Division of Health Service Regulation (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD **WICKSHIRE CREEKS CROSSING** RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 000 initial Comments D 000 The Adult Care Licensure Section and Hoke County Department of Social Services conducted a follow-up survey and complaint investigation on March 5-6, 2024. The complaint investigation was initiated by the Hoke County Department of Social Services on February 20, 2024. It shall always bethe 4/5/24 procedure of the community D 358 D 358 10A NCAC 13F .1004(a) Medication Administration to assure that the preparation 10A NCAC 13F .1004 Medication Administration and administration of medications (a) An adult care home shall assure that the preparation and administration of medications. prescription and non-prescription, prescription and non-prescription, and treatments and treatments by staff that by staff are in accordance with: (1) orders by a licensed prescribing practitioner are in accordance with: which are maintained in the resident's record; and orders by a licensed prescribing (2) rules in this Section and the facility's policies and procedures. practitioner which are maintained in the residents record and the This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Facility's policies and procedures. Non-compliance continues with increased The medication carts are being 41512 severity resulting in residents placed at audited twice weekly by the ARCC, AMCC | Designee. substantial risk that death or serious physical harm, abuse, neglect, or exploitation will occur. THIS IS A TYPE A2 VIOLATION The carts audits consist of 4/5/24 checking medications, checking Based on observations, interviews, and record reviews, the facility failed to ensure medications do not chush signs and a review were administered as ordered for 3 of 4 residents (#2, #8, #9) observed during the medication pass of the medication not available including errors with medications for enlarged prostate (#2), iron deficiency anemia (#2), policies. constipation (#2, #8, #9), acid reflux (#2, #8), high blood pressure and/or chest pain (#8), high At the Completion of the audi phosphorus levels (#8), mood stabilizer (#9), Division of Health Service Regulation LABORATORY, DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

STATEMEN	of Health Service Re				FORM	APPROV
AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G:	(X3) DATE SU COMPLE	
		HAL047015	B. WING_		R-0) 6/2024
IAME OF F	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE	1 03/00	12024
VICKSHII	RE CREEKS CROSSIN		YETTEVILLE F			
			RD, NC 28376			
(X4) ID PREFIX	SUMMARY:	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	 _	
TAG	REGULATORY O	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RE	(X5) COMPLETE DATE
D 358	Continued From page		D 358	No Appalance la		
	probiotic for gut hea	alth (#8), Vitamin B		the ARCO AMCO Desig	inee	
	supplement (#8), a :	topical pain patch (#8) and a		will notify the RCCIN	100176	
	medication used to:	Slow the rate of decline in		of a	ACCI DE	signer
	residents (#1, #2) in	; and for 2 of 5 sampled		/	7 Abc I	1156.1
	medications for high	cluding errors with blood pressure (#1),		discrepancies and or co	10,00	1/2/29
	diabetes (#1), urine	retention (#1), a blood thinner		President designation of the	ricemb	
	(#1), a muscle relax	er (#1), a nasal spray for		found during the audit		
1	allergy symptoms (# reflux (#2).	1), and a medication for acid		The RCC MCC will then	notify	اسال
	T1 6 "			the physician, family n	rember	4/5/2
	The findings are:			and pharmacy to obta		
	1. The medication er	ror rate was 55% as		0000	IN THE	
1 1	evidenced by 15 erro	ors out of 27 apportunities		missing medication on	d review	1
1.5	ouring the 7:00am/8:	00am medication page on		the missing medication	Drotoco	ls.
	03/05/24 and the 8:0	Oam medication pass on		The Community	Piore	
	03/06/24.			The Community comple	ited	
a	a. Review of Residen	nt #2's current FL-2 dated		an all Staff and Med To	ich 3	21/24
1 0	02/29/24 revealed:			Inservice on 3/21/24 1	ov the	1
-	Diagnoses included	chronic ischemic heart				
0	ilsease, polyneuropa	thy, and spinal stenosis		Community RN consulta	1	
F	rinere was an order (Release (DR) Enterio	for Ferrous Sulfate Delayed Coated (EC) 324mg 1		She inserviced every	one on.	
ta	ablet two times a day	for iron. (Ferrous Sulfate is			1	
a	n iron supplement us	sed to treat iron deficiency		Diabetes, Do not crush i	ncas,	
a	nemia. Ferrous Sulf	ate is delayed release and		Insulin, Sliding Scale, H Hyperglycemia, med adn	VDC1	
n	as an enteric coating	to prevent stomach		The state of a		7.61-
l ei	ritation and upset an	d reduce the risk of		Hyperglycemia, mea dan	IIII STALL	CONT
n	ot be crushed or che	errous Sulfate DR should		time frames, parameters,	meds no	+
-T	here was an order for	or may crush medication			1	
ar	na mix with food/bev	erage to facilitate]	available, leaving meds of		
m	edication administra	tion.		reading orders on the MAR		
R	eview of Resident #3	2's hospital after visit		med process+timely an	d Meds	
SL	mmary (AVS) dated	2's nospital after visit 02/21/24 - 02/24/24		not evallable		
re	vealed the resident's	diagnoses included	The	not available. onserviced the	3	21/24
he	matemesis (vomiting	g blood) with nausea and	The c	oisultant also in serviced H	ne kuca	nd i

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B. WING 03/06/2024 HAL047015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) assistant RCC on Putting D 358 Continued From page 2 D 358 in orders on PCC correctly esophagitis (inflammation of the esophagus). not using abbreviations on orders, Observation of the 8:00am medication pass on applying the words * DO NOT CRUSH* 03/05/24 revealed: -The medication aide (MA) prepared morning to all med-orders that are medications for Resident #2, including one uncrushable, make sure parameters Ferrous Sulfate 324mg tablet. -The MA crushed all of Resident #2's oral tablets, are added on the orders' correctly including the Ferrous Sulfate, mixed them in and put in place that RCC and MCC applesauce and administered them to the resident at 9:28am. to review all orders for accuracy. Observation of Resident #2's medications on The community also purchased hand on 03/05/24 at 2:30pm revealed: -There was a supply of Ferrous Sulfate 324mg AM, PM and DONOT CRUSH +4 5/24 tablets, with the prescription label torn off and only about 1/4th of the label still attached to the Stickers that have been placed bottle. -There was a warning on the manufacturer's label on the medications according to not to crush or chew the medication. the way the physician has written the order. Review of Resident #2's March 2024 electronic medication administration record (eMAR) The EDWIII review notes 45/24 revealed: -There was an entry for Ferrous Sulfate 324mg from trainings and meetings to give 1 tablet two times a day for iron scheduled ensure the proper subjects for 8:00am and 8:00pm. -Ferrous Sulfate was documented as are being reviewed. administered from 03/01/24 - 03/05/24. -There was no information noted on the eMAR to The Community has also 4/5/24 indicate the medication should not be crushed. -There was an entry for may crush medication Staffed 2 med aides on and mix with food/beverage to facilitate medication administration. AL and changed the treatment times to be administered Interview with Resident #2 on 03/05/24 at 10:01am revealed: Ofter all of the pills have -The MAs usually crushed all of his medications. -It was easier for him to swallow the medications been passed out. if they were crushed.

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B. WING HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 358 | Continued From page 3 D 358 The RCC/MCC/Designee will check orders weekly -He denied any current symptoms of stomach upset or pain. to ensure all orders match Interview with the MA on 03/05/24 at 2:09pm the MAR. revealed: -She usually crushed all of Resident #2's The ED/Designee will perform prin checks to medications. -She thought the order to crush medications meant she could crush everything. ensure medications and -She did not know if the facility had a Do Not Crush (DNC) list. orders are on hand and correctly entered on the Interview with the Assistant Resident Care Coordinator (ARCC) on 03/05/24 at 2:42pm revealed: -There was a DNC list in a notebook on all medication carts. -She did not think the eMARs or the medication labels were marked with medications that could not be crushed. -The MAs knew about the DNC list and should refer to it before crushing any medications. -Resident #2's Ferrous Sulfate should not have been crushed. Interview with the Administrator on 03/05/24 at 4:02pm revealed: -There was a DNC list on the medication cart and in the medication room. -The MAs should reference the DNC list prior to crushing medications. -The MAs were trained and knew there was a DNC list available -Resident #2's Ferrous Sulfate should not have been crushed. Review of the facility's DNC medication list revealed Ferrous Sulfate DR was included on the list as a medication that should not be crushed.

Division of Health Service Regulation (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ R-C B. WING HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD **WICKSHIRE CREEKS CROSSING** RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) ID (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 D 358 Continued From page 4 Attempted telephone interview with the resident's primary care provider (PCP) on 03/06/24 at 4:18pm was unsuccessful. Telephone interview with the PCP's on call provider on 03/06/24 at 4:29pm revealed: -Ferrous Sulfate should not be crushed. -Crushing Ferrous Sulfate could cause the resident to have gastrointestinal irritation or precipitate gastrointestinal bleeding. b. Review of Resident #2's current FL-2 dated 02/29/24 revealed: -There was an order for Finasteride 5mg 1 tablet one time a day for prostate. (Finasteride is used to treat urinary retention caused by enlarged prostate. Finasteride is film-coated and should not be crushed.) -There was an order for may crush medication and mix with food/beverage to facilitate medication administration. Observation of the 8:00am medication pass on 03/05/24 revealed: -The medication aide (MA) prepared morning medications for Resident #2, including one Finasteride 5mg tablet. -The MA crushed all of Resident #2's oral tablets, including the Finasteride, mixed them in applesauce and administered them to the resident at 9:28am. Observation of Resident #2's medications on hand on 03/05/24 at 2:30pm revealed: -There was a supply of Finasteride 5mg tablets dispensed on 10/03/23. -There was no information noted on the label to indicate the medication should not be crushed.

