05/24, 02/06/24 and				ı
	02/13/24.	111 011 02/03/24, 02/00/24 and				ı
		······································				ı
	**	ver out of his medications.				ı
		y the medication was not				ı
	administered.					ı
		sted as Eliquis on the bottle				ı
	so the MA may not ha	ave known they were the				ı
	same.					ı
	-Resident #1's family	member was supposed to				ı
	bring all his medication	ons but was having difficulty				ı
	with the outside phare	macy.				ı
	-When family was una					ı
	medication, the facility					ı
		contracted pharmacy and				ı
	the facility would pay					ı
		agreed to allow the facility to				ı
	,	from the facility's contracted				ı
	pharmacy and she we					ı
		Julu pay.				ı
	Intonvious with the AR	CC on 03/06/24 at 11:30am				ı
	revealed:	GC 011 03/00/24 at 11.30am				ı
		-U-I - fan andarina				ı
	-The MA was respons	sible for ordering				I
	medications.					1
	-She did cart audits w					I
		nind the MA on a daily basis.				I
	-The resident was ne	ver out of his medications.				I
	-She was not aware F	Resident #1 was not				I
	administered Apixaba	an on 02/05/24, 02/06/24 and				1
	02/13/24.					1

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administered.

-She did not know why the medication was not

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DIVISION	n nealth Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
			D MINIO		R-0	
		HAL047015	B. WING		03/0	6/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZIP CODE		
01 11						
WICKSHIP	RE CREEKS CROSSING		TTEVILLE ROA	4U		
		RAEFORD	, NC 28376			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	REGULATORT OR L	GO DENTIFTING INFORMATION)	TAG	DEFICIENCY)	IMIE	DATE
				,		
D 358	Continued From page	: 42	D 358			
	-The Apixaban was lis	sted as Eliquis on the bottle				
	-	ave known they were the				
	same.					
		nt Resident #1's family a				
		luded all of the prescription				
	-	at medications needed to be				
	refilled.	at modications needed to be				
		nt #1's family responded				
		nt #1's family responded				
	stating she was unab	ie to obtain 2 of the				
	medications.	15 :1 ( #41 6 :1 #				
		ked Resident #1's family the				
		ons she was unable to				
		ıld get the primary care				
		e a prescription that would				
	_	tain the medication from				
	their contracted pharr	nacy. (The medication				
	names were not listed	d in the message.)				
	Interview with the Adr	ninistrator on 03/06/24 at				
	1:00pm revealed:	3				
	-The MA was respons	sible for ordering				
		medication reached a 7 to				
		medication reached a / to				
	10 day supply.	ested to check the				
	-The ARCC was expe					
	• • •	en she did the cart audit				
	weekly.	manadianation than the second				
	• •	medication, they should				
		nen there was a 7 to 10 day				
	supply left.					
		meant the medication had				
	been ordered and wa					
	-The MA should have					
	whatever the exception of "09".	on was if they used the code				
		n that the MA checked the				
	cart thoroughly as we					
		ed to the RCC and ARCC				
	regarding unavailable					
		an out the MA was to call				

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the pharmacy to get the medication refilled, report

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL047015	B. WING			R-C 3/06/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
WICKSHII	RE CREEKS CROSSING		YETTEVILLE ROAD RD, NC 28376	)		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	to a supervisor (RCC their efforts to get the The MA was to follow until the medication would family did not provide timely manner, they would contracted pharmacy for the medication.  The RCC and the AF contacting the facility within 24 hours of the medication.  She was not aware administered Apixaba 02/13/24.  She did not know who was not administered Apixaba 02/13/24.  Telephone interview who the PCP on 03/06/24 doses of Apixaban in blood clots.  b. Review of Resider dated 01/11/24 revea Dulaglutide subcutan 1.5mg/0.5ml inject 1. a day every Wedness Review of Resident # medication administrative and the subcutan of Resident # medication administrative was an entry subcutaneously solutinject 1.5mg subcutal inject 1.	and ARCC) and document medication.  Wup daily with the pharmacy was obtained ide the medication in a would order from the facility's and the facility would pay  RCC were responsible for 's contracted pharmacy family not providing the Resident #1 was not an on 02/05/24, 02/06/24 and any Resident #1's medication with the on-call provider for at 4:16pm revealed missed creased the resident's risk of the third three was an order for eously solution pen-injector 5mg subcutaneously 1 time day (used to treat diabetes).  Et's February 2024 electronic ation record (eMAR)  for Dulaglutide ion pen-injector 1.5mg/0.5ml	D 358			

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or doring of the second of the	IDENTIFICATION NOMBER.	A. BUILDING: _		
		HAL047015	B. WING		R-C 03/06/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
WICKSHIE	RE CREEKS CROSSING		TTEVILLE ROA	AD	
		RAEFORD	NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTE
D 358	Continued From page	e 44	D 358		
	-There was an entry o	of 09 for Dulaglutide ion pen-injector 1.5mg/0.5ml			
	exception report reve -There was no exception Dulaglutide subcutant 1.5mg/0.5ml on 02/2 -The exception for the	tion listed for the 09 entry for eously solution pen-injector 1/24. e 09 entry for Dulaglutide ion pen-injector 1.5mg/0.5ml			
	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.				
	Dulaglutide) but was medications he tookHe had never experi	d 5:10pm revealed: ns on time. ny medications. licity (brand name for			
	person on 03/05/24 a -She picked Resident outside pharmacyThere was a distribut Resident #1's pharma -She was not aware of any medications.	#1's medication up from an			

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Division c	Division of Health Service Regulation					
	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					5.0	
			B WING		R-C	
		HAL047015	B. WING		03/06/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STAT	TE. ZIP CODE		
			ETTEVILLE ROA			
WICKSHIF	RE CREEKS CROSSING			AD .		
			D, NC 28376			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	()	
PREFIX	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		۱ ا
TAG		230 IDENTIFIEND INFORMATION	TAG	DEFICIENCY)	IAIE	
			+	-		$\dashv$
D 358	Continued From page	e 45	D 358			
	medications.					
		posed to inform her 2 weeks				
		nt #1 needing medication				
	refills.					
	I					
	Interview with a medi	` ,				
ļ	03/06/24 at 9:40am re	evealed:				
	-She went to the Res	ident Care Coordinator				
	(RCC) to request insu	ulin when there were 4				
ļ	insulin pens left.					
	-	sulin refill once for Resident				
	•	it was not available in				
		d not recall whether or not				
	she noticed any other					
	unavailable.	modications some				
	diavallabio.					
	Interview with the RC	CC on 03/06/24 at 11:30am				
	revealed:	0 011 00/00/24 at 11.00am				
	-The MA was respons	sible for ordering				
	medications.	able for ordering				
	-The Assistant Reside	ant Cara Coordinator				
	(ARCC) did cart audit	be ordered when they were				
	down to a 7 to 10 day	· · · · ·				
		e medications, they tried to				
	,	of the need for a refill to the				
	family.					
		ed to follow up with the				
		cation was not received				
	within two days.					
ļ		ide the medication on time,				
	they got the medication					
	contracted pharmacy	•				
		e medication had been				
	ordered, they were a	waiting arrival and it had not				
	been administered for	r that day.				
	-There should have b	peen an explanation for any				
	entry that was docum					
		nind the MA on a daily basis.				

-She was not aware Resident #1 was not

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Division	Division of Health Service Regulation					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
			_		_	
			B. WING		R-C	
		HAL047015	B. WING		03/0	6/2024
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZIP CODE		
TO THE OT THE	TO VIDER OR OUT FIER					
WICKSHIF	RE CREEKS CROSSING		TTEVILLE ROA	AD		
		RAEFORD	, NC 28376			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG REGULATORY OR LS		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RIATE	DATE
				DEI IOIENOT)		
D 358	Continued From page	e 46	D 358			
	Continuou i ioni page	3 10				
	administered Dulaglu	tide on 02/21/24 and				
	02/28/24.					
	-Resident #1 was nev	er out of his medications.				
	-She did not know wh	ry the medication was not				
	administered.	•				
	-Resident #1's family	member was supposed to				
		ons but was having difficulty				
	with the outside phar					
	-The missed Dulaglut					
	possibly been due to					
		le to obtain the medication.				
	•					
	-When family was una					
	medication, the facility					
		contracted pharmacy and				
	the facility would pay					
		agreed to allow the facility to				
		from the facility's contracted				
	pharmacy and she wo	ould pay.				
	lakan dan dalam dalam A.D.	00 00/00/04 - 4.44-00				
	revealed:	CC on 03/06/24 at 11:30am				
		- United from a contraction of				
	-The MA was respons	sible for ordering				
	medications.					
	-She did cart audits w	•				
		ind the MA on a daily basis.				
		ver out of his medications.				
	-She was not aware F					
	administered Dulaglu	tide on 02/21/24 and				
	02/28/24.					
	-She did not know why the medication was not					
	administered.					
	-On 02/07/24, she se	nt Resident #1's family a				
		luded all of the prescription				
		at medications needed to be				
	refilled.					
		ent #1's family responded				
	stating she was unab					
	-	IE IO ODIAIII Z OI IIIE				
	medications.		1			

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-On 02/08/24, she asked Resident #1's family the name of the medications she was unable to

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER'S AND PLAN OF CORRECTION IDENTIFICATION		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
•	2		A. BUILDING: _			
		HAL047015	B. WING		R-C 03/06/2	024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		8398 FAYI	ETTEVILLE ROA	AD		
WICKSHIF	RE CREEKS CROSSING	RAEFORI	D, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE C	(X5) COMPLETE DATE
D 358	Continued From page	· 47	D 358			
	provider (PCP) to writ allow the facility to ob their contracted pharr were not identified.)	uld get the primary care e a prescription that would tain the medication from nacy. (The medications				
	Interview with the Administrator on 03/06/24 at 1:00pm revealed: -The MA was responsible for ordering					
		medication reached a 7 to				
	<ul><li>10 day supply.</li><li>-It was also the expect</li></ul>	tation that the ARCC				
		on supply when she did the				
	cart audit weekly.	,				
		medication, they should				
	supply left.	nen there was a 7 to 10 day				
	-"On order" probably been ordered and wa	meant the medication had some some some some some some some some				
	-The MA should have					
	whatever the exception of "09".	on was if they used the code				
	-The MA was expected thoroughly as well as and talk to the RCC a	the overstock medications				
	unavailable medication	9 9				
		he medication refilled, report				
		and ARCC) and document				
	their efforts to get the					
	-The MA was to follow	up daily with the pharmacy				
	until the medication w					
		de the medication in a				
		ould order from the facility's				
		and the facility would pay				
	for the medication.	ICC ware recognible for				
		RCC were responsible for scontracted pharmacy				
	-	family not providing the				