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Review of Resident #2's March 2024 electronic

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R-C HAL047015 B. WNG 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 358 Continued From page 5 D 358 medication administration record (eMAR) -There was an entry for Finasteride 5mg 1 tablet once time a day for prostate scheduled for 8:00am. -Finasteride was documented as administered daily from 03/01/24 - 03/05/24. -There was no information noted on the eMAR to indicate the medication should not be crushed. -There was an entry for may crush medication and mix with food/beverage to facilitate medication administration. -There was no documentation to indicate if the resident's medication was being crushed. Interview with Resident #2 on 03/05/24 at 10:01am revealed: -The MAs usually crushed all of his medications. -It was easier for him to swallow the medications if they were crushed. -The medications did not usually hurt his stomach and he was not aware of any side effects from his medications. Interview with the MA on 03/05/24 at 2:09pm revealed: -She usually crushed all of Resident #2's medications. -She thought the order to crush medications meant she could crush everything. -She did not know if the facility had a Do Not Crush (DNC) list. Interview with the Assistant Resident Care Coordinator (ARCC) on 03/05/24 at 2:42pm revealed: -There was a DNC list in a notebook on all medication carts. -She did not think the eMARs or the medication. labels were marked with medications that could

PRINTED: 03/27/2024 **FORM APPROVED** Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R-C HAL047015 B. WING 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD **WICKSHIRE CREEKS CROSSING** RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 358 Continued From page 6 D 358 not be crushed. -The MAs knew about the DNC list and should refer to it before crushing any medications. -Resident #2's Finasteride should not have been crushed. Interview with the Administrator on 03/05/24 at 4:02pm revealed: -There was a DNC list on the medication cart and in the medication room. -The MAs should reference the DNC list prior to crushing medications. -The MAs were trained and knew there was a DNC list available. -Resident #2's Finasteride should not have been crushed. Review of the facility's DNC medication list revealed Finasteride was included on the list as a medication that should not be crushed. Attempted telephone interview with the resident's primary care provider (PCP) on 03/06/24 at 4:18pm was unsuccessful. Telephone interview with the PCP's on call provider on 03/06/24 at 4:29pm revealed: -Finasteride should not be crushed. -She was not aware of any specific concerns for the resident receiving crushed Finasteride. c. Review of Resident #2's current FL-2 dated 02/29/24 revealed an order for Pantoprazole 40mg 1 tablet two times a day for acid reflux.

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reflux disease.)

(Pantoprazole is used to treat gastroesophageal

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

resident suffered from persistent

Division of Health Service Regulation

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY PLETED
	H. Carlo	HAL047015	B. WNG			R-C /06/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
WICKSHII	RE CREEKS CROSSING		YETTEVILLE 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 ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	gastroesophageal ref Review of Resident # summary (AVS) dated revealed: -The resident's diagnicy (vomiting blood) with (inflammation of the electron of the el	2's hospital after visit d 02/21/24 - 02/24/24 coses included hematemesis nausea and esophagitis esophagus). To start taking Pantoprazole es a day. Coam medication pass on (MA) prepared and dications scheduled for 2 at 9:28am. The area and administer esident when he received dications. The administered as ordered. The area and administered as administered on 02/26/24. The area and administered as administered on 03/01/24 - 03/04/24.	D 358			
	Interview with Reside revealed:	nt #2 on 03/05/24 at 1:05pm	,			

Division of Health Service Regulation (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: R-C B. WING 03/06/2024 HAL047015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 Continued From page 8 D 358 -He thought he received Pantoprazole every day. -He was not sure if Pantoprazole was in the medication cup he received that morning. -He had problems with acid reflux, but he was not having any symptoms of acid reflux today. Interview with the MA on 03/05/24 at 2:09pm revealed: -She did not administer Resident #2's Pantoprazole that morning, 03/05/24, because she overlooked it in the medication cart. -She did not think the resident had any Pantoprazole available to administer. Interview with the Assistant Resident Care Coordinator (ARCC) on 03/05/24 at 2:42pm revealed: -The MAs were responsible for ordering medications. -If a medication was unavailable or on order, the MAs should notify her or the Resident Care Coordinator (RCC). -The MAs were supposed to double check the medication cart to make sure medications were available when administering medications. Interview with the Administrator on 03/05/24 at 4:02pm revealed: -If a medication was not in the medication cart, the MAs should notify the RCC, ARCC, or Memory Care Director (MCD). -The RCC, ARCC, or MCD would check behind the MAs to see if the medication was in the cart or the back-up supply. -The ARCC did a weekly cart audit and "9 times out of 10", the medications were available. Attempted telephone interview with the resident's PCP on 03/06/24 at 4:18pm was unsuccessful.

Division of Health Service Regulation

CTATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED							
	1905	HAL047015	B. WING		R-C 03/06/2024							
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE								
			YETTEVILLE ROAI									
WICKSHIE	RE CREEKS CROSSING	RAEFOR	RD, NC 28376									
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDI (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH COF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
D 358	Continued From page	9	D 358		# F - 1977							
	doses of Pantoprazol resident's risk of gast	at 4:29pm revealed missing										
	02/29/24 revealed an packet (17gm) one tir	t #2's current FL-2 dated order for Miralax give 1 ne a day for constipation. used to treat and prevent										
	03/05/24 revealed: -The medication aide (17gm) of Miralax pow 8-ounce styrofoam cu -The MA took the styr the resident's room at table at 9:37amThe resident asked it MA indicated it was M -The MA left the resident.	ofoam cup with Miralax to nd sat it on the bedside f that was Miralax and the liralax.										
	medication administrative revealed: -There was an entry for (17gm) one time a date for 8:00am -Miralax was docume from 03/01/24 - 03/05 Observation of Residuation	for Miralax give 1 packet by for constipation scheduled inted as administered daily fi/24. ent #2's room on 03/05/24 at fifth Miralax was still sitting										

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED R-C	
HAL047015			B. WNG		03/06/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE	
WICKSHIP	RE CREEKS CROSSING		YETTEVILLE ROAD RD, 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETE
D 358	Continued From page	e 10	D 358	-	
	-There were approxing with Miralax remaining. Interview with Reside 10:01am revealed: -He had not finished MiralaxThe MAs usually left Miralax in his room a the day until it was guident any current diarrhea.	mately 2 ounces of water ag in the cup. ent #2 on 03/05/24 at drinking the water with the cup with water and and he usually drank it during one. ent issues with constipation or			
	1:05pm revealed the	dent #2's room on 03/05/24 at styrofoam cup with water onger sitting on the bedside			
	revealed he thought	ent #2 on 03/05/24 at 1:05pm he had finished drinking the e could not recall a time.			
	revealed: -There were certain take their medication did not observe becamedications on their -She did not usually Miralax because he -She saw a styrofoac can today, 03/05/24, thought he drank the medication pass. Interview with the As Coordinator (ARCC) revealed:	A on 03/05/24 at 2:09pm residents she had to observe as and some residents she ause they would take the own. observe Resident #2 take the would drink it on his own. In cup in Resident #2's trash around 1:00pm so she a Miralax from this morning's esistant Resident Care on 03/05/24 at 2:42pm			

PRINTED: 03/27/2024 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R-C B. WING HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 D 358 Continued From page 11 -The MA should have waited and observed Resident #2 drink all of the Miralax. Interview with the Administrator on 03/05/24 at 4:02pm revealed the MA should have observed Resident #2 take all of his medication, including the Miralax to make sure the resident did not spit it out or pour it out. Attempted telephone interview with the resident's primary care provider (PCP) on 03/06/24 at 4:18pm was unsuccessful. e. Review of Resident #8's current FL-2 dated 02/01/24 revealed: -Diagnoses included essential primary hypertension, stage 4 chronic kidney disease, anemia, weakness, peripheral vascular disease, osteoarthritis, edema, and generalized abdominal pain. -There was an order for Nifedipine ER 30mg 1 tablet 2 times a day for high blood pressure, hold if systolic blood pressure (SBP) is less than (<) 100. (Nifedipine ER is used to treat high blood pressure and chest pain.) Review of Resident #8's physician's order dated 02/23/24 revealed an order to change Nifedipine ER 30mg to once a day, if SBP is less than or equal to 130, then hold the daily dose. Observation of the 8:00am medication pass on

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03/05/24 revealed:

monitor was 122/74.

blood pressure.

-The medication aide (MA) took Resident #8's

-The resident's blood pressure reading on the

-The MA prepared and administered Nifedipine ER 30mg to the resident at 9:54am instead of

holding the medication as ordered.

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: R-C O3/06/20 NAME OF PROVIDER OR SUPPLIER WICKSHIRE CREEKS CROSSING SUMMARY STATEMENT OF DEFICIENCIES D PROVIDER'S PLAN OF CORRECTION		TE SURVEY		(X2) MULTIPLE C	(X1) PROVIDER/SUPPLIER/CLIA	OF DEFICIENCIES	STATEMENT
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD RAEFORD, NC 28376 (X4) ID PREPIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREPIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 12 Review of Resident #8's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Nifedipine ER 30mg give 1 tablet once time a day for high blood pressure, hold if SBP greater than (-2) 130. -Nifedipine ER was scheduled at 8:00am and documented as administered daily from 03/01/24 - 03/05/24. -The resident's blood pressure was checked daily at 8:00am and ranged from 122/74 - 147/62 from 03/01/24 - 03/05/24. Interview with Resident #8 on 03/05/24 at 12:55pm revealed: -She thought her high blood pressure had improved after her primary care provider (PCP) added some medications. -The MAs did not usually hold any of her blood pressure medications; she received them every day. -About 2 weeks ago (could not recall date or		MPLETED	СОМІ	A. BUILDING:	IDENTIFICATION NUMBER:	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	
WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 (34) ID PREFIX	24	R-C 03/06/2024		B. WING	HAL047015		
WICKSHIRE CREEKS CROSSING RAFORD, NC 28376 (A4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 358 Review of Resident #8's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Nifedipine ER 30mg give 1 tablet once time a day for high blood pressure, hold if SBP greater than (>) 130. -Nifedipine ER was scheduled at 8:00am and documented as administered daily from 03/01/24 -03/05/24. -The resident's blood pressure was checked daily at 8:00am and ranged from 122/74 - 147/62 from 03/01/24 - 03/05/24. Interview with Resident #8 on 03/05/24 at 12:55pm revealed: -She thought her high blood pressure had improved after her primary care provider (PCP) added some medications. -The MAs did not usually hold any of her blood pressure medications; she received them every day. -About 2 weeks ago (could not recall date or			ZIP CODE	RESS, CITY, STATE	STREFT ADD	POVIDER OR SUPPLIER	NAME OF DE
WICKSHIRE CREEKS CROSSING (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTION STATEMENT OF DEFICIENCIES) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 12 D 358 Review of Resident #8's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Nifedipine ER 30mg give 1 tablet once time a day for high blood pressure, hold if SBP greater than (>) 130. -Nifedipine ER was scheduled at 8:00am and documented as administered daily from 03/01/24 - 03/05/24. -The resident's blood pressure was checked daily at 8:00am and ranged from 122/74 - 147/62 from 03/01/24 - 03/05/24. Interview with Resident #8 on 03/05/24 at 12:55pm revealed: -She thought her high blood pressure had improved after her primary care provider (PCP) added some medications; she received them every day. -About 2 weeks ago (could not recall date or						NO VIDEN ON SUFFEIEN	INCHES OF PE
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revealed: -There was an entry for Nifedipine ER 30mg give 1 tablet once time a day for high blood pressure, hold if SBP greater than (>) 130Nifedipine ER was scheduled at 8:00am and documented as administered daily from 03/01/24 - 03/05/24The resident's blood pressure was checked daily at 8:00am and ranged from 122/74 - 147/62 from 03/01/24 - 03/05/24. Interview with Resident #8 on 03/05/24 at 12:55pm revealed: -She thought her high blood pressure had improved after her primary care provider (PCP) added some medicationsThe MAs did not usually hold any of her blood pressure medications; she received them every dayAbout 2 weeks ago (could not recall date or							
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- 03/05/24. -The resident's blood pressure was checked daily at 8:00am and ranged from 122/74 - 147/62 from 03/01/24 - 03/05/24. Interview with Resident #8 on 03/05/24 at 12:55pm revealed: -She thought her high blood pressure had improved after her primary care provider (PCP) added some medicationsThe MAs did not usually hold any of her blood pressure medications; she received them every dayAbout 2 weeks ago (could not recall date or					cheduled at 8:00am and	-Nifedipine ER was s	
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added some medications. -The MAs did not usually hold any of her blood pressure medications; she received them every day. -About 2 weeks ago (could not recall date or						-She thought her high	
pressure medications; she received them every dayAbout 2 weeks ago (could not recall date or					ons.	added some medicat	
-About 2 weeks ago (could not recall date or						pressure medications	
						-About 2 weeks ago	
cloud" and her head went down. -She was positive that her blood pressure was					vent down.	cloud" and her head	
low and caused these symptoms. -She did not report the symptoms to anyone					symptoms.	low and caused thes	
because she got better.					•	· ·	
Interview with the MA on 03/05/24 at 2:09pm revealed:						revealed:	
-She was going by the instructions on the eMAR when she administered Resident #8's Nifedipine					ed Resident #8's Nifedipine	when she administer	
ER that morning, 03/05/24She did not enter the order on the eMAR to hold Nifedipine ER if the SBP was >130.					order on the eMAR to hold	-She did not enter th	
-The MAs did not enter orders on the eMAR and she was not sure who was responsible for entering the orders.				:	er orders on the eMAR and	-The MAs did not en she was not sure wh	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	COMPLETED						
		HAL047015	B. WING	R-C 03/06/2024							
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD RAEFORD, NC 28376										
(X4) ID PREFIX TAG			BE COMPLETE								
D 358	-She was not aware hold the Nifedipine E or equal to 130. Interview with the Ast Coordinator (ARCC) revealed: -The Resident Care (Care Director (MCD)) responsible for entering systemShe entered Reside into the eMAR syster -She thought the order of the the same of the system into the eMAR syster -She looked at the ordered it incorrectly -According to the ordered it incorrectly -According to the ordered it incorrectly -According to the ordered incorrectly with the Add 4:02pm revealed: -The ARCC entered incorrectly into the element of the same ordered. Attempted telephone PCP on 03/06/24 at a sepecially correctly correctly into the element of the same ordered.	Resident #8's order was to R if the SBP was less than sistant Resident Care on 03/05/24 at 2:42pm Coordinator (RCC), Memory and ARCC were ng orders into the eMAR of the Was to hold the Nifedipine eater than 130. der incorrectly and therefore, into the eMAR system. er, Resident #8's Nifedipine in held that morning, 03/05/24 is less than 130. ministrator on 03/05/24 at the Nifedipine ER order MAR system. pine ER should have been was less than or equal to 130 interview with the resident's 4:18pm was unsuccessful.	D 358	DEFICIENCY)							
	-Not holding the Nife	dipine ER could cause the blood pressure and increase									

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED R-C 03/06/2024	
ANDIDING	HAL047015		B. WING			
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
			YETTEVILLE ROAL			
WICKSHIF	RE CREEKS CROSSING	RAEFO	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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From pag	e 14	D 358			
D 336	f. Review of Residen 02/01/24 revealed at 250mg take 2 capsu gastrointestinal healt (Florastor is a probio gastrointestinal healt Observation of the 8 03/05/24 revealed the prepared and admin 250mg capsule instered and admin 250mg capsule instered and administered for 2 capsules 2 tin weeks scheduled for Florastor Probiotic administered from 0 Interview with Resid 12:55pm revealed: She did not know if medication.	at #8's current FL-2 dated in order for Florastor Probiotic les 2 times a day for th, take for 12 weeks. Stic used to benefit th.) :00am medication pass on the medication aide (MA) istered 1 Florastor Probiotic lead of 2 capsules as ordered. #8's March 2024 electronic ration record (eMAR) for Florastor Probiotic 250mg the medication aide (MAR) for Florastor Probiotic 250mg the saday for GI health for 12 to 8:00am and 8:00pm. capsule was documented as 3/01/24 - 03/05/24. Ident #8 on 03/05/24 at the she received a Probiotic atty having any stomach				
	revealed: -She usually admini capsules to Resider -She overlooked it a	and made an error that when she administered 1				
	Interview with the A Coordinator (ARCC revealed:	ssistant Resident Care) on 03/05/24 at 2:42pm trained to read the eMARs				

FORM APPROVED Division of Health Service Regulation (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R-C B. WING 03/06/2024 HAL047015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 D 358 Continued From page 15 and administer medications according to the instructions on the eMAR. -Resident #8 should have received two Florastor Probiotic capsules instead of 1 capsule. Interview with the Administrator on 03/05/24 at 4:02pm revealed the MA should have read both the eMAR and medication label and administered 2 capsules of Florastor Probiotic instead of 1 capsule. Attempted telephone interview with the resident's primary care provider (PCP) on 03/06/24 at 4:18pm was unsuccessful. Telephone interview with the PCP's on call provider on 03/06/24 at 4:29pm revealed only receiving half the dose of Florastor Probiotic could cause the medication not to be as effective in restoring gut flora and preventing diarrhea. g. Review of Resident #8's current FL-2 dated 02/01/24 revealed an order for Lidocaine Patch 4%, apply 1 patch to the right shoulder and neck topically in the morning for pain, remove at bedtime. (Lidocaine Patch is a topical patch used to treat pain.) Observation of the 8:00am medication pass on 03/05/24 revealed: -The medication aide (MA) prepared and administered morning medications to Resident #8 at 9:54am. -The MA did not apply or offer to apply a Lidocaine Patch to the resident's right shoulder

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and neck when the resident was administered her

-There was no Lidocaine Patch on the resident's

other morning medications

right shoulder and neck.

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: R-C B. WING HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 D 358 Continued From page 16 Observation of Resident #8 on 03/05/24 at 12:55pm revealed the resident had a Lidocaine Patch on the side of her lower left leg but there was no Lidocaine Patch on her right shoulder and neck. Interview with Resident #8 on 03/05/24 at 12:55pm revealed: -The MA put the Lidocaine Patch on her left lower leg sometime later in the morning (could not recall time). -The MA did not offer to put a Lidocaine Patch on her right shoulder and neck. -She denied any current pain in her right shoulder and neck. Review of Resident #8's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Lidocaine Patch 4% apply to right shoulder and neck topically in the morning for pain and remove at bedtime scheduled for 8:00am. -Lidocaine Patch was documented as applied daily from 03/01/24 - 03/05/24. -The Lidocaine Patch was documented as being applied to the neck and rear left shoulder on 03/01/24; the left leg and both shoulders on 03/02/24; the front left knee on 03/03/24; left front knee on 03/04/24; and the left leg on 03/05/24. Observation of Resident #8's medications on hand on 03/05/24 at 2:24pm revealed: -There was a supply of Lidocaine 4% Patches dispensed on 02/27/24. -The instructions were to apply topically to right shoulder and neck every morning for pain and remove at bedtime per schedule. Interview with the MA on 03/05/24 at 2:09pm

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PRINTED: 03/27/2024 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R-C B. WING HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 358 Continued From page 17 D 358 revealed: -She usually put Resident #8's Lidocaine Patch on the resident's lower left leg near her knee because that was where the resident usually told her to put it. -She did not usually put a Lidocaine Patch on the resident's right shoulder and neck. -She had not notified the PCP to get an order to put the Lidocaine Patch on the resident's leg because she was applying the patch where the resident told her to put it. Interview with the Assistant Resident Care Coordinator (ARCC) on 03/05/24 at 2:42pm revealed: -The MA should have applied Resident #8's Lidocaine Patch to her right shoulder and neck as indicated in the order and on the eMAR. -The MA should have notified her, the Resident Care Coordinator (RCC) or the primary care provider (PCP) that the resident was requesting the patch be applied to a different area and they could have gotten an order. Interview with the Administrator on 03/05/24 at 4:02pm revealed the MA should have read both the eMAR and medication label and administered the medication as ordered. Attempted telephone interview with the resident's PCP on 03/06/24 at 4:18pm was unsuccessful. Telephone interview with the PCP's on call provider on 03/06/24 at 4:29pm revealed not

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untreated area.

applying the Lidocaine Patch to the area ordered could put the resident at risk of pain in the