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medication.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			74. BOILBING			С
		HAL047015	B. WING		1	6/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE CREEKS CROSSING		TTEVILLE ROA	AD		
		RAEFORD,	NC 28376		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	<del>2</del> 48	D 358			
D 358	-She was not aware F administered Dulaglut 02/28/24She did not know wh was not administered -Checking behind the medication audit which twice a week.  Telephone interview with e PCP on 03/06/24 doses of Dulaglutide a sugar and increased to that measures average past 3 months).  c. Review of Resident dated 01/11/24 reveal Losartan potassium of time a day (used to treat the transport of the the potassium oral tablet order".	Resident #1 was not tide on 02/21/24 and by Resident #1's medication  MA was the function of the sh would now be conducted with the on-call provider for at 4:16pm revealed missed affected the weekly blood the Hemoglobin A1C (test ge blood sugar levels over at #1's physician's orders led there was an order for oral tablet 100mg 1 tablet 1 teat hypertension).  1's February 2024 electronic ation record (eMAR)  For Losartan potassium oral 1 time a day scheduled for tam.  10f 09 for Losartan potassium 02/06/24 and 02/24/24.  1's February 2024 facility aled:  209 entry for Losartan 100mg on 02/06/24 was "on tion listed for the 09 entry for total time and tion listed for the 09 entry for total time and tion listed for the 09 entry for total time and tion listed for the 09 entry for total time and tion listed for the 09 entry for total time and time a	D 358			
	02/24/24.	ent #1's medications on				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED	
		HAL047015	B. WING			R-C 3/06/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	·	
14/10/2011		8398 FAY	ETTEVILLE ROA	AD		
WICKSHI	RE CREEKS CROSSING	RAEFORI	D, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	bottle of Losartan pot dispensed with 90 tab.  Interview with Reside 9:40am, 10:50am and He got his medication. He had not missed a He knew what it felt I pressure and had not pressure since being.  Telephone interview with person on 03/05/24 a She picked Resident outside pharmacy. There was a distributing Resident #1's pharma She was not aware of any medications.  Resident #1 should medications.  The facility was suppin advance of Resider refills.	2:22am revealed there was a assium oral tablet 100mg blets on 01/17/24.  Int #1 on 03/06/24 at the discrepance of time. In y medications. It is to have high blood experienced high blood at the facility.  In the facility.  In the facility of the facility of the facility of the facility.  In the facility of the facilit	D 358			
	ordering medicationsThe Assistant Reside (ARCC) did cart audit -Medications were to down to a 7 to 10 day -If family provided the give 14 days notice of family.	(MA) was responsible for ent Care Coordinator s weekly. be ordered when they were a supply. I medications, they tried to f the need for a refill to the				
		ed to follow up with the cation was not received				

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within two days.

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
	HAL047015	B. WING		R-C <b>03/06/2024</b>
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
MICKELLIDE ODEEKS ODGESING	8398 FAYE	TTEVILLE ROA	AD	
WICKSHIRE CREEKS CROSSING	RAEFORD	, NC 28376		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 358 Continued From pag	e 50	D 358		
-If family did not provided they got the medicate contracted pharmacy. "On order" meant the ordered, they were a been administered for There should have entry that was docure. No one checked be she was not aware administered Losarta. Resident #1 was need she was not know we administered.  -Resident #1's family bring all his medication with the outside phare. When family was ure medication, the facility would pay resident #1's family order the medication pharmacy and she we will like the facility with the AF revealed:  -The MA was responsed to the medications.  -She did cart audits we have administered Losart 02/24/24.  -She did not know we administered.	vide the medication on time, ion from the facility's and paid for it. The medication had been awaiting arrival and it had not or that day. The medication for any mented as "09". The medication for any mented as "09". The medication is an on 02/06/24 and 02/24/24. The medication was not an on 02/06/24 and 02/24/24. The medication was not are member was supposed to ons but was having difficulty macy. The medication the recontracted pharmacy and are for it. The medication was not agreed to allow the facility to from the facility's contracted arould pay.  The medication on time, in the facility to from the facility's contracted arould pay.  The medication on time, in the facility to from the facility's contracted arould pay.  The medication on time, in the facility to from the facility's contracted arould pay.  The medication on time, in the facility to from the facility's contracted arould pay.  The medication on time, in the facility to from the facility's contracted arould pay.  The medication on time, in the facility to from the facility's contracted arould pay.  The medication on time, in the facility to from the facility to from the facility's contracted arould pay.  The medication on time, in the facility to from the facility to from the facility is contracted arould pay.  The medication on time, in the facility is an intervention of the facility is contracted around the fac			

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text message that included all of the prescription numbers to show what medications needed to be

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		1141 047045	B. WING		R-(	
		HAL047015	B. WIIVO		03/0	6/2024
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
WICKSHIRE CREEKS CROSSING			TTEVILLE RO	AD		
			, NC 28376		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 51	D 358			
D 358	refilledOn 02/08/24, Reside stating she was unable medicationsOn 02/08/24, she asle name of the medicatic obtain so that she couprovider (PCP) to write allow the facility to obtheir contracted pharm were not identified.)  Interview with the Adresse of the medications once the 10 day supplyIt was also the expectate audit weeklyIf family provided the have been notified who supply left"On order" probably been ordered and was the exception of "09"The MA was expected thoroughly as well as and talk to the RCC as unavailable medicationWhen a medication of the pharmacy to get the to a supervisor (RCC their efforts to get the -The MA was to follow.	ant #1's family responded le to obtain 2 of the le ked Resident #1's family the cons she was unable to all get the primary care the a prescription that would tain the medication from macy. (The medications ministrator on 03/06/24 at sible for ordering medication reached a 7 to extation that the ARCC on supply when she did the extended ment there was a 7 to 10 day meant the medication had so not administered, been documenting on was if they used the code and to check the cart the overstock medications and ARCC regarding ons. If an out, the MA was to call the medication refilled, report and ARCC) and document medication. If you was in the pharmacy we paid to the pharmacy with the pharmacy	D 358			
	the pharmacy to get to to a supervisor (RCC their efforts to get the -The MA was to follow until the medication w	he medication refilled, report and ARCC) and document medication. v up daily with the pharmacy				

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timely manner, they would order from the facility's

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		_		R-C	
	HAL047015	B. WING		03/06/2024	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIRE CREEKS CROSSING	8398 FAYE RAEFORD,	TTEVILLE ROA NC 28376	AD		
PREFIX (EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
for the medication.  -The RCC and the AR contacting the facility's within 24 hours of the medication.  -She was not aware R administered Losartar -She did not know why was not administered -Checking behind the medication audit which twice a week.  Telephone interview where the PCP on 03/06/24 and doses of Losartan incomplyertension which conducted 01/11/24 reveal Metformin HCI oral table (used to treat diabetes).  Review of Resident #* medication administration and the second of the seco	and the facility would pay  CCC were responsible for a contracted pharmacy family not providing the Resident #1 was not an on 02/06/24 and 02/24/24. The provident was the function of the had would now be conducted with the on-call provider for at 4:16pm revealed missed reased the risk of bould lead to organ failure.  The physician's orders are there was an order for blet 500mg 2 times a day as an order for colet 500mg 2 times a day as an order for blet 500mg 2 times and a day and 8:00pm.  The physician HCl oral tablet scheduled for am and 8:00pm.  The open of the	D 358			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		
					R-C	
		HAL047015	B. WING		03/06/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
			ETTEVILLE RO			
WICKSHIP	RE CREEKS CROSSING	RAEFORI	D, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	E
D 358	Continued From page	: 53	D 358			
	· -	e 09 entry for Metformin HCl b:00am on 02/18/24 was "on				
	hand on 03/06/24 at 9 bottle of Metformin H	ent #1's medications on 0:22am revealed there was a Cl oral tablet 500mg 2 packs olets on 02/19/24 with 49 left d with 180 tablets on				
		l 5:10pm revealed: ns on time.				
	person on 03/05/24 a -She had no medicati behalfShe picked Resident outside pharmacyThere was a distribut Resident #1's pharma -She was not aware of any medicationsResident #1 should r medicationsThe facility was supp	#1's medication up from an				
	(RCC) on 03/06/24 at	(MA) was responsible for				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND I LAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _	<del></del>	JONII ELTEB
		HAL047015	B. WING		R-C <b>03/06/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
			ETTEVILLE ROA		
WICKSHII	RE CREEKS CROSSING		), NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 358	Continued From page	: 54	D 358		
	(ARCC) did cart audit -Medications were to down to a 7 to 10 day -If family provided the give 14 days notice of familyThe MA was suppose pharmacy if the medication within two daysIf family did not provithey got the medication contracted pharmacy -"On order" meant the ordered, they were aven been administered for -"Not on the cart" mean on the cart, had been arrival and it had not be dayIf the medication was should have requeste that they called the pithey borrowed the mean that it was not on the -No one checked beh -She was not aware F administered Metform 02/18/24Resident #1 was nevel -She did not know what administeredWhen family was una medication, the facility medication from their the facility would pay -Resident #1's family	be ordered when they were supply.  medications, they tried to f the need for a refill to the ed to follow up with the cation was not received de the medication on time, on from the facility's and paid for it. e medication had been vaiting arrival and it had not ordered, they were awaiting peen administered for that as not on the cart, the MA d a refill and documented that edication instead of saying cart. ind the MA on a daily basis. Resident #1 was not in HCl on 02/17/24 and the medication was not ordered. The medications was not ordered, they were awaiting peen administered for that a refill and documented that edication instead of saying cart. In the MA on a daily basis. Resident #1 was not in HCl on 02/17/24 and the obtain the could obtain the contracted pharmacy and for it. agreed to allow the facility to from the facility's contracted			