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

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WNG HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 358 Continued From page 18 D 358 Carbonate Oral Packet 0.8grams give 1 packet 3 times a day related to chronic kidney disease. (Sevelamer Carbonate lowers phosphate levels in chronic kidney disease/dialysis patients.) Review of Resident #8's primary care provider (PCP) visit dated 02/05/24 revealed: -The resident was admitted to the facility on 01/30/24. -The resident had end stage renal disease and received dialysis 3 times a week. Observation of the 8:00am medication pass on 03/05/24 revealed the medication aide (MA) prepared and administered Resident #8's Sevelamer Carbonate at 9:54am, 54 minutes beyond the allowed time frame. Review of Resident #8's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Sevelamer Carbonate Oral Packet 0.8gm give 1 packet 3 times a day related to chronic kidney disease. -Sevelamer Carbonate was scheduled to be administered at 8:00am, 12:00pm, and 5:00pm. -Sevelamer Carbonate was documented as administered from 03/01/24 - 03/05/24 except on 03/04/24 at 12:00pm and 5:00pm when the resident was out of the facility. Interview with Resident #8 on 03/05/24 at 12:55pm revealed: -She went to dialysis three times a week. -She sometimes received her morning medications as late as 10:00am. -She had not noticed any side effects or symptoms when her medications were late. Interview with the MA on 03/05/24 at 2:09pm

PRINTED: 03/27/2024 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R-C HAL047015 B. WING 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 358 I Continued From page 19 D 358 revealed: -Resident #8's Sevelamer Carbonate was administered late that morning, 03/05/24. -She was the only MA assigned to administer medications in the assisted living (AL) side of the facility. -It was a big medication pass and she ran late sometimes because there were so many residents and medications to administer. -She administered Resident #8's 12:00pm dose of Sevelamer Carbonate at lunch time around 12:30pm (about 2 and ½ hours after the late morning dose). Interview with the Assistant Resident Care Coordinator (ARCC) on 03/05/24 at 2:42pm revealed: -She was not aware the MA was running late with the morning medications on 03/05/24 until she noticed the MA was still at the medication cart administering medications (could not recall the time). -She started helping the MA administer the rest of the morning medications on 03/05/24 once she realized the medication pass was late. Interview with the Administrator on 03/05/24 at 4:02pm revealed: -If a MA was running late with a medication pass, the MA should notify the ARCC, Resident Care Coordinator (RCC), or Memory Care Director (MCD) so they could help.

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-If a MA was running too far behind on a medication pass, they should let the PCP know

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

and get advisement on what to do.

Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: ___ R-C B. WING 03/06/2024 HAL047015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 Continued From page 20 D 358 provider on 03/06/24 at 4:29pm revealed administering a medication late that was ordered 3 times a day could put the resident at risk of side i. Review of Resident #8's current FL-2 dated 02/01/24 revealed an order for Hydralazine 100mg 1 tablet 3 times a day for high blood pressure, hold if systolic blood pressure (SBP) is less than (<) 100. (Hydralazine is used to lower blood pressure.) Observation of the 8:00am medication pass on 03/05/24 revealed: -The medication aide (MA) checked Resident #8's blood pressure and the reading on the monitor was 122/74. -The MA prepared and administered Resident #8's Hydralazine 100mg at 9:54am, 54 minutes beyond the allowed time frame. Review of Resident #8's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Hydralazine 100mg 1 tablet 3 times a day for high blood pressure, hold if SBP is less than 100. -Hydralazine was scheduled to be administered at 8:00am, 2:00pm, and 8:00pm. -Hydralazine was documented as administered 3 times a day from 03/01/24 - 03/05/24 except on 03/01/24 and 03/04/24 when the resident was documented as out of the facility. -The resident's blood pressure was checked 3 times a day and ranged from 122/74 - 162/69. Interview with Resident #8 on 03/05/24 at 12:55pm revealed: -She sometimes received her morning

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medications as late as 10:00am.

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R-C B. WING 03/06/2024 HAL047015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 D 358 Continued From page 21 -She had not noticed any side effects or symptoms when her medications were late. -She thought her high blood pressure had improved after her primary care provider (PCP) added some medications. -About 2 weeks ago (could not recall date or time), she was sitting at a table and saw a "white cloud" and her head went down. -She was positive that her blood pressure was low and caused these symptoms. -She did not report the symptoms to anyone because she got better. Interview with the MA on 03/05/24 at 2:09pm revealed: -Resident #8's Hydralazine was administered late that morning, 03/05/24. -She was the only MA assigned to administer medications in the assisted living (AL) side of the facility. -It was a big medication pass and she ran late sometimes because there were so many residents and medications to administer. -She had just administered Resident #8's 2:00pm dose of Hydralazine about a minute ago, around 2:08pm (about 4 hours after the late morning dose). Interview with the Assistant Resident Care Coordinator (ARCC) on 03/05/24 at 2:42pm revealed: -She was not aware the MA was running late with the morning medications on 03/05/24 until she noticed the MA was still at the medication cart administering medications (could not recall the -She started helping the MA administer the rest of the morning medications on 03/05/24 once she

Division of Health Service Regulation

realized the medication pass was late.

Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ R-C B. WING HAL047015 03/06/2024 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) 1D COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 358 Continued From page 22 D 358 Interview with the Administrator on 03/05/24 at 4:02pm revealed: -If a MA was running late with a medication pass, the MA should notify the ARCC, Resident Care Coordinator (RCC), or Memory Care Director (MCD) so they could help. -If a MA was running too far behind on a medication pass, they should let the PCP know and get advisement on what to do. Attempted telephone interview with the resident's PCP on 03/06/24 at 4:18pm was unsuccessful. Telephone interview with the PCP's on call provider on 03/06/24 at 4:29pm revealed receiving Hydralazine doses too close together could cause the resident to have low blood pressure and increase the risk of falls. j. Review of Resident #8's current FL-2 dated 02/01/24 revealed an order for Pantoprazole 40mg 1 tablet 2 times a day for gastroesophageal reflux disease. (Pantoprazole is used to treat acid reflux.) Observation of the 8:00am medication pass on 03/05/24 revealed the medication aide (MA) prepared and administered Resident #8's Pantoprazole scheduled for 7:00am at 9:54am, 1 hour and 54 minutes beyond the allowed time Review of Resident #8's March 2024 electronic medication administration record (eMAR) -There was an entry for Pantoprazole 40mg 1 tablet 2 times a day for GERD scheduled for 7:00am and 4:00pm. -Pantoprazole was documented as administered from 03/01/24 - 03/05/24 except on 03/04/24 at

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER:

A. BUILDING:

R-C

HAL047015

B. WING

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WICKSHIRE CREEKS CROSSING

8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

	RAEFOR	D, NC 28376		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 23	D 358		-
	4:00pm when the resident was out of the facility.			
	Interview with Resident #8 on 03/05/24 at			
	12:55pm revealed:			
	-She sometimes received her morning			
	medications as late at 10:00am.			
	-She had not noticed any side effects or			
	symptoms when her medications were late.			
	Interview with the MA on 03/05/24 at 2:09pm revealed:			
ļ	-She usually administered Resident #8's			
	Pantoprazole scheduled for 7:00am with the			
	8:00am medications to save time.			
	-Resident #8's Pantoprazole was administered			
	late that morning, 03/05/24.			
	-She was the only MA assigned to administer			
	medications in the assisted living (AL) side of the]		
	facility.			
	-It was a big medication pass and she ran late			
	sometimes because there were so many			
	residents and medications to administer.			
	Interview with the Assistant Resident Care	0		
	Coordinator (ARCC) on 03/05/24 at 2:42pm revealed:			
	-She was not aware the MA was running late with			
	the morning medications on 03/05/24 until she	1 1		
	noticed the MA was still at the medication cart			
	administering medications (could not recall the			
	time).			
	-She started helping the MA administer the rest of			
	the morning medications on 03/05/24 once she			
	realized the medication pass was late.			
	Interview with the Administrator on 03/05/24 at			
	4:02pm revealed:			
	-If a MA was running late with a medication pass,			
	the MA should notify the ARCC, Resident Care			
	Coordinator (RCC), or Memory Care Director			

STATEMENT	of Health Service Regu FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
ANDIEN	or defined	HAL047015	A. BUILDING: B. WING		R-C 03/06/2024
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE		
WICKSHIE	RE CREEKS CROSSING		YETTEVILLE ROAI 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE OF THE APPR	BE COMPLETE
D 358	Continued From pag	e 24	D 358		
	(MCD) so they could				
	-If a MA was running				
		y should let the primary care			
	· · · · · ·	and get advisement on what			
	to do.				
	Attempted telephone	interview with the resident's			
		4:18pm was unsuccessful.			
	Telephone interview	with the PCP's on call			
	provider on 03/06/24				
	receiving Pantoprazo	ole late could cause the			
	medication to be less	s effective and increase the			
	resident's acid reflux	symptoms.			
	k. Review of Resider	nt #8's current FL-2 dated			
		n order for Senna Plus	1		1
	8.6/50mg take 1 tab				
	1	a Plus is a laxative and stool			
	softener used to trea	at and prevent constipation.)			
	Observation of the 8 03/05/24 revealed:	:00am medication pass on			
	-The medication aid	e (MA) prepared and			
		edications scheduled for			
	8:00am to Resident	#8 at 9:54am.			
	-The MA did not pre	pare and administer Senna			
	Plus to the resident	when she received her other			
	morning medications				
	-Senna Plus was no	t administered as ordered.			
	Observation of Resi	dent #8's medications on			
		: 2:11pm revealed there was			
	no Senna Plus avail	able for administration.			
	Review of Resident	#8's March 2024 electronic			
		ration record (eMAR)			
W	revealed:				
	-There was an entry	for Senna Plus 8.6/50mg 1			
	tablet 2 times a day	scheduled for 8:00am and			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL047015		(X2) MULTIPLE (A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		B. WING			R-C / 06/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATI	E, ZIP CODE		
WICKSHIP	RE CREEKS CROSSING		YETTEVILLE ROAI RD, NC 28376	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
D 358	twice a day from 03/0 -Senna Plus was doc administered at 8:00a "ordering medication" Interview with Reside 12:55pm revealed: -She was supposed t dayAt one time, she was constipation but it wa Interview with the MA revealed: -She did not administ that morning, 03/05/2 medication cartThe MAs were respo medications when the the supplyShe was not sure if had been orderedShe had not had tim supply of medications see if there was any Telephone interview at the facility's contra at 3:26pm revealed: -Resident #8 was a r on 01/30/24The pharmacy had r dispense any Senna 03/05/24.	sumented as administered 01/24 - 03/04/24. Sumented as not being am on 03/05/24 due to '. ent #8 on 03/05/24 at to receive Senna Plus every as having problems with as better now. A on 03/05/24 at 2:09pm ter Resident #8's Senna Plus every exercise it was not in the consible for ordering ere were 7 pills remaining in Resident #8's Senna Plus et o check the back-up in the medication room to	D 358			
	Interview with the As	sistant Resident Care				

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Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ___ R-C B. WNG 03/06/2024 HAL047015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID. (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 D 358 Continued From page 26 Coordinator (ARCC) on 03/05/24 at 2:42pm revealed: -The MAs were responsible for ordering medications. -She checked the medications on hand with the eMARs each week to make sure medications were available for administration. -If medications were not in the medication cart, the MAs should check the back up supply in the medication room. -Resident #8's Senna Plus should have been available for administration. Interview with the Administrator on 03/05/24 at 4:02pm revealed: -If a medication was unavailable during a medication pass, the MA should notify the ARCC, Resident Care Coordinator (RCC), or the Memory Care Director (MCD). -The MA should immediately check the back-up supply of medications during the medication pass to see if the medication was available in the medication room. Attempted telephone interview with the resident's primary care provider (PCP) on 03/06/24 at 4:18pm was unsuccessful. Telephone interview with the PCP's on call provider on 03/06/24 at 4:29pm revealed if the resident was supposed to receive Senna Plus as a scheduled dose, not receiving the Senna Plus could cause the resident to have constipation and more likely to have an impaction. I. Review of Resident #8's current FL-2 dated 02/01/24 revealed an order for Virt-Caps softgel give 1 capsule every day for supplement. (Virt-Caps softgel is a prescription Vitamin B supplement for conditions which may require

Division of Health Service Regulation (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ R-C B. WING HAL047015 03/06/2024 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 358 Continued From page 27 D 358 increased amounts of Vitamin B supplements, such as kidney disease.) Review of Resident #8's primary care provider (PCP) visit dated 02/05/24 revealed: -The resident was admitted to the facility on 01/30/24. -The resident had end stage renal disease and received dialysis 3 times a week. Observation of the 8:00am medication pass on 03/05/24 revealed: -The medication aide (MA) prepared and administered oral medications scheduled for 8:00am to Resident #8 at 9:54am. -The MA did not prepare and administer Virt-Caps to the resident when she received her other morning medications. -Virt-Caps were not administered as ordered. Observation of Resident #8's medications on hand on 03/05/24 at 2:11pm revealed there were no Virt-Caps available for administration. Review of Resident #8's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Virt-Caps softgel give 1 capsule every day for supplement scheduled for 8:00am. -Virt-Caps softgel was not documented as administered from 03/01/24 - 03/05/24 due to "needs to be ordered" and "on order". Interview with Resident #8 on 03/05/24 at 12:55pm revealed: -She went to dialysis three times a week. -She was not sure if she received Virt-Caps or if she had missed any doses.

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Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: R-C B. WING 03/06/2024 HAL047015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8398 FAYETTEVILLE ROAD **WICKSHIRE CREEKS CROSSING** RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 Continued From page 28 D 358 Interview with the MA on 03/05/24 at 2:09pm revealed: -She did not administer Resident #8's Virt-Caps that morning, 03/05/24, because it was not in the medication cart. -The MAs were responsible for ordering medications when there were 7 pills remaining in the supply. -She was not sure if Resident #8's Virt-Caps had been ordered. -She had not had time to check the back-up supply of medications in the medication room to see if there was any available. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/06/24 at 3:26pm revealed: -Resident #8 was a new admission to the facility on 01/30/24. -The pharmacy had not been requested to dispense any Virt-Caps until 02/26/24. -Virt-Caps was a non-covered medication by the resident's insurance. -The pharmacy faxed the facility to notify them of the non-coverage for Virt-Caps on 02/26/24. -The pharmacy did not hear back from the facility about Virt-Caps until 03/05/24. -The facility requested a 15-day supply of Virt-Caps be dispensed on 03/05/24 and the facility was going to pay out-of-pocket for the Virt-Caps. Interview with the Assistant Resident Care Coordinator (ARCC) on 03/05/24 at 2:42pm revealed: -The MAs were responsible for ordering medications. -She checked the medications on hand with the eMARs each week to make sure medications

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were available for administration.

Division of Health Service Regulation (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ R-C B. WING 03/06/2024 HAL047015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 D 358 Continued From page 29 -If medications were not in the medication cart, the MAs should check the back-up supply in the medication room. -She was not aware Resident #8's Virt-Caps were not available for administration until today, 03/05/24 -She contacted the facility's contracted pharmacy today, 03/05/24, about Resident #8's Virt-Caps. -The resident's insurance would not pay for the Virt-Caps. -They would notify the resident's provider about Virt-Caps. Interview with the Administrator on 03/05/24 at 4:02pm revealed: -If a medication was unavailable during a medication pass, the MA should notify the ARCC. Resident Care Coordinator (RCC), or the Memory Care Director (MCD). -The MA should immediately check the back-up supply of medications during the medication pass to see if the medication was available in the medication room. Attempted telephone interview with the resident's PCP on 03/06/24 at 4:18pm was unsuccessful. Telephone interview with the PCP's on call provider on 03/06/24 at 4:29pm revealed not receiving Virt-Caps as ordered could cause the resident to have vitamin deficiencies. m. Review of Resident #8's current FL-2 dated 02/01/24 revealed an order for Sodium Bicarbonate 650mg take 1 tablet 3 times a day. (Sodium Bicarbonate is a supplement that may slow the rate of decline of kidney disease.) Review of Resident #8's primary care provider (PCP) visit dated 02/05/24 revealed:

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Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ R-C B. WING 03/06/2024 HAL047015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 D 358 Continued From page 30 -The resident was admitted to the facility on 01/30/24. -The resident had end stage renal disease and received dialysis 3 times a week. Observation of the 8:00am medication pass on 03/05/24 revealed: -The medication aide (MA) prepared and administered oral medications scheduled for 8:00am to Resident #8 at 9:54am. -The MA did not prepare and administer Sodium Bicarbonate to the resident when she received her other morning medications. -Sodium Bicarbonate was not administered as ordered. Review of Resident #8's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Sodium Bicarbonate 650mg 1 tablet 3 times a day for supplement scheduled for 8:00am, 2:00pm, and 8:00pm. -Sodium Bicarbonate was documented as administered from 03/01/24 - 03/04/24 except on 03/01/24 and 03/04/24 at 2:00pm when the resident was out of the facility. -Sodium Bicarbonate was documented as not administered at 8:00am on 03/04/24 and 03/05/24 due to "ordering the medication". Interview with Resident #8 on 03/05/24 at 12:55pm revealed: -She went to dialysis three times a week. -She was not sure if she received Sodium Bicarbonate or if she had missed any doses. Interview with the MA on 03/05/24 at 2:09pm revealed: -She did not administer Resident #8's Sodium Bicarbonate that morning, 03/05/24, because it

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FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R-C B. WNG 03/06/2024 HAL047015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 D 358 Continued From page 31 was not in the medication cart. -The MAs were responsible for ordering medications when there were 7 pills remaining in the supply. -She was not sure if Resident #8's Sodium Bicarbonate had been ordered. -She had not had time to check the back-up supply of medications in the medication room to see if there was any available. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/06/24 at 3:26pm revealed: -Resident #8 was a new admission to the facility on 01/30/24. -The pharmacy dispensed 90 Sodium Bicarbonate tablets (one month supply) on 02/27/24 and they were delivered to the facility on 02/27/24. -There should still be some Sodium Bicarbonate tablets available for administration in the facility. Interview with the Assistant Resident Care Coordinator (ARCC) on 03/05/24 at 2:42pm revealed: -The MAs were responsible for ordering medications. -She checked the medications on hand with the eMARs each week to make sure medications were available for administration. -If medications were not in the medication cart. the MAs should check the back up supply in the medication room. -Resident #8's had a supply of Sodium Bicarbonate in the back up supply in the medication room.

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-The MA should have checked the back up supply

during the morning medication pass and administered the Sodium Bicarbonate.

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		OOWIF	LLILD
					F	R-C
		HAL047015	B. WING		03	/06/2024
IIIX N. W.	THE REPORT OF THE PERSON NAMED IN COLUMN 1			TIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
WICKSHIE	RE CREEKS CROSSING		YETTEVILLE ROAL)		
		RAEFOI	RD, NC 28376			
(X4) ID		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH		(X5) COMPLETE
PREFIX TAG		LISC IDENTIFYING INFORMATION)	PREFIX	CROSS-REFERENCED TO THE APP		DATE
				DEFICIENCY)		
D 358	Continued From pag	22	D 358			
D 330			D 000			
	Interview with the Ac	dministrator on 03/05/24 at				
	4:02pm revealed:					
		unavailable during a				
		MA should notify the ARCC,				
	Resident Care Coord	dinator (RCC), or the Memory				
	Care Director (MCD)					
		nediately check the back-up				
	supply of medication	ns during the medication pass				
	to see if the medicat	ion was available in the				
	medication room.					
		e interview with the resident's				
	PCP on 03/06/24 at	4:18pm was unsuccessful.				
	T-1	with the DCDIs on call				
	-	with the PCP's on call				
	•	1 at 4:29pm revealed not carbonate as ordered could				
	_	o have acid-base issues with				
		te and carbon dioxide.				
	balancing bicarbona	te and carbon dioxide.				
	n. Review of Reside	nt #9's current FL-2 dated				
	01/07/24 revealed:					
	-Diagnoses included	l frontotemporal				
		der, essential hypertension,				
	and hyperlipidemia.					
	• • •	for Depakote DR 250mg 1				
	tablet twice a day. (Depakote DR is a				
	delayed-release med	dication that can be used to				
	treat mood disorders	s.)				
		3:00am medication pass on				
	03/06/24 revealed:	- (BAA)				
		e (MA) prepared morning				
		ident #9, including one				
:	Depakote DR 250m	•				
		of Resident #9's oral tablets,				ĺ
İ		ote DR, mixed them in a				
		and administered one				
		p of the yogurt cup to the				
	resident at 8:34am.					