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Interview with the ARCC on 03/06/24 at 11:30am

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BUILDING: _		D 0	
	HAL047015	B. WING		R-C <b>03/06/2024</b>	
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
WICKSHIRE CREEKS CROSSING	8398 FAY	ETTEVILLE ROA	AD		
WICKSTINE CREEKS CROSSING	RAEFOR	D, NC 28376			
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 358 Continued From page 5	55	D 358			
revealed: -The MA was responsib medicationsShe did cart audits were. No one checked behinder the resident was nevered. She was not aware Restadministered Metforming 02/18/24She did not know why administeredOn 02/07/24, she sented text message that including the medicationsOn 02/08/24, Resident stating she was unable medicationsOn 02/08/24, she asked name of the medication obtain so that she could provider (PCP) to write allow the facility to obtain their contracted pharmat were not identified.)  Interview with the Adminditional contracted contracted contracted in the medications once the medication cart audit weeklyIf family provided the medication cart audit weeklyIf family provided the medication once the medication cart audit weeklyIf family provided the medication on the supply left.	ekly. d the MA on a daily basis. er out of his medications. esident #1 was not h HCl on 02/17/24 and the medication was not  Resident #1's family a ded all of the prescription medications needed to be #1's family responded to obtain 2 of the d Resident #1's family the es she was unable to d get the primary care a prescription that would in the medication from acy. (The medications  nistrator on 03/06/24 at  ole for ordering nedication reached a 7 to ation that the ARCC in supply when she did the				

Division of Health Service Regulation

-"Not on the cart" meant the medication was not

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STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL047015	B. WING		R-C <b>03/06/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZIP CODE		
			TTEVILLE ROA			
WICKSHIRE CREEKS CROSSING RAEFORI			NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	56	D 358			
D 336	on the cart but could be medications or overstand and talk to the RCC at unavailable medication.  The MA was expected thoroughly as well as and talk to the RCC at unavailable medication.  When a medication of the pharmacy to get the to a supervisor (RCC their efforts to get the asymptotic than the medication with the medication with the medication with the medication.  The RCC and the AR contacting the facility within 24 hours of the medication.  She was not aware administered Metform 02/18/24.  She did not know who was not administered decident the medication audit which the medication audit which the medication and the medication	have been in the backup cock medications. been documenting on was if they used the code and to check the cart the overstock medications and ARCC regarding ons. an out, the MA was to call the medication refilled, report and ARCC) and document medication. In up daily with the pharmacy was obtained de the medication in a would order from the facility's and the facility would pay  RCC were responsible for s contracted pharmacy family not providing the  Resident #1 was not hin HCl on 02/17/24 and by Resident #1's medication  MA was the function of the sh would now be conducted  with the on-call provider for at 4:16pm revealed missed Cl increased the t used to measure average er the past 3 months) and	D 336			

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					R-C	
		HAL047015	B. WING		03/06	6/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE CREEKS CROSSING		ETTEVILLE ROA	AD		
			), NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	<del>.</del> 57	D 358			
		led there was an order for capsule 0.4mg 1 time a day tention).				
	medication administrative revealed:					
	-There was an entry for Tamsulosin HCl oral capsule 0.4mg 1 time a day scheduled for administration at 8:00am.					
	capsule 0.4mg on 02/	of 09 for Tamsulosin HCl oral (22/24, 02/23/24, 02/24/24, 2/27/24, 02/28/24 and				
	exception report reve					
	•	e 09 entry for Tamsulosin ng on 02/22/24. 02/26/27 norder".				
	-There was no except	tion listed for the 09 entry for capsule 0.4mg on 02/23/24,				
	-The exception for the	e 09 entry for Tamsulosin ng on 02/28/24 was "not on				
	hand on 03/06/24 at 9	ent #1's medications on 0:22am revealed there was a Cl oral capsule 0.4mg 30 03/05/24 with 29 left.				
		d 5:10pm revealed: ns on time.				
	been no increased ur					

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DIVISION	n nealth Service Negu	ialion					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
					R-	C	
		HAL047015	B. WING		1	06/2024	
		11AE047013			1 03/0	0/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE			
14/10/10/11		8398 FAY	ETTEVILLE RO	AD			
WICKSHI	RE CREEKS CROSSING	RAEFOR	D, NC 28376				
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	 N	(X5)	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE	
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE	
				DEFICIENCY)			
D 358	Continued From page	÷ 58	D 358				
		sident Care Coordinator					
	(RCC) on 03/06/24 at						
		(MA) was responsible for					
	ordering medicationsThe Assistant Reside						
	(ARCC) did cart audit						
	down to a 7 to 10 day	be ordered when they were					
		medications, they tried to					
		f the need for a refill to the					
	family.	The fleed for a fellif to the					
		ed to follow up with the					
		cation was not received					
	within two days.	Cation was not received					
	_	de the medication on time,					
	they got the medication						
	contracted pharmacy						
		e medication had been					
		vaiting arrival and it had not					
	been administered for						
		ant the medication was not					
		ordered, they were awaiting					
	· ·	been administered for that					
	day.						
	-If the medication was	s not on the cart, the MA					
	should have requeste	ed a refill and documented					
	that they called the pl	narmacy or documented that					
	they borrowed the me	edication instead of saying					
	that it was not on the	cart.					
	-There should have b	een an explanation for any					
	entry that was docum	ented as "09".					
	-No one checked beh	ind the MA on a daily basis.					
	-She was not aware F	Resident #1 was not					
	administered Tamsulo	osin HCl on					
	02/22/24-02/29/24.						
	-Resident #1 was nev	er out of his medications.					
	-She did not know wh	y the medication was not					
	administered.						
		member was supposed to					
	bring all his medication	ons but was having difficulty					

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
			D. MINO		R-	_
		HAL047015	B. WING		03/0	6/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE CREEKS CROSSING		ETTEVILLE RO	AD		
			D, NC 28376			I
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 59	D 358			
	with the outside phare	macv.				
		isin HCl doses could have				
	possibly been due to					
		le to obtain the medication.				
	-When family was una					
	medication, the facility	y could obtain the contracted pharmacy and				
	the facility would pay					
		agreed to allow the facility to				
	order the medication from the facility's contracted					
	pharmacy and she we	ould pay.				
		CC on 03/06/24 at 11:30am				
	revealed: -The MA was respons	sible for ordering				
	medications.	sible for ordering				
	-She did cart audits w	veekly.				
		ind the MA on a daily basis.				
		ver out of his medications.				
	-She was not aware F					
	administered Tamsulo 02/22/24-02/29/24.	DSIII HCI OII				
		ny the medication was not				
	administered.					
		nt Resident #1's family a				
	•	luded all of the prescription				
	refilled.	at medications needed to be				
		ent #1's family responded				
	stating she was unab					
	medications.					
		ked Resident #1's family the				
		ons she was unable to				
		uld get the PCP to write a ld allow the facility to obtain				
		heir contracted pharmacy.				
	(The medications wer					
	Interview with the Adr	ministrator on 03/06/24 at				

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1:00pm revealed:

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DIVISION C	Division of Health Service Regulation							
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED		
					R-	-C		
		HAL047015	B. WING		1	06/2024		
NAME OF D		CTDEET AL	ADDECC CITY CTA	TE 7/D CODE				
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT					
WICKSHIE	RE CREEKS CROSSING		ETTEVILLE ROA	∕D				
		RAEFOR	D, NC 28376					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE		
IAG			IAG	DEFICIENCY)	100			
D 358	Continued From page 60		D 358					
	-The MA was respons	sible for ordering						
		e medication reached a 7 to						
	10 day supply.							
	-It was also the expec	ctation that the ARCC		İ				
	checked the medicati	ion supply when she did the		Í				
	cart audit weekly.			Í				
	T -	e medication, they should		Í				
		hen there was a 7 to 10 day						
	supply left.			İ				
		meant the medication had		Í				
	been ordered and wa							
		ant the medication was not		Í				
		have been in the backup		Í				
	medications or overst							
	-The MA should have	_						
	of "09".	on was if they used the code						
		on that the MA checked the		Í				
	cart thoroughly as we	ell as the overstock ed to the RCC and ARCC		Í				
	regarding unavailable			Í				
		ran out, the MA was to call						
		the medication refilled, report						
		and ARCC) and document		Í				
	their efforts to get the	•		Í				
	,	w up daily with the pharmacy		Í				
	until the medication w			Í				
	-If family did not provi	ide the medication in a		Í				
		would order from the facility's		Í				
		and the facility would pay		Í				
	for the medication.			Í				
		RCC were responsible for						
		's contracted pharmacy						
		e family not providing the						
	medication.	- · · · · · · · ·						
	-She was not aware F							
	administered Tamsulo	OSIN HOI ON						
	02/22/24-02/29/24.	ov Donidout #41a usadination						
	-She did not know wh	ny Resident #1's medication		i				