PRINTED: 03/27/2024 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B. WNG HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 358 Continued From page 33 D 358 -There were pieces of crushed pills left around the rim of the yogurt cup and in the yogurt inside the cup. -The MA sat the yogurt cup on the table beside the resident's breakfast plate and walked out of the dining room. -At 9:04am, a second MA assisted Resident #9 with her breakfast including feeding the yogurt with crushed medications to the resident. Observation of Resident #9's medications on hand on 03/06/24 at 12:33pm revealed: -There was a supply of Depakote DR 250mg tablets dispensed on 02/06/24. -There was a warning on the label not to crush or chew the medication, swallow whole. Review of Resident #9's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Depakote DR 250mg 1 tablet two times a day for mood stabilization scheduled for 8:00am and 4:00pm. -Depakote DR was documented as administered from 03/01/24 - 03/05/24. -There was no information noted on the eMAR to

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revealed:

indicate the medication should not be crushed.

-There was an entry for may crush appropriate medications/open capsules if not contraindicated

Interview with the MA on 03/06/24 at 12:32pm

-She usually crushed all of Resident #9's tablets

-She was not aware of a Do Not Crush (DNC) list and had not been trained to use a DNC list before

-Staff documented the entry for crushing medications for day shift, evening shift, and night shift from 03/01/24 - 03/05/24 (day shift).

every shift for swallowing.

and opened any capsules.

If continuation sheet 35 of 96

Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: R-C 03/06/2024 HAL047015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8398 FAYETTEVILLE ROAD **WICKSHIRE CREEKS CROSSING** RAEFORD, NC 28376 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 Continued From page 34 D 358 crushing medications. -She did not notice the warning label on the Depakote DR packaging that indicated the medication should not be crushed. Review of the facility's DNC medication list revealed Depakote DR was included on the list as a medication that should not be crushed. Interview with the Memory Care Director (MCD) on 03/06/24 at 12:57pm revealed: -There was a DNC list in each notebook on each medication cart. -The MAs were trained to check the DNC list prior to crushing medications. -Resident #9's Depakote DR should not be crushed. -If medications were crushed, the MAs were supposed to mix the crushed medications in a small amount of applesauce or yogurt in the plastic medication cup to make sure all of the crushed medications were administered. -Once the MAs administered crushed medications from the small plastic medication cup to a resident, the MAs were supposed to dispose of it in the trash can on the medication cart. -All residents in the SCU were confused so medications should not be left unattended with any resident. Interview with the Administrator on 03/06/24 at 1:09pm revealed: -There was a DNC list on each medication cart. -The MAs should check the DNC list prior to crushing medications. -The MAs should observe each resident take their medication. Attempted telephone interview with the resident's

Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ R-C B. WING 03/06/2024 HAL047015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 D 358 Continued From page 35 primary care provider (PCP) on 03/06/24 at 4:18pm was unsuccessful. Telephone interview with the PCP's on call provider on 03/06/24 at 4:29pm revealed: -Depakote DR should not be crushed. -Crushing Depakote DR would cause the medication to be released immediately so the medication would not last as long in the resident's system which could cause the resident to have increased agitation. Based on observations, interviews, and record review, it was determined that Resident #9 was not interviewable. o. Review of Resident #9's current FL-2 dated 01/07/24 revealed an order for Miralax 17gm (1 scoop) once daily. (Miralax is a laxative used to treat and prevent constipation. Miralax is a powder and the inside of the cap on the bottle has a marking for 17g that should be used to measure the dosage at the top of the white section of the inner cap.) Observation of the 8:00am medication pass on 03/06/24 revealed: -There was a white section lining the inside of the purple cap on the Miralax bottle. -There was "17g" imprinted near the top of the white section with an arrow pointing up to indicate the measurement for 17g was at the top of the white section inside the cap. -The medication aide (MA) poured the Miralax powder halfway below the marking for the 17g -The MA did not measure the Miralax correctly and the full dosage was not mixed in the cup of water. -The MA mixed the Miralax powder in water and

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Division of Health Service Regulation (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ R-C B. WNG 03/06/2024 HAL047015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 D 358 Continued From page 36 administered it to Resident #9 at 8:34am. -The resident drank all of the water with Miralax. Review of Resident #9's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Miralax give 17gm (1 scoop) one time a day for constipation scheduled for 8:00am. -Miralax was documented as administered daily from 03/01/24 - 03/05/24. Interview with the MA on 03/06/24 at 12:32pm revealed: -She thought the marking to measure the Miralax was the bottom of the "17" imprinted on the inside of the cap. -She had not seen the arrow pointing to the top of the white inner lining as the mark for 17gm. -She did not realize she had been measuring the Miralax incorrectly. -The resident had not complained of any constipation issues to her. Interview with the Memory Care Director (MCD) on 03/06/24 at 12:57pm revealed: -The MAs should use the cap of the Miralax bottle to measure the correct dosage. -She had not received any reports of Resident #9 having any current issues with constipation. Interview with the Administrator on 03/06/24 at 1:09pm revealed the MAs had been trained to use the lid on the Miralax bottle to measure the Miralax Powder. Attempted telephone interview with the resident's primary care provider (PCP) on 03/06/24 at 4:18pm was unsuccessful.

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R-C B. WING_ HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 358 Continued From page 37 D 358 Telephone interview with the PCP's on call provider on 03/06/24 at 4:29pm revealed if the resident did not get the full dose of Miralax, it would be less effective in treating the resident's constipation. Based on observations, interviews, and record review, it was determined that Resident #9 was not interviewable. 2. Review of Resident #2's current FL-2 dated 02/29/24 revealed diagnoses included chronic ischemic heart disease, polyneuropathy, and spinal stenosis. Review of Resident #2's physician's order dated 01/18/24 revealed an order for Omegrazole 20mg every morning. (Omeprazole is used to treat gastroesophageal reflux disease.) Review of Resident #2's physician's orders dated 02/12/24 revealed: -There was an order to discontinue Omegrazole 20mg every morning. -There was an order to start taking Omeprazole 10mg 1 capsule every morning starting on 02/13/24 Review of Resident #2's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Omeprazole 20mg 1 capsule in the morning for acid reflux scheduled at 8:00am. -Omeprazole 20mg was documented as administered daily from 02/01/24 - 02/14/24. -There was an entry for Omeprazole 10mg 1 capsule one time a day for gastroesophageal reflux disease with a start date documented as 02/15/24.

Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ R-C B. WING 03/06/2024 HAL047015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES iD (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 D 358 Continued From page 38 -Omeprazole 10mg was documented as not administered at 8:00am from 02/15/24 - 02/20/24 and 02/22/24 due to "not on the cart" and "on order". Attempted telephone interview with the resident's outside pharmacy provider on 03/06/24 at 3:50pm was unsuccessful. Review of Resident #2's hospital after visit summary (AVS) dated 02/21/24 - 02/24/24 revealed: -The resident's diagnoses included hematemesis (vomiting blood) with nausea and esophagitis (inflammation of the esophagus). -There was an order to start taking Pantoprazole 40mg 1 tablet two times a day. (Pantoprazole is used to treat gastroesophageal reflux disease.) Interview with Resident #2 on 03/05/24 at 1:05pm revealed: -He thought he received a medication for acid reflux every day. -He was not sure if he had missed any doses of acid reflux medication. -He had problems with acid reflux, but he was not having any symptoms of acid reflux today. -He denied any current symptoms of vomiting blood. Interview with the Assistant Resident Care Coordinator (ARCC) on 03/05/24 at 2:42pm revealed: -The MAs were responsible for ordering medications. -If a medication was unavailable or on order, the MAs should notify her or the Resident Care Coordinator (RCC). -The MAs were supposed to double check the medication cart to make sure medications were

Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ R-C B. WING 03/06/2024 HAL047015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE ID PREFIX (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) D 358 D 358 Continued From page 39 available when administering medications. Interview with the Administrator on 03/05/24 at 4:02pm revealed: -If a medication was not in the medication cart, the MAs should notify the RCC, ARCC, or Memory Care Director (MCD). -The RCC, ARCC, or MCD would check behind the MAs to see if the medication was in the cart or the back-up supply. -The ARCC did a weekly cart audit and "9 times out of 10", the medications were available. Attempted telephone interview with the resident's primary care provider (PCP) on 03/06/24 at 4:18pm was unsuccessful. Telephone interview with the PCP's on call provider on 03/06/24 at 4:29pm revealed in general missing doses of medications for acid reflux could increase the resident's risk of gastrointestinal irritation and precipitate the resident's recent gastrointestinal bleed. 3. Review of Resident #1's current FL-2 dated 11/16/23 revealed diagnoses included progressive supranuclear ophthalmoplegia, secondary Parkinsonism and spinal stenosis. a. Review of Resident #1's physician's orders dated 01/11/24 revealed there was an order for Apixaban oral tablet 2.5mg 1 tablet 2 times a day (used to treat blood clots). Review of Resident #1's February 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Apixaban oral tablet 2.5mg 1 tablet 2 times a day scheduled for administration at 9:00am and 9:00pm.

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE ((X3) DATI	(X3) DATE SURVEY		
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WICKSHII	RE CREEKS CROSSING		YETTEVILLE ROAI RD, NC 28376	U			
NA ID	CHMMADVCT						
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D 358	Continued From page	∋ 40	D 358				
	-There was an entry	of 09 for Apixaban oral tablet 02/05/24, 02/06/24 and e chart code says					
	exception report reve -The exception for the	e 09 entry for Apixaban oral					
	was "on order".	m on 02/05/24 and 02/06/24					
		tion listed for the 09 entry for 2.5mg on 02/13/24 for the					
	hand on 03/06/24 at 9 bottle of Apixaban ora	ent #1's medications on 0:22am revealed there was a al tablet 2.5mg give 1 tablet sed with 180 tablets on					
	Interview with Reside 9:40am, 10:50am and -He got his medication -He had not missed a	f 5:10pm revealed: ns on time.				4	
	(RCC) on 03/06/24 at	(MA) was responsible for ent Care Coordinator					
	-Medications were to a down to a 7 to 10 day -If family provided the give 14 days notice of familyThe MA was suppose pharmacy if the medic within two days.	be ordered when they were					

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ R-C 03/06/2024 HAL047015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 D 358 Continued From page 41 they got the medication from the facility's contracted pharmacy and paid for it. -"On order" meant the medication had been ordered, they were awaiting arrival and it had not been administered for that day. -There should have been an explanation for any entry that was documented as "09". -No one checked behind the MA on a daily basis. -She was not aware Resident #1 was not administered Apixaban on 02/05/24, 02/06/24 and 02/13/24. -Resident #1 was never out of his medications. -She did not know why the medication was not administered. -The Apixaban was listed as Eliquis on the bottle so the MA may not have known they were the -Resident #1's family member was supposed to bring all his medications but was having difficulty with the outside pharmacy. -When family was unable to obtain the medication, the facility could obtain the medication from their contracted pharmacy and the facility would pay for it. -Resident #1's family agreed to allow the facility to order the medication from the facility's contracted pharmacy and she would pay. Interview with the ARCC on 03/06/24 at 11:30am revealed: -The MA was responsible for ordering medications. -She did cart audits weekly. -No one checked behind the MA on a daily basis. -The resident was never out of his medications. -She was not aware Resident #1 was not administered Apixaban on 02/05/24, 02/06/24 and 02/13/24. -She did not know why the medication was not

Division of Health Service Regulation

administered.

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STATEMENT	of Health Service Regi of Deficiencies of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From pag	je 42	D 358		
	The Anivahan was	isted as Eliquis on the bottle			Tari III
		have known they were the			
	same.	,			
		ent Resident #1's family a			
	text message that in	cluded all of the prescription			
	numbers to show wh	nat medications needed to be			
	refilled.				
	-On 02/08/24, Resid	ent #1's family responded			
		ble to obtain 2 of the			
	medications.	that Davidson Hale Semilledhe			
		sked Resident #1's family the			
		tions she was unable to			
	provides (PCP) to w	ould get the primary care rite a prescription that would			
		obtain the medication from			
		rmacy. (The medication			
	names were not liste				
	1:00pm revealed:	dministrator on 03/06/24 at			
	-The MA was respo				
		ne medication reached a 7 to			
	10 day supply.				
	-The ARCC was exp	vhen she did the cart audit			
!	weekly.	Wien site did the cart addit			
		ne medication, they should			
	have been notified v	when there was a 7 to 10 day			
	-"On order" probabl	y meant the medication had			
		vas not administered.			
l l		ve been documenting			
	of "09".	tion was if they used the code			
		tion that the MA checked the			
		vell as the overstock			
1	1	ked to the RCC and ARCC			
[regarding unavailab				
		n ran out, the MA was to call	ŀ		
1	I the pharmacy to de	t the medication refilled, report			

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R-C HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 358 Continued From page 43 D 358 to a supervisor (RCC and ARCC) and document their efforts to get the medication. -The MA was to follow up daily with the pharmacy until the medication was obtained -If family did not provide the medication in a timely manner, they would order from the facility's contracted pharmacy and the facility would pay for the medication. -The RCC and the ARCC were responsible for contacting the facility's contracted pharmacy within 24 hours of the family not providing the medication. -She was not aware Resident #1 was not administered Apixaban on 02/05/24, 02/06/24 and 02/13/24. -She did not know why Resident #1's medication was not administered -Checking behind the MA was the function of the medication audit which would now be conducted twice a week. Telephone interview with the on-call provider for the PCP on 03/06/24 at 4:16pm revealed missed doses of Apixaban increased the resident's risk of blood clots. b. Review of Resident #1's physician's orders dated 01/11/24 revealed there was an order for Dulaglutide subcutaneously solution pen-injector 1.5mg/0.5ml inject 1.5mg subcutaneously 1 time a day every Wednesday (used to treat diabetes). Review of Resident #1's February 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Dulaglutide

8:00am. Division of Health Service Regulation

subcutaneously solution pen-injector 1.5mg/0.5ml inject 1.5mg subcutaneously 1 time a day scheduled for administration every Wednesday at

Division of Health Service Regulation (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ R-C B. WING 03/06/2024 HAL047015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 D 358 Continued From page 44 -There was an entry of 09 for Dulaglutide subcutaneously solution pen-injector 1.5mg/0.5ml on 02/21/24 and 02/28/24. Review of Resident #1's February 2024 facility exception report revealed: -There was no exception listed for the 09 entry for Dulaglutide subcutaneously solution pen-injector 1.5mg/0.5ml on 02/21/24. -The exception for the 09 entry for Dulaglutide subcutaneously solution pen-injector 1.5mg/0.5ml on 02/28/24 was "on order". Observation of Resident #1's medications on hand on 03/06/24 at 9:22am revealed there were 2 boxes of Dulaglutide subcutaneously solution pen-injector 1.5mg/0.5ml dispensed on 02/23/24 with (4 pens each box dispensed) with 7 pens Interview with Resident #1 on 03/06/24 at 9:40am, 10:50am and 5:10pm revealed: -He got his medications on time. -He had not missed any medications. -He knew he took Trulicity (brand name for Dulaglutide) but was unsure of what other medications he took. -He had never experienced high blood sugar or low blood sugar so he did not know what that felt like. Telephone interview with Resident #1's contact person on 03/05/24 at 4:10pm revealed: -She picked Resident #1's medication up from an outside pharmacy. -There was a distribution problem on behalf of Resident #1's pharmacy in February 2024. -She was not aware of Resident #1 running out of any medications. -Resident #1 should not have run out of any

Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R-C B. WING 03/06/2024 HAL047015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 D 358 Continued From page 45 medications. -The facility was supposed to inform her 2 weeks in advance of Resident #1 needing medication refills. Interview with a medication aide (MA) on 03/06/24 at 9:40am revealed: -She went to the Resident Care Coordinator (RCC) to request insulin when there were 4 insulin pens left. -She requested an insulin refill once for Resident #1 when she noticed it was not available in February 2024 but did not recall whether or not she noticed any other medications being unavailable. Interview with the RCC on 03/06/24 at 11:30am revealed: -The MA was responsible for ordering medications. -The Assistant Resident Care Coordinator (ARCC) did cart audits weekly. -Medications were to be ordered when they were down to a 7 to 10 day supply. -If family provided the medications, they tried to give 14 days notice of the need for a refill to the family. -The MA was supposed to follow up with the pharmacy if the medication was not received within two days. -If family did not provide the medication on time, they got the medication from the facility's contracted pharmacy and paid for it. -"On order" meant the medication had been ordered, they were awaiting arrival and it had not been administered for that day. -There should have been an explanation for any entry that was documented as "09".

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-No one checked behind the MA on a daily basis. -She was not aware Resident #1 was not

Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: __ R-C B. WNG 03/06/2024 HAL047015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID. (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 D 358 | Continued From page 46 administered Dulaglutide on 02/21/24 and 02/28/24. -Resident #1 was never out of his medications. -She did not know why the medication was not administered. -Resident #1's family member was supposed to bring all his medications but was having difficulty with the outside pharmacy. -The missed Dulaglutide doses could have possibly been due to Resident #1's family member not being able to obtain the medication. -When family was unable to obtain the medication, the facility could obtain the medication from their contracted pharmacy and the facility would pay for it. -Resident #1's family agreed to allow the facility to order the medication from the facility's contracted pharmacy and she would pay. Interview with the ARCC on 03/06/24 at 11:30am revealed: -The MA was responsible for ordering medications. -She did cart audits weekly. -No one checked behind the MA on a daily basis. -The resident was never out of his medications. -She was not aware Resident #1 was not administered Dulaglutide on 02/21/24 and 02/28/24. -She did not know why the medication was not administered. -On 02/07/24, she sent Resident #1's family a text message that included all of the prescription numbers to show what medications needed to be -On 02/08/24, Resident #1's family responded stating she was unable to obtain 2 of the medications. -On 02/08/24, she asked Resident #1's family the

name of the medications she was unable to

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B. WNG HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 358 | Continued From page 47 D 358 obtain so that she could get the primary care provider (PCP) to write a prescription that would allow the facility to obtain the medication from their contracted pharmacy. (The medications were not identified.) Interview with the Administrator on 03/06/24 at 1:00pm revealed: -The MA was responsible for ordering medications once the medication reached a 7 to 10 day supply. -It was also the expectation that the ARCC checked the medication supply when she did the cart audit weekly. -If family provided the medication, they should have been notified when there was a 7 to 10 day supply left. -"On order" probably meant the medication had been ordered and was not administered. -The MA should have been documenting whatever the exception was if they used the code of "09". -The MA was expected to check the cart thoroughly as well as the overstock medications and talk to the RCC and ARCC regarding unavailable medications. -When a medication ran out, the MA was to call the pharmacy to get the medication refilled, report to a supervisor (RCC and ARCC) and document their efforts to get the medication. -The MA was to follow up daily with the pharmacy until the medication was obtained -If family did not provide the medication in a timely manner, they would order from the facility's contracted pharmacy and the facility would pay for the medication. -The RCC and the ARCC were responsible for contacting the facility's contracted pharmacy

medication.

within 24 hours of the family not providing the

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: R-C B. WNG HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD **WICKSHIRE CREEKS CROSSING** RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY D 358 D 358 Continued From page 48 -She was not aware Resident #1 was not administered Dulaglutide on 02/21/24 and 02/28/24. -She did not know why Resident #1's medication was not administered -Checking behind the MA was the function of the medication audit which would now be conducted twice a week. Telephone interview with the on-call provider for the PCP on 03/06/24 at 4:16pm revealed missed doses of Dulaglutide affected the weekly blood sugar and increased the Hemoglobin A1C (test that measures average blood sugar levels over past 3 months). c. Review of Resident #1's physician's orders dated 01/11/24 revealed there was an order for Losartan potassium oral tablet 100mg 1 tablet 1 time a day (used to treat hypertension). Review of Resident #1's February 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Losartan potassium oral tablet 100mg 1 tablet 1 time a day scheduled for administration at 8:00am. -There was an entry of 09 for Losartan potassium oral tablet 100mg on 02/06/24 and 02/24/24. Review of Resident #1's February 2024 facility exception report revealed: -The exception for the 09 entry for Losartan potassium oral tablet 100mg on 02/06/24 was "on -There was no exception listed for the 09 entry for Losartan potassium oral tablet 100mg on 02/24/24. Observation of Resident #1's medications on

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FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 358 Continued From page 49 D 358 hand on 03/06/24 at 9:22am revealed there was a bottle of Losartan potassium oral tablet 100mg dispensed with 90 tablets on 01/17/24. Interview with Resident #1 on 03/06/24 at 9:40am, 10:50am and 5:10pm revealed: -He got his medications on time. -He had not missed any medications. -He knew what it felt like to have high blood pressure and had not experienced high blood pressure since being at the facility. Telephone interview with Resident #1's contact person on 03/05/24 at 4:10pm revealed: -She picked Resident #1's medication up from an outside pharmacy. -There was a distribution problem on behalf of Resident #1's pharmacy in February 2024. -She was not aware of Resident #1 running out of any medications. -Resident #1 should not have run out of any medications. -The facility was supposed to inform her 2 weeks in advance of Resident #1 needing medication refills. Interview with the Resident Care Coordinator (RCC) on 03/06/24 at 11:30am revealed: -The medication aide (MA) was responsible for ordering medications. -The Assistant Resident Care Coordinator (ARCC) did cart audits weekly. -Medications were to be ordered when they were down to a 7 to 10 day supply. -If family provided the medications, they tried to give 14 days notice of the need for a refill to the

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within two days.

family.