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was not administered

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL047015	B. WING			R-C 8 <b>/06/2024</b>
	ROVIDER OR SUPPLIER	8398 FAY	DDRESS, CITY, STATE VETTEVILLE ROAI RD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	-Checking behind the medication audit which twice a week.  Telephone interview with PCP on 03/06/24 doses of Tamsulosin lurgency.  f. Review of Resident dated 01/11/24 reveal Tizanidine HCl oral taday (used to treat pair Review of Resident # medication administrative revealed:  -There was an entry find 2mg 3 times a day so at 8:00am, 2:00pm ar -There was an entry of at 8:00am on 02/05/24 at 00/05/24.  Review of Resident # exception for the oral tablet 2mg at 8:000/02/05/24 and 02/06/2 "on order."  - The exception for the oral tablet 2mg at 8:00 on 02/17/24 was "not -The exception for the oral tablet 2mg at 8:00 on 02/18/24 for the 8:00ar 02/18/24 for the 8:00ar 02/18/24 for the 8:00ar 02/18/24 for the 8:00ar 02/18/24 for the 8:00ar 02/18/24 for the 8:00ar 02/18/24 for the 8:00ar 02/18/24 for the 8:00ar 02/18/24 for the 8:00ar 02/18/24 for the 8:00ar 02/18/24 for the 8:00ar 02/18/24 for the 8:00ar 03/05/24 for the 8:00ar 02/18/24 for the 8:00ar 03/05/24 for the 8:00ar 02/18/24 for the 8:00ar 02/18/24 for the 8:00ar 02/18/24 for the 8:00ar 03/05/24 for the 8:00ar 02/18/24 for the 8:00ar 02/18/24 for the 8:00ar 03/05/24 for the 8:00ar 02/18/24 for the 8:00ar 03/05/24 for the 8:00ar 02/18/24	MA was the function of the h would now be conducted with the on-call provider for at 4:16pm revealed missed HCl increased urinary  #1's physician's orders led there was an order for blet 2mg 2mg 3 times a n).  1's February 2024 electronic letton record (eMAR)  or Tizanidine HCl oral tablet heduled for administration at 8:00pm.  of 09 for Tizanidine HCl 2mg 4, 02/06/24, and 02/17/24 at land 02/17/24, and at 8:00pm  1's February 2024 facility led:  e 09 entry for Tizanidine HCl 2mg and 2:00pm on 4 for the 8:00am dose was led 09 entry for Tizanidine HCl 2mg, 2:00pm and 8:00pm on the cart".	D 358			

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hand on 03/06/24 at 9:22am revealed there were

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R-C	
		HAL047015	B. WING		03/06/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
W#01/01 III		8398 FAYE	TTEVILLE ROA	AD		
WICKSHI	RE CREEKS CROSSING	RAEFORD,	NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	Ξ
D 358	Continued From page	: 62	D 358			
2 000	3 packs of Tizanidine	HCl oral tablet 2mg 30 each pack on 02/19/24 with	B 600			
	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 a -He had not had any p heel; no increased pa	pain other than pain in his				
	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 Reside (ARCC) did cart audit -Medications were to					
		supply. medications, they tried to f the need for a refill to the				
	pharmacy if the medic	ed to follow up with the cation was not received				
	they got the medication					
		and paid for it. e medication had been vaiting arrival and it had not				
		that day. ant the medication was not ordered, they were awaiting				
	arrival and it had not l day.	peen administered for that				
	should have requeste	s not on the cart, the MA d a refill and documented narmacy or documented that				
		dication instead of saying				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL047015	B. WING	B. WING		5/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		8398 FAYE	TTEVILLE ROA	AD		
WICKSHIE	RE CREEKS CROSSING	RAEFORD	NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 63	D 358			
D 358	-No one checked beh-She was not aware fadministered Tizanidi 02/06/24, 02/17/24 ar-Resident #1 was new-She did not know whadministeredResident #1's family bring all his medication with the outside phare-When family was unamedication, the facility medication from their the facility would pay-Resident #1's family order the medication pharmacy and she well-the medication pharmacy and she well-the MA was responsimedicationsShe did cart audits well-the resident was new-She was not aware fadministered Tizanidi 02/06/24, 02/17/24 ar-She did not know whadministeredOn 02/07/24, she se text message that inconumbers to show wharefilled.	ind the MA on a daily basis. Resident #1 was not ne HCl on 02/05/24, nd 02/18/24. Ver out of his medications. Ny the medication was not member was supposed to ons but was having difficulty macy. able to obtain the y could obtain the contracted pharmacy and for it. agreed to allow the facility to from the facility's contracted build pay.  CC on 03/06/24 at 11:30am sible for ordering veekly. ind the MA on a daily basis. ver out of his medications. Resident #1 was not ne HCl on 02/05/24, nd 02/18/24. by the medication was not  nt Resident #1's family a luded all of the prescription at medications needed to be  ont #1's family responded	D 358			
		ked Resident #1's family the				

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obtain so that she could get the primary care

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-C	
	HAL047015 B. WING			03/06/2024		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
MICKELL	RE CREEKS CROSSING	8398 FAYE	TTEVILLE ROA	AD		
WICKSHII	NE CREEKS CROSSING	RAEFORD	, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	Ξ
D 358	Continued From page	e 64	D 358			
	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.)					
	1:00pm revealed: -The MA was respons medications once the 10 day supplyIt was also the expecehecked the medicaticart audit weeklyIf family provided the have been notified who supply left"On order" probably been ordered and ware on the cart but could	medication reached a 7 to ctation that the ARCC on supply when she did the medication, they should hen there was a 7 to 10 day meant the medication had s not administered. ant the medication was not have been in the backup				
	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					

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-The PCP was supposed to be notified of any

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL047015	B. WING		R-C <b>03/06/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIF	RE CREEKS CROSSING		TTEVILLE ROA	AD		
I			, 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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 65	D 358			
D 358	missed medicationShe was not aware Fadministered Tizanidin 02/06/24, 02/17/24 ar -She did not know wh was not administered -Checking behind the medication audit which twice a week.  Telephone interview with PCP on 03/06/24 doses of Tizanidine Hamuscle spasm and particular particular properties of Resident dated 01/11/24 reveal Flonase nasal spray 2 (used to treat allergy services and each nostril administration administrative and control of Resident # revealed: -There was an entry of sprays in each nostril administration in the result of the revealed of Resident # exception report revealed: -There was an entry of sprays in each nostril administration in the result of Resident # exception report revealed: -There was an entry of the revealed of Resident # exception report revealed: -There was an entry of the revealed of Resident # exception report revealed: -There was an entry of the revealed of Resident # exception report revealed: -There was an entry of the revealed of Resident # exception report revealed: -There was an entry of the revealed of Resident # exception report revealed: -There was an entry of the revealed of Resident # exception report revealed: -There was an entry of the revealed of Resident # exception report revealed: -There was an entry of Resident # exception report revealed: -There was an entry of the revealed of Resident # exception report revealed: -There was an entry of the revealed of the r	Resident #1 was not ne HCl on 02/05/24, and 02/18/24.  by Resident #1's medication  MA was the function of the sh would now be conducted  with the on-call provider for at 4:16pm revealed missed Cl increased the risk of ain.  by the there was an order for 2 sprays in each nostril daily symptoms).  construct the there was an order for 2 sprays in each nostril daily symptoms).  construct the there was an order for 2 sprays in each nostril daily symptoms).  construct the there was an order for 2 sprays in each nostril daily symptoms).  construct the there was an order for 2 sprays in each nostril daily symptoms).  construct the there was an order for 2 sprays in each nostril daily symptoms).  construct the there was an order for 2 sprays in each nostril daily symptoms).  construct the there was an order for 2 sprays and 2 spray 2 scheduled for morning at 8:00am.  construct the there was an order for the operation of the operation o	D 358			
		al spray with an expiration re was no dispense date.)				

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

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DIVISION	n nealth Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
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			B. WING		R-	
		HAL047015	B. WING		03/0	6/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		8398 FAVE	TTEVILLE ROA	ΔD		
WICKSHIP	RE CREEKS CROSSING		, NC 28376			
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(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
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			+			
D 358	Continued From page	e 66	D 358			
	9:40am, 10:50am and	1 5:10nm revealed:				
	-He got his medication					
	-He had not missed a					
		•				
	-He had not had any	allergy symptoms.				
	Interview with the Res	sident Care Coordinator				
	(RCC) on 03/06/24 at					
	` ,	(MA) was responsible for				
	ordering medications.	. , .				
	•					
	-The Assistant Reside					
	(ARCC) did cart audit					
		be ordered when they were				
	down to a 7 to 10 day					
	• •	medications, they tried to				
	-	f the need for a refill to the				
	family.					
		ed to follow up with the				
		cation was not received				
	within two days.					
	_	de the medication on time,				
	they got the medication	on from the facility's				
	contracted pharmacy	and paid for it.				
	-"On order" meant the	e medication had been				
	ordered, they were av	vaiting arrival and it had not				
	been administered for	rthat day.				
	-No one checked beh	ind the MA on a daily basis.				
	-She was not aware F	Resident #1 was not				
	administered Flonase	on 02/05/24 an 02/14/24.				
	-Resident #1 was nev	er out of his medications.				
	-She did not know wh	y the medication was not				
	administered.	-				
		member was supposed to				
		ons but was having difficulty				
	with the outside pharr					
	-When family was una					
	medication, the facility					
		contracted pharmacy and				
	the facility would pay					
	-Resident #1's family	agreed to allow the facility to				

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order the medication from the facility's contracted

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DIVISION	or riealth Service Negu	iation				
	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
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			B. WING		R-C	
		HAL047015	D. WING		03/0	6/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
		8398 FAYE	TTEVILLE ROA	AD		
WICKSHIE	RE CREEKS CROSSING	RAEFORD	, NC 28376			
0(1) 15	STIMMADY ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	ı.	0/5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
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				DEFICIENCY)		
D 358	Continued From page	67	D 358			
D 330	Continued From page	: 07	5336			
	pharmacy and she wo	ould pay.				
	Interview with the AR	CC on 03/06/24 at 11:30am				
	revealed:					
	-The MA was respons	sible for ordering				
	medications.					
	-She did cart audits w					
		ind the MA on a daily basis.				
		ver out of his medications.				
	-She was not aware F					
		on 02/05/24 an 02/14/24.				
	-She did not know wh	y the medication was not				
	administered.					
		nt Resident #1's family a				
	text message that inc	luded all of the prescription				
		at medications needed to be				
	refilled.					
		nt #1's family responded				
	stating she was unab	le to obtain 2 of the				
	medications.					
		ked Resident #1's family the				
	name of the medication	ons she was unable to				
		uld get the primary care				
	provider (PCP) to writ	te a prescription that would				
	allow the facility to ob	tain the medication from				
	their contracted pharr	macy. (The medications				
	were not listed in the	message.)				
		ministrator on 03/06/24 at				
	1:00pm revealed:					
	-The MA was respons					
		medication reached a 7 to				
	10 day supply.					
	-It was also the exped					
		on supply when she did the				
	cart audit weekly.					
		medication, they should				
		nen there was a 7 to 10 day				
	supply left.					
	-"On order" probably	meant the medication had				