-The MA was supposed to follow up with the pharmacy if the medication was not received

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
AND PENN OF CONNECTION		(DEITH OWNOR HOMBEN	A. BUILDING:		D.C
	HAL047015		B. WING		R-C 03/06/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE	
, Daniel Ci I i		8398 FA	YETTEVILLE ROAI		
WICKSHIF	RE CREEKS CROSSING		RD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETE ATE DATE
D 358	Continued From pag	ge 50	D 358		
		vide the medication on time,			
		tion from the facility's			
	contracted pharmac				
		ne medication had been			
		awaiting arrival and it had not			
	been administered for				
		been an explanation for any			
	entry that was docur	mented as "09".			
		hind the MA on a daily basis.			
		Resident #1 was not			
		an on 02/06/24 and 02/24/24.			
		ever out of his medications.			
	-She did not know w	hy the medication was not			
	administered.				
		y member was supposed to			
	bring all his medicat	tions but was having difficulty			
	with the outside pha	rmacy.			
	-When family was u	nable to obtain the			
	medication, the facil	lity could obtain the			
		ir contracted pharmacy and			
	the facility would pa	y for it.			
		y agreed to allow the facility to			*
	order the medication	n from the facility's contracted			
	pharmacy and she				
		RCC on 03/06/24 at 11:30am			
	revealed:	M. L. Communications			
	-The MA was respo	nsible for ordering			
	medications.				
	-She did cart audits				
		ehind the MA on a daily basis			
		never out of his medications.			
		Resident #1 was not			
		rtan on 02/06/24 and	[
	02/24/24.				Į.
		why the medication was not			
	administered.				ļ
		sent Resident #1's family a	l l		
Į		ncluded all of the prescription			
	numbers to show w	hat medications needed to be			

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B. WNG HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 358 Continued From page 51 D 358 refilled. -On 02/08/24, Resident #1's family responded stating she was unable to obtain 2 of the medications. -On 02/08/24, she asked Resident #1's family the name of the medications she was unable to obtain so that she could get the primary care provider (PCP) to write a prescription that would allow the facility to obtain the medication from their contracted pharmacy. (The medications were not identified.) Interview with the Administrator on 03/06/24 at 1:00pm revealed: -The MA was responsible for ordering medications once the medication reached a 7 to 10 day supply. -It was also the expectation that the ARCC checked the medication supply when she did the cart audit weekly. -If family provided the medication, they should have been notified when there was a 7 to 10 day supply left. -"On order" probably meant the medication had been ordered and was not administered. -The MA should have been documenting whatever the exception was if they used the code of "09". -The MA was expected to check the cart thoroughly as well as the overstock medications and talk to the RCC and ARCC regarding unavailable medications. -When a medication ran out, the MA was to call the pharmacy to get the medication refilled, report to a supervisor (RCC and ARCC) and document their efforts to get the medication. -The MA was to follow up daily with the pharmacy until the medication was obtained -If family did not provide the medication in a timely manner, they would order from the facility's

Division of Health Service Regulation

	DER/SUPPLIER/CLIA FICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:			SURVEY PLETED
HAL	047015	B. WING			R-C /06/2024
NAME OF PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE	1 00	,00,2024
WICKSHIRE CREEKS CROSSING		YETTEVILLE ROAL			
WIGHTINE GREEKS GROSSING	RAEFOI	RD, NC 28376			
(X4) ID SUMMARY STATEMENT OF DEPARTMENT OF D	ECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
contracted pharmacy and the factor the medication. The RCC and the ARCC were recontacting the facility's contracted within 24 hours of the family not medication. She was not aware Resident #1 administered Losartan on 02/06/2-She did not know why Resident was not administered Checking behind the MA was the medication audit which would not twice a week. Telephone interview with the onthe PCP on 03/06/24 at 4:16pm in doses of Losartan increased the hypertension which could lead to d. Review of Resident #1's physicated 01/11/24 revealed there was Metformin HCI oral tablet 500mg (used to treat diabetes). Review of Resident #1's Februar medication administration record revealed: There was an entry for Metformi 500mg 2 times a day scheduled if administration at 8:00am and 8:00. There was an entry of 09 for Metablet 500mg on 02/17/24 and 02 8:00am dose and on 02/17/24 for dose. Review of Resident #1's Februar exception report revealed: The exception for the 09 entry for oral tablet 500mg on 02/17/24 at	esponsible for d pharmacy providing the was not 24 and 02/24/24. #1's medication e function of the w be conducted call provider for revealed missed risk of organ failure. cian's orders as an order for 2 times a day y 2024 electronic (eMAR) n HCl oral tablet for 0pm. tformin HCl oral t/18/24 for the r the 8:00pm	D 358			

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R-C B. WING HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD **WICKSHIRE CREEKS CROSSING** RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 358 Continued From page 53 D 358 -The exception for the 09 entry for Metformin HCI oral tablet 500mg at 8:00am on 02/18/24 was "on order". Observation of Resident #1's medications on hand on 03/06/24 at 9:22am revealed there was a bottle of Metformin HCI oral tablet 500mg 2 packs dispensed with 30 tablets on 02/19/24 with 49 left and 1 bottle dispensed with 180 tablets on 02/23/24. Interview with Resident #1 on 03/06/24 at 9:40am, 10:50am and 5:10pm revealed: -He got his medications on time. -He had not missed any medications. -He had never experienced high blood sugar or low blood sugar so he did not know what that felt like. Telephone interview with Resident #1's contact person on 03/05/24 at 4:10pm revealed: -She had no medication concerns on the facility's behalf. -She picked Resident #1's medication up from an outside pharmacy. -There was a distribution problem on behalf of Resident #1's pharmacy in February 2024. -She was not aware of Resident #1 running out of any medications. -Resident #1 should not have run out of any medications. -The facility was supposed to inform her 2 weeks in advance of Resident #1 needing medication refills. Interview with the Resident Care Coordinator (RCC) on 03/06/24 at 11:30am revealed: -The medication aide (MA) was responsible for ordering medications.

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-The Assistant Resident Care Coordinator

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: __ R-C 03/06/2024 HAL047015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 D 358 Continued From page 54 (ARCC) did cart audits weekly. -Medications were to be ordered when they were down to a 7 to 10 day supply. -If family provided the medications, they tried to give 14 days notice of the need for a refill to the -The MA was supposed to follow up with the pharmacy if the medication was not received within two days. -If family did not provide the medication on time, they got the medication from the facility's contracted pharmacy and paid for it. -"On order" meant the medication had been ordered, they were awaiting arrival and it had not been administered for that day. -"Not on the cart" meant the medication was not on the cart, had been ordered, they were awaiting arrival and it had not been administered for that day. -If the medication was not on the cart, the MA should have requested a refill and documented that they called the pharmacy or documented that they borrowed the medication instead of saying that it was not on the cart. -No one checked behind the MA on a daily basis. -She was not aware Resident #1 was not administered Metformin HCI on 02/17/24 and 02/18/24. -Resident #1 was never out of his medications. -She did not know why the medication was not administered. -When family was unable to obtain the medication, the facility could obtain the medication from their contracted pharmacy and the facility would pay for it. -Resident #1's family agreed to allow the facility to order the medication from the facility's contracted pharmacy and she would pay. Interview with the ARCC on 03/06/24 at 11:30am

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B. WING HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 358 Continued From page 55 D 358 revealed: -The MA was responsible for ordering medications. -She did cart audits weekly. -No one checked behind the MA on a daily basis. -The resident was never out of his medications. -She was not aware Resident #1 was not administered Metformin HCI on 02/17/24 and 02/18/24. -She did not know why the medication was not administered. -On 02/07/24, she sent Resident #1's family a text message that included all of the prescription numbers to show what medications needed to be refilled. -On 02/08/24, Resident #1's family responded stating she was unable to obtain 2 of the medications. -On 02/08/24, she asked Resident #1's family the name of the medications she was unable to obtain so that she could get the primary care provider (PCP) to write a prescription that would allow the facility to obtain the medication from their contracted pharmacy. (The medications were not identified.) Interview with the Administrator on 03/06/24 at 1:00pm revealed: -The MA was responsible for ordering medications once the medication reached a 7 to 10 day supply. -It was also the expectation that the ARCC checked the medication supply when she did the cart audit weekly. -If family provided the medication, they should have been notified when there was a 7 to 10 day supply left. -"On order" probably meant the medication had been ordered and was not administered.

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

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R-C HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 358 Continued From page 56 D 358 on the cart but could have been in the backup medications or overstock medications. -The MA should have been documenting whatever the exception was if they used the code of "09". -The MA was expected to check the cart thoroughly as well as the overstock medications and talk to the RCC and ARCC regarding unavailable medications. -When a medication ran out, the MA was to call the pharmacy to get the medication refilled, report to a supervisor (RCC and ARCC) and document their efforts to get the medication. -The MA was to follow up daily with the pharmacy until the medication was obtained If family did not provide the medication in a timely manner, they would order from the facility's contracted pharmacy and the facility would pay