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Division of	of Health Service Regu	iation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING		COMPL	ETED
			7 50.25 10.			
					R-	·C
		HAL047015	B. WING	<del></del>	03/0	06/2024
			•			
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		8398 FAYE	TTEVILLE RO	AD		
WICKSHIE	RE CREEKS CROSSING	RAEFORD	, NC 28376			
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(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
170		,	IAG	DEFICIENCY)		
D 358	Continued From page	e 68	D 358			
	been ordered and wa					
		n that the MA checked the				
	cart thoroughly as we	II as the overstock				
	medications and talke	ed to the RCC and ARCC				
	regarding unavailable	medications.				
	-When a medication r	an out, the MA was to call				
		he medication refilled, report				
		and ARCC) and document				
	their efforts to get the					
		v up daily with the pharmacy				
	until the medication w					
		de the medication in a				
		vould order from the facility's				
		and the facility would pay				
	for the medication.					
		RCC were responsible for				
	contacting the facility'	s contracted pharmacy				
	within 24 hours of the	family not providing the				
	medication.	,				
	-She was not aware F	Resident #1 was not				
	administered Flonase	on 02/05/24 an 02/14/24.				
		y Resident #1's medication				
	was not administered	-				
		MA was the function of the				
	_	th would now be conducted				
		in would now be conducted				
	twice a week.					
		vith the on-call provider for				
		at 4:16pm revealed missed				
	doses of Flonase cau	sed congestion and				
	increased allergies.					
	Telephone interview v	vith Resident #1's				
	responsible person or					
	revealed:	·				
		:#1's medication up from an				[
	outside pharmacy.	ap nom an				
		tion problem on behalf of				
	Resident #1's pharma					
	-one was not aware o	of Resident #1 running out of	1			

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STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL047015	B. WING		R-C 03/06/2024	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZIP CODE	1 00/0	0/2024
			ETTEVILLE ROA			
WICKSHII	RE CREEKS CROSSING	RAEFORI	D, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	69	D 358			
	any medicationsResident #1 should redicationsThe facility was suppin advance of Resider refills.  Interview with a MA or revealed: -The MA was responsed medicationsMedication was suppin there were 7 to 10 pilledIf family provided the supposed to inform the was running low where carts were audited endered to enough medication"On order" on the elvert medication was not administration was not on and was not administrationsThe was unsure why medications that were alf a medication was resupposed to select "On as to why the medication was resupposed to select "On as to why the medication was not aware of getting a resident's medication was not aware of getting a resident's medication was not aware of getting a resident's medication was not aware of getting a resident's medication was not aware of getting a resident's medication was not aware of getting a resident's medication was not aware of getting a resident's medication was not aware of getting a resident's medication was not aware of getting a resident's medication was not aware of getting a resident's medication was not aware of getting a resident's medication was not aware of getting a resident's medication was not aware of getting a resident's medication was not aware of getting a resident's medication was not aware of getting a resident's medication was not aware of getting a resident's medication was not aware of getting a resident's medication was not aware of getting a resident's medication was not aware of getting a resident's medication was not on the second was not aware of getting a resident's medication was not on the second was not aware of getting a resident's medication was not on the second was not aware of getting a resident's medication was not on the second was not aware of getting a resident's medication was not aware of getting a resident's medication was not aware of getting a resident was not aware of getting a resident was not aware of getting a resident was not aware of getting a resident was not aware of getting a resi	not have run out of any losed to inform her 2 weeks int #1 needing medication  In 03/06/24 at 9:40am  Sible for ordering  losed to be ordered when is left. In medication, the MA was the family that the medication in there were 7 to 10 pills left. Invery couple of weeks by the to make sure they had  IAR meant a request for a to the pharmacy and the in the cart or in overstock thered. In Resident #1 had several the "on order". Into available, the MA was 9" and write a progress note tion was not available. In fany policies regarding the dication when it ran out to ovided a refill. In the use of a back up  In the use of a back up  In the use of a back up  In the use of a back up  In the use of a back up  In the use of a back up  In the use of a back up  In the use of a back up  In the use of a back up  In the use of a back up  In the use of a back up  In the use of a back up				

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The facility failed to administer medications as

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					R-C	
		HAL047015	B. WING		03/0	6/2024
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIR	RE CREEKS CROSSING		TTEVILLE ROA	AD		
		RAEFORD	NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	<del>2</del> 70	D 358			
	ordered to 3 of 4 reside medication passes on resulting in a 55% medication for acid reafter missing the dose gastrointestinal bleed #2 was administered tablet and did not recacid reflux on 03/05/2 increased risk for gas precipitating a gastroi #8's blood pressure may systolic blood pressure putting the resident at and increased falls. If doses of several medications being unthinner, medications for pressure, and a must resident at increased decreased blood sugar high blood pressure, in the failure of the facil medications as orderes substantial risk of serin neglect and constitute.  The facility provided a accordance with G.S. this violation.	dents observed during the a 03/05/24 and 03/06/24 adication error rate. It least 7 doses of a afflux and had a hospital visit it is and was diagnosed with and esophagitis. Resident a crushed Ferrous Sulfate it is a new medication for 4 putting the resident at trointestinal irritation and intestinal bleed. Resident inedication was not held for a re less than 130 on 03/05/24 it risk of low blood pressure resident #1 missed multiple ications due to the available including a blood for diabetes, high blood and the relaxer putting the risk of blood clots, ar control, increase risk of muscles spasms and pain. The part of placed the residents at ious physical harm and as a Type A2 Violation.				
D 364	10A NCAC 13F .1004 Administration	e(g) Medication	D 364			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
74101 1244	or contraction	IDENTIFICATION NOMBER.	A. BUILDING: _			
		HAL047015	B. WING		R- 03/0	C <b>6/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE CREEKS CROSSING	8398 FAYE RAEFORD,	TTEVILLE ROA NC 28376	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
D 364	(g) The facility shall eadministered to reside or one hour after the time unless precluded.  This Rule is not met Based on observation reviews, the facility fawere administered with the scheduled times f (#11, #13, #14) in the the facility on 3/05/24 ordered multiple times too close to the next stime and medications consistent time interveffectiveness.  The findings are:  Review of the facility's Policies and Procedu 10/01/20 revealed the medications were administered within one hour before prescribed or schedule emergency situations.  Review of the facility's 03/05/24 revealed: -The facility's current residentsThere were 40 reside assisted living (AL) si-There were 26 reside special care unit (SCI)	Medication Administration ensure that medications are ents within one hour before prescribed or scheduled by emergency situations.  as evidenced by: as, interviews, and record illed to ensure medications thin one hour before or after for 3 of 5 residents observed assisted living (AL) side of resulting in medications and aday being administered ascheduled administration not being administered at als to ensure therapeutic  as Medication Administration res with effective date of a facility would ensure that ministered to the residents are or one hour after the led time unless precluded by a scensus report dated in-house census was 66 and the facility. The sents currently residing in the de of the facility.  In the sent of the facility in the de of the facility in the de of the facility in the de of the facility is sisted living (AL) side of the sisted living (AL) side of the	D 364			
	facility on 03/05/24 at					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-C	
		HAL047015	B. WING		03/06/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHI	RE CREEKS CROSSING	8398 FAYE RAEFORD,	TTEVILLE ROA NC 28376	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 364	revealed: -She was still administ medications to the rest AL -There was usually or administer medication on first shiftShe usually started at 7:00am and she usual 10:00amShe had finished adminished still have 5 m 8:00am medications of the residents who live but she still have 5 m 8:00am medications of the AL revealed the Assistant (ARCC) went to the 1 a second laptop comp MA administer medicate the 100 hall.  Observation of the AL revealed the MA and administering medicate facility.  Interview with the ARC 10:32am revealed she administering morning resident in the AL side	was administering all. on 03/05/24 at 9:55am stering the 8:00am sidents on the 100 hall in the me MA assigned to as to all residents in the AL administering medications at ally finished around ministering medications to ad on the 200 hall in the AL ore residents to administer on the 100 hall in the AL any emergencies that down her medication pass. on 03/05/24 at 10:05am at Resident Care Coordinator 00 hall medication cart with outer and started helping the ations to the residents on on 03/05/24 at 10:32am ARCC finished tions in the AL side of the	D 364			
	2:09pm revealed:	iui uie ivia on 03/03/24 at				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		. ,	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMP	LETED	
			5 14/110			R-C	
		HAL047015	B. WING		03	/06/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
MICKETII	WICKSHIRE CREEKS CROSSING 8398 FA			AD			
WICKSHII	NE CREEKS CROSSING	RAEFORI	D, NC 28376				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
D 364	Continued From page	e 73	D 364				
D 304	-She was the only MA medications in the AL -She was responsible medications to reside hallIt was a big medicati sometimes because t residents and medica-She started working about the second were-She started with the then went to 200 hall -She had told the ARC big medication pass are -The ARCC would some medications when the -The ARCC helped he medications that more	A assigned to administer side of the facility. If for administering on the 100 hall and 200 on pass and she ran late here were so many tions to administer. It as a MA independently lek of February 2024. If ingerstick blood sugars, and then to 100 hall. If in the past that it was a leand they needed more MAs. If it was a leand they needed more MAS. If it was a leand they needed more MAS. If it was a leand they needed more MAS. If it was a leand they needed more MAS. If it was a leand they needed more MAS. If it was a leand they needed more MAS. If it was a leand they needed more MAS. If it was a leand they needed more MAS. If it was a leand they needed more MAS. If it was a leand they needed more MAS.	D 304				
	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						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED	
		HAL047015	B. WING			R-C 3/06/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
WICKSHI	RE CREEKS CROSSING		YETTEVILLE ROAD RD, NC 28376	)		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 364	medication pass in the running late.  -If a MA was running the MA was suppose and they would help.  Interview with the Add 4:02pm revealed:  -There was usually 1 SCU.  -Some of the early moreon of the early	late with a medication pass, d to notify her or the RCC or get help.  ministrator on 03/05/24 at  MA in the Al and 1 in the redications (6:00am and istered by third shift to help to f morning medications for the ARCC, Resident Care or Memory Care Director vere running late with the hey could get help for them.  2024 electronic medication ls (eMARs) for the 3 ho received late medications ince daily on 03/05/24 ints had medications ordered times a day. [For tiple administrations, vals are necessary to prevent erse reactions.]  at #11's current FL-2 dated agnoses included essential pation, hypothyroidism, is disease, and ase.  ledication aide (MA) in the	D 364			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
74101 2741	or contraction	ibertii io, iiioit iomberi	A. BUILDING: _			
		HAL047015	B. WING		R-C 03/06/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE CREEKS CROSSING		TTEVILLE ROA	AD		
		RAEFORD,	NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
D 364	Continued From page	e 75	D 364			
	hour and 30 minutes frame.	beyond the allowed time				
	medication administrative revealed Sinemet (for	11's March 2024 electronic ation record (eMAR) Parkinson's disease) was day at 8:00am, 2:00pm, and				
	care provider (PCP) of revealed: -Resident #11's medicadministered on time effectivenessReceiving Sinemet la	to ensure therapeutic ate could cause the resident and stiffness which could				
	12/05/23 revealed dia hemiplegia, insomnia disorder, gastroesoph	, hypertension, bipolar nageal reflux disease, ess leg syndrome, retention				
	assisted living (AL) si administering morning revealed the MA adm medications schedule	edication aide (MA) in the de of the facility g medications on 03/05/24 inistered Resident #13's ed for 8:00am at 10:18am, 1 beyond the allowed time				
	medication administra revealed: -There were 5 medica	ations, Famotidine (for acid eizures or mood disorders),				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL047015	B. WING		R-C <b>03/06/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE. ZIP CODE	1 00:00:202.	
			TTEVILLE ROA			
WICKSHII	RE CREEKS CROSSING	RAEFORD,	NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 364	-Tylenol Arthritis (for pay for 8:00am and 4 -Ferrous Gluconate (ischeduled 3 times a continuous forms)  Telephone interview was care provider (PCP) or revealed: -Resident #13's medical administered on time effectivenessAdministering medical late, could lower the seresident at risk of have a resident to have be continuous formsA delay in getting pain the resident to have be continuous forms.  C. Review of Resident 108/31/23 revealed discorders late, could dencephalopathy, over traumatic brain injury, hyperlipidemia.  Observation of the meassisted living (AL) signal medications schedule hour and 7 minutes be frame.	eptal (for seizures) y at 8:00am and 8:00pm. pain) was scheduled twice a :00pm. ron supplement) was day at 8:00am, 2:00pm, and  with Resident #13's primary on 03/05/24 at 3:52pm  cations should be to ensure therapeutic  ations used to treat seizures seizure threshold and put the ing seizures. ations used to treat mood cause the resident to have  in medication could cause breath through pain.  It #14's current FL-2 dated diagnoses included metabolic factive bladder, insomnia, constipation, and  edication aide (MA) in the de of the facility g medications on 03/05/24 inistered Resident #14's ed for 8:00am at 10:07am, 1 eyond the allowed time	D 364			
	medication administra	14's March 2024 electronic ation record (eMAR)  medications, Zonisamide				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R-C	
		HAL047015	B. WING		03/06/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE CREEKS CROSSING	8398 FAYE' RAEFORD,	TTEVILLE ROA	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE COMPLETE	
				DEFICIENCY)		
D 364	Continued From page	: 77	D 364			
	(for seizures) and Senna-S (for constipation) were scheduled twice a day at 8:00am and 8:00pm.					
	care provider (PCP) or revealed:	vith Resident #14's primary on 03/05/24 at 3:52pm				
	-Resident #14's medications should be administered on time to ensure therapeutic effectiveness.					
		ations used to treat seizures seizure threshold and put the ing seizures.				
D 366	10A NCAC 13F .1004 Administration	(i) Medication	D 366			
	10A NCAC 13F .1004	Medication Administration				
	medication administra staff person who adm immediately following	ne administration on the ation record shall be by the inisters the medication administration of the dent and observation of the				
	resident actually takin to the administration of medication. Pre-char					
	This Rule is not met a Based on observation reviews, the facility fa staff who administere observed 2 of 4 reside medications during th	as evidenced by: us, interviews and record iled to ensure medication d medications actually ents (#2, #9) taking their				
	The findings are:					
	Review of the facility's	s Medication Administration				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
			A. BOILDING.			_
		HAL047015	B. WING		R- 03/0	6/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE CREEKS CROSSING	8398 FAYE RAEFORD,	TTEVILLE ROANNE 1807	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 366	10/01/20 revealed the administration on the record (MAR) shall be administered the med following administration resident and observation taking the medication of another resident's in the second of another resident's in the second of another resident's in the second of another resident's in the second of another resident's in the second of another resident's in the second of another resident's in the second of another resident's in the second of another resident's in the second of another resident's in the second of another resident and hyperlipidemia.  There was an order for tablet twice a day. (Did delayed-release meditareat mood disorders.)  Review of Resident # medication administration administrat	res with effective date of a recording of the medication administration aby the staff person who dication immediately on of the medication to the cition of the resident actually prior to the administration medication.  It #9's current FL-2 dated  Frontotemporal er, essential hypertension,  For Norvasc 5mg 1 tablet end to lower blood pressure.)  For Depakote DR 250mg 1 repakote DR is a cation that can be used to end to have a cation that can be used to end to record (eMAR)  For Norvasc 5mg 1 tablet at 8:00am.   D 366	DETICITION 1)			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		HAL047015	B. WING		R-C <b>03/06/2024</b>	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
8398 FAYE			ETTEVILLE ROA	AD		
WICKSHIE	RE CREEKS CROSSING		), NC 28376	, <del>-</del>		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	( - /	
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		
D 366	Continued From page	e 79	D 366			
	-There were 23 other	SCU residents sitting at				
		hout the dining room eating				
	breakfast.	3 3				
	-The medication aide	(MA) prepared morning				
	medications for Resid					
	•	tablet and one Norvasc				
	5mg tablet.					
		h tablets and mixed them in				
	. , ,	and administered one				
	·	of the yogurt cup to the				
	resident at 8:34am.	f amade admille left amound				
		f crushed pills left around				
	the cup.	cup and in the yogurt inside				
	•	npt to have the resident eat				
	anymore yogurt with t					
	medication.					
		rt cup on the table beside				
		st plate and walked out of				
	the SCU dining room.					
	-The MA did not stay	in the dining room to				
	observe the resident.					
		nurses' station outside of the				
		ed sitting at the desk.  npt to go back to Resident				
		e had eaten the yogurt.				
		e nad eaten the yogurt. ent picked up the cup of				
		spoonfuls but there was still				
	crushed medication p					
	•	al care aide (PCA) stopped				
	· ·	and provided feeding				
		of her breakfast, including				
	2 spoonfuls of yogurt.					
		ent started eating some of				
	the yogurt again but o	•				
		MA was walking by and				
		sident #9 with eating her				
		eding the remainder of the				
		nedications to the resident.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-C	
		HAL047015	B. WING		03/06/202	24
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE CREEKS CROSSING		ETTEVILLE ROA	AD		
			D, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COM	(X5) MPLETE DATE
D 366	Continued From page	e 80	D 366			
	Interview with the MA revealed: -She usually crushed and opened any caps applesauceShe usually handed the resident take the applesauce herselfThat morning on 03/0 crushed medications and tried to keep all of at the top of the yoguture. She gave the resident with crushed medicate the resident received medications because -She did not think about the resident received medications were of supposed to mix the ostall amount of apple plastic medication cupyogurt, to make sure medications were adrugourt, to make sure medications from the cup to a resident, the dispose of it in the tracartAll residents in the Standard medications should in any residentThe MAs were supportake all their medications to the supportance of the mass were supportated and their medications.	all of Resident #9's tablets sules and mixed in  the resident a spoon and let crushed medication in  06/24, she mixed the in the whole cup of yogurt of the crushed medications rt cup.  nt one spoonful of yogurt ions, but she was not sure if all of the crushed she forgot to check. Out it until "after the fact".  mory Care Director (MCD) om revealed: crushed, the MAs were crushed medications in a desauce or yogurt in the small po, not the whole cup of all of the crushed ministered.  nistered crushed small plastic medication  MAs were supposed to ish can on the medication  CU were confused so ot be left unattended with				
	1:00nm revealed:	าแแรแสเบเ บาเ บร/บัง/24 สเ				

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-The MAs had been trained and should observe

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DIVISION	n nealth Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			-		
					R-C
		HAL047015	B. WING		03/06/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
MICKOLU	DE ODEEKO ODOGONO	8398 FAYE	TTEVILLE RO	AD	
WICKSHIP	RE CREEKS CROSSING	RAEFORD	, NC 28376		
044) 15	CLIMMADV CT	ATEMENT OF DEFICIENCIES	<u>.</u>	PROVIDER'S PLAN OF CORRECTION	1 0/5
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	()
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
		,		DEFICIENCY)	
D 366	Continued From page	e 81	D 366		
	each resident take the				
	-Resident #9 was in t	he SCU and the MA should			
	have observed the re-	sident take all the yogurt			
	with crushed medicat				
	Based on observation	ns, interviews, and record			
		ined that Resident #9 was			
	not interviewable.				
	2. Review of Residen	t #2's current FL-2 dated			
	02/29/24 revealed:				
	-Diagnoses included	chronic ischemic heart			
	_	thy, and spinal stenosis.			
		•			
		for Miralax give 1 packet			
		y for constipation. (Miralax			
	is a laxative used to to	reat and prevent			
	constipation.)				
	, ,				
	Observation of the 8:0	00am medication pass in the			
		de of the facility on 03/05/24			
	- , ,	de of the facility off 03/03/24			
	revealed:				
		(MA) prepared 1 packet			
	(17gm) of Miralax pov	wder mixed in water in an			
	8-ounce styrofoam cu	ıp.			
		ofoam cup with Miralax to			
	_	nd sat it on the bedside			
	table at 9:37am.	na cat it on the bouside			
		f Alandania - NASandari - Lat			
		f that was Miralax and the			
	MA indicated it was M				
	-The MA left the resid	lent's room without			
	observing or asking th	ne resident to take the			
	Miralax.				
	Review of Resident #	2's March 2024 electronic			
	medication administra	alion record (elviAK)			
	revealed:				
	-There was an entry f	or Miralax give 1 packet			
	(17gm) one time a da	y for constipation scheduled			
	for 8:00am	•			

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-Miralax was documented as administered daily

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			
7412 1 2741	or connection	IBERTIN ISTRICT NOMBER	A. BUILDING:			PLETED
						R-C
		HAL047015	B. WING		03	/06/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E, ZIP CODE		
		8398 FAY	ETTEVILLE ROA	D		
WICKSHII	RE CREEKS CROSSING	RAEFOR	D, NC 28376			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	COMPLETE DATE
D 366	Continued From page	e 82	D 366			
	from 03/01/24 - 03/05	5/24.				
	10:01am revealed:	ent #2's room on 03/05/24 at				
	on the corner of the b	edside table.				
	-There were approxing with Miralax remaining	nately 2 ounces of water g in the cup.				
	Interview with Reside 10:01am revealed:	nt #2 on 03/05/24 at				
	-He had not finished of	drinking the water with				
	Miralax.	the our with water and				
		the cup with water and nd he usually drank it during one.				
	1:05pm revealed the	ent #2's room on 03/05/24 at styrofoam cup with water onger sitting on the bedside				
		nt #2 on 03/05/24 at 1:05pm ne had finished drinking the				
	_	could not recall a time.				
	Interview with the MA revealed:	on 03/05/24 at 2:09pm				
		esidents she had to observe				
		s and some residents she				
		use they would take the				
	medications on their of					
	-	bbserve Resident #2 take the ould drink it on his own.				
		cup in Resident #2's trash				
		around 1:00pm so she				
		Miralax from this morning's				
		ent in the AL side of the				
		used and had wandering				

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-C	
		HAL047015	B. WING		03/06	5/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIP	RE CREEKS CROSSING	8398 FAYE RAEFORD,	TTEVILLE ROA	AD		
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETE DATE
D 366	Continued From page	e 83	D 366			
	behaviors but that res hospital.	ident was currently in the				
	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 medicationsThe 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 377	10A NCAC 13F .1006	s(a) Medication Storage	D 377			
	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	s Medication Storage				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
744012741	or contraction	IDENTIFICATION NOMBER.	A. BUILDING: _			
		HAL047015	B. WING		R-0 03/00	C 6/ <b>2024</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHIE	RE CREEKS CROSSING	8398 FAYE	TTEVILLE ROA	AD		
	TE OREERO OROGONIO	RAEFORD	, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 377	Continued From page	<del>2</del> 84	D 377			
D 377	Policies and Procedur 10/01/20 revealed: -Medications that are stored in the resident's afe and secure manual medications must be within the resident's revealed: -Medications must be within the resident's revealed: -Medications must be within the resident's revealed: -Diagnoses included disease, polyneuropal and revealed: -Diagnoses included disease, polyneuropal and revealed for foot and four supervised. (Asperminor aches and pain at bedtime for foot and four supervised. (Asperminor aches and pain at bedtime to legs and self-administer unsupropical foam used to the arrown and order for the self-administer unsupropical foam used to the self-administer unsupr	self-administered and s room shall be stored in a ner. stored behind lock and key oom.  2's current FL-2 dated chronic ischemic heart thy, and spinal stenosis. For Aspercreme Maximum Spray apply topically at eg pain; may self-administer roreme is used to treat s.) for Theraworx apply topically difeet for pain; may ervised. (Theraworx is a reat muscle cramps.) for Refresh Plus eye drops eye every 4 hours as (Refresh Plus is a lubricant to dry eyes.)  ent #2's room in the assisted facility on 03/05/24 at a private room with no ations sitting on top of the	D 377			
	dose eye drops.	of Resident #2's room on				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
		HAL047015	B. WING		R-C <b>03/06/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		8398 FAYE	TTEVILLE ROA	AD	
WICKSHIE	RE CREEKS CROSSING	RAEFORD	, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 377	Continued From page	÷ 85	D 377		
	03/05/24 at 10:01am -Resident #2 was in h -The Aspercreme, Th were sitting on top of A third observation of 03/05/24 at 1:05pm re -Resident #2 was in h	revealed: is room. eraworx, and Refresh Plus the resident's bedside table.  Resident #2's room on evealed:			
		the resident's bedside table.			
	revealed: -He self-administered on his bedside table.	ructed to put the			
	stored when a resider medications. -There was one resident facility who was confu	evealed: w medications were to be			
	(RCC) on 03/06/24 at -She thought the facil to store self-administe -The residents did no store the medications -The facility did not us wandering behaviors facility.	ity's policy allowed residents ered medications at bedside. It have a locked drawer to			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
74101 12/41			A. BUILDING: _		JOHN ELTES
		HAL047015	B. WING		R-C
		HAL047015			03/06/2024
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
WICKSHIE	RE CREEKS CROSSING		ETTEVILLE ROA	AD	
			), NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 377	Continued From page	e 86	D 377		
	behaviors in the AL to	her knowledge.			
D 644	6:11pm revealed: -The facility's policy for self-administered med medications should be the resident's roomThe self-administere accessible to other re-Resident #2's self-accesshould be stored in a	dications was those e stored in a locked area in d medications should not be esidents or staff. dministered medications locked area in his room.	D 644		
D 611	10A NCAC 13F .1801 Control Policies & Pro	l(b) Infection Prevention &	D 611		
	PROCEDURES (b) The facility's infection procedures shall be in and shall address the (1) Standard ar precautions, including (A) respirate etiquette; (B) environ disinfection; (C) reprocedure resident mediculate (E) access personal protective expersonal protective expersonal protective expersonal mediculations and when including contact precautions, and (2) When and here	control policies and implemented by the facility of following: and transmission-based g: cory hygiene and cough imental cleaning and disinfection of dical equipment; ygiene; cibility and proper use of quipment (PPE); and of transmission-based in each type is indicated,			

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MALDATOIS  HALDATOIS  B. WING  B. WING  B. WING  MALDATOIS  B. WING  MING  MIN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  WCKSHIRE CREEKS CROSSING  RAEFORD, NC 28376   (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (PACH DEFICIENCY)  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	AND PLAN OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _			
WICKSHIRE CREEKS CROSSING  RAEFORD, NC 28376    CAUTION   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)   DREFIX TAG   DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)   D 611      D 611   Continued From page 87		HAL047015	B. WING		I	)24
(A) ID PREFIX (EACH DEFICIENCY MIST BE PRECIDED BY PILL PREFIX TAG (EACH DEFICIENCY)  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 in the event of a communicable disease outbreak in prevent the spread of illness, such as isolating infected residents, 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	NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX RECULATORY OR LSC IDENTIFYING INFORMATION)  D B PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION)  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 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	WICKSHIRE CREEKS CROSSING	8398 FAYE	TTEVILLE ROA	AD		
PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE DATE	WICKSTINE CKEEKS CKOSSING	RAEFORD,	NC 28376			
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	PREFIX (EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE CO	OMPLETE
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	confirmed reportable case or condition, or coutbreak in accordance Section;  (3) Measures for taking in the event of outbreak to prevent the isolating infected reside group activities and correstricting outside visit screening staff, reside illness; and use of soot the residents; and (4) Strategies for staffing issues and enneeds of the residents disease outbreak.  This Rule is not met at TYPE B VIOLATION  Based on observation reviews, the facility farecommendations and the federal Centers for Prevention (CDC) and the facility's infection of procedures were followed residents with a position. The findings are:  Review of the federal and Prevention (CDC) Prevention and Control Healthcare Personnel Disease 2019 (COVID 05/08/23 revealed: -Facilities should ensured.	communicable disease communicable disease ce with Rule .1802 of this or the facility to consider a communicable disease are spread of illness, such as dents; limiting or stopping communal dining; limiting or tation to the facility; ents, and visitors for signs of curce control as tolerated by or addressing potential issuring staffing to meet the siduring a communicable as evidenced by:  as, interviews, and record illed to ensure diguidance established by or Disease Control and diguidelines established in control policies and wed for 2 of 2 sampled ve COVID-19 diagnosis.  Centers for Disease Control of Recommendations for During the Coronavirus 0-19) Pandemic dated cure that everyone is aware	D 611			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING			
		HAL047015	B. WING		R-C 03/06/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHII	RE CREEKS CROSSING	8398 FAYE	TTEVILLE ROA	AD		
WICKSIIII	NE CREEKS CROSSING	RAEFORD,	NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
D 611	Continued From page	e 88	D 611			
	practices in the facility -Facilities should post current infection preve at the entrance and o waiting areas or dinin alerts should be dated staff, and residents an alerts reflect current in control recommendat -Healthcare personne patient with suspected infection should use a Occupational Safety a approved particulate higher, gown, gloves,	t visual alerts to include ention and control practices ther strategic areas such as g rooms. The posted visual d to ensure that visitors, re aware that the posted infection prevention and ions. el who enter the room of a d or confirmed COVID-19 a National Institute for				
	Manual dated 09/26/2 -The Administrator and Director were responsimembers on current for related to infection coronal control of the coronal c	d Health and Wellness sible for directing staff federal CDC guidelines introl.  a the facility with two or more VID-19.  utbreak is identified among a vendors, families, visitors, ents, etc. should be made is experiencing an outbreak ered an airborne disease irborne disease include is room door closed and				

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DIVISION	n nealth Service Regu	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			D WING		R-C
		HAL047015	B. WING	<del>-</del>	03/06/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE	
		8398 FAVE	TTEVILLE ROA	AD.	
WICKSHIP	RE CREEKS CROSSING		), NC 28376	AD	
		RAEFURL	, NC 20376		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	( - /
PREFIX	,	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
TAG	REGULATORY OR E	GO IDENTIFY TING INFORMATION)	TAG	DEFICIENCY)	IAIL SIIIL
				,	
D 611	Continued From page	e 89	D 611		
	should be worn with the	•			
		o residents with COVID-19			
		d asymptomatic) must be in			
		VID-19 PPE (N95, eye			
	protection, gown, glov	•			
	•	9 positive and symptomatic			
	residents as well as n	on-COVID-19 positive			
	residents in other area	as of the building, staff need			
	to wear at minimum, a	a procedure mask in			
	non-COVID-19 positiv	e resident rooms only in the			
	event of an outbreak	(2 or more individuals			
	positive for COVID-19	9).			
	-Staff members shoul	d clean hands often, after			
		after contact with an ill			
		ands with soap and water			
	for 20 seconds. If soa				
		are not visibly dirty, an			
		anitizer containing at least			
	60% alcohol may be u				
		firmed positive COVID-19			
	case with a resident of				
		alth and Wellness Director			
		cal health department and			
	follow the local health	departments			
	recommendations.				
	Observation of the	transa of the facility on			
	03/05/24 at 8:45am re	trance of the facility on			
		ated signs posted on either			
		nce door that read "please			
	wear a facemask".	1 . 1 . 1 . 1			
		le which indicated there			
		COVID-19 cases in the			
	building.				
		ception area at the front			
	entrance of the facility	/ on 03/05/24 at 8:46am			
	revealed:				
	-There was a hov of d	lienneahla euraical maeke	1		

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and a hand sanitizer station.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		· ,	SURVEY PLETED	
		HAL047015	B. WING			R-C 8/06/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE	,	
WICKSHII	RE CREEKS CROSSING	8398 FAY	ETTEVILLE ROAD	)		
Wickerin	THE STREET OF THE STREET	RAEFOR	D, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 611	Continued From page	90	D 611			
		ot inform the survey team of uses at the time of entrance				
	8:48am revealed ther	ncierge on 03/05/24 at e were two residents with sted living (AL) section of				
	12/05/23 revealed dia	t #13's current FL-2 dated agnoses included uropathy, hemiplegia, and				
	from a local hospital of -Resident #13 was set facility on 03/02/24 for shortness of breath (\$ for a brief loss of cons	13's history and physical dated 03/04/24 revealed: ent to the hospital from the r having syncope and Syncope is a medical term sciousness or fainting).  ID-19 test at the hospital				
	from a local hospital of	13's discharge summary dated 03/04/24 revealed that charged back to the facility				
	03/04/24 revealed dia catheter, Type 2 diab failure with preserved kidney disease stage mellitus, coronary art	id artery disorder, and				
	from a local hospital of	15's discharge summary dated 03/04/24 revealed: o the emergency room on				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	HAL047015	B. WING			R-C 8 <b>/06/2024</b>	
NAME OF PROVIDER OR SUPPLIER		.DDRESS, CITY, STATE	ZIR CODE	1 00	700/2024	
NAME OF TROVIDER OR SOFT EIER		YETTEVILLE ROAD				
WICKSHIRE CREEKS CROSSING		RD, NC 28376	•			
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
drainage bagResident #15 tested   -Resident #15 was ad treated for a urinary treatinine and potassis -Resident #15 was dis and returned to the facility from 9:28am	g blood in his catheter  positive for COVID-19. Imitted to the hospital and act infection and elevated itum levels. Scharged from the hospital cility on 03/04/24.  O hall on the AL side of the 9:55am revealed: Scident #15 resided on the et alert staff or visitors e on isolation/quarantine. Carts/supplies outside of staff.  Cation aide (MA) on evealed: Resident #15 was positive tered medications to rning yet. Ident #13 was positive for need to administer ent #13 last.  If the AL 100 hall of the om 10:17am to 10:22am  ent Care Coordinator as a medication aide (MA). On cart with PPE outside of the medication cart ou	D 611				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
		HAL047015	B. WING		R-C <b>03/06/2024</b>
		HAL047013			03/06/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
MICKOLIII	DE ODEEKO ODOGONO	8398 FAYI	TTEVILLE RO	AD	
WICKSHII	RE CREEKS CROSSING	RAEFORI	), NC 28376		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE DATE
				DEFICIENCY)	
D 611	Continued From page	92	D 611		
		(PCA) wearing a surgical			
	mask and no other Pl	PE exited Resident #13's			
	room.				
		Resident #13's room without			
		efore entering the room.			
		esident #13's room and left			
	the door open approx				
		ash or sanitize her hands			
	immediately after exit				
		bare hands to use the touch			
	· -	ter to enter information into			
		tion administration record			
	(eMAR) system.				
		bare hands to unlock the			
		open the drawer to put a			
	medication card in the				
		shing the medication cart			
	down the hallway.	P			
		ne medication cart at the end			
	of the hallway and ap	plied hand sanitizer.			
	Intomicus with the AD	CC 03/05/24 -+ 10:22			
		CC on 03/05/24 at 10:23am			
	revealed:	required to wear a most			
		required to wear a mask ering a resident's room with			
	COVID-19.	ening a resident's room with			
		dent #13 was positive for			
	COVID-19.	MONTH TO WAS POSITIVE TO			
		PE when she entered			
		to administer Resident #13's			
	medications.	to darininotor resolutin # 103			
		vord of mouth" to know			
		positive for COVID-19.			
	Interview with the Adr	ministrator on 03/05/24 at			
	10:40am revealed:				
		2 residents in the facility			
	who had tested positi	<del>_</del>			
	-Resident #13 and Re				

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returned to the facility from the hospital yesterday,

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
			7. BOILDING.		R-C
		HAL047015	B. WING		03/06/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
MICKSHII	RE CREEKS CROSSING	8398 FAY	ETTEVILLE ROA	AD	
WICKSHII	NE CREEKS CROSSING	RAEFOR	D, NC 28376		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 611	Continued From page	93	D 611		
	O3/04/24.  -Both residents tested while they were in the -Both residents were -Both residents reside facility and were on is -They were trying to gmask or stay in their range of the residents of the recently did not do COVID-19; they only symptomatic.  -She recently (could range of the resident of the CDC guide someone with COVID symptoms for at least to quarantine but were -When facility staff was positive residents, stagloves and wash their to the resident.  -Prior to the 2 resident there were several repositive for COVID-19.  -There was no official which residents were -Facility staff usually of the resident of	d positive for COVID-19 e hospital emergency room. asymptomatic. ed on the AL side of the solation/quarantine. get the residents to wear a rooms. o mass testing for tested if someone was not give a specific date) saw elines now indicated if o-19 was without a fever or e 24 hours, they did not have ar a mask. as caring for COVID-19 aff should wear a mask and or hands after providing care atts currently with COVID-19, sidents and staff who tested of a couple of weeks ago. I signage or list to indicate positive for COVID-19. communicated this of mouth during shift and when a resident spital. bost signage indicating there ive individuals in the facility; notified visitors as they  on the Administrator on evealed: ave any recent updates to			

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updating all policies.

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DIVISION	n nealth Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
					l 5.	_
			D WING		R-(	
		HAL047015	B. WING		03/0	6/2024
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE ZIP CODE		
	1011211 011 001 1 21211					
WICKSHIP	RE CREEKS CROSSING		TTEVILLE RO	AD		
		RAEFORD	, NC 28376			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORT OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	MATE	DATE
				,		
D 611	0 611 Continued From page 94		D 611			
	<b>-</b>					
		d Environmental Services				
		sible for ensuring that all				
		ed infection control policies				
	and procedures.					
	-The facility no longer	restricted visitors during				
	COVID-19 outbreaks.					
	-Visitors should be inf	formed that there were				
	positive cases of CO\	/ID-19 in the facility and				
	asked to wear masks	-				
	-She was not aware t	hat the receptionist did not				
	immediately inform su	rveyors of COVID-19 cases				
	upon entrance to the	facility on 03/05/24.				
	· · · · · ·	d always wear a mask in a				
		the resident had tested				
	positive for COVID-19					
	-The facility had a CC					
		stacted the local health				
		message on a nurse's				
	•	receive a return call with any				
	instructions or guidan					
	_	eak at the facility that				
		asted approximately 10-14				
	days.	asted approximately 10-14				
	•	to call the health department				
	again during that time	· · · · · · · · · · · · · · · · · · ·				
	•	no were currently positive for				
	COVID-19 returned fr	, ·				
	03/04/24.	om me nospital on				
		ne local health department				
		•				
		eak of COVID-19 because				
	she had been too bus					
		wear a mask and gloves in a				
		ad COVID-19, but many				
	chose not to wear full	personal protective				
	equipment (PPE).					
		with the the local health				
		n 03/06/24 at 11:40am and				
	3:48pm were unsucce	essful.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDIEAN	SI GORREOTION	IDENTIFICATION NOWIDEN.	A. BUILDING:			
HAL047015 B. WING			R-C 03/06/			
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WICKSHII	RE CREEKS CROSSING	8398 FAYE <sup>-</sup> RAEFORD,	TTEVILLE ROANC 28376	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 611	The facility failed to e established by the fecton control and Preventic established infection procedures were being members to enter two residents' rooms with personal protective events of COV signage indicating a could increase the ris spread of COVID-19 facility. This failure was a fety, and welfare of constitutes a Type B. The facility provided a accordance with G.S. this violation.	nsure the recommendations deral Centers for Disease on (CDC) and the facility's control policies and ag followed by allowing staff or COVID-19 positive out the recommended quipment and failing to VID-19 positive cases with COVID-19 outbreak, which k of transmission and to other residents in the as detrimental to the health, if the residents and Violation.  The plan of protection in a 131D-34 on 03/07/24 for	D 611			

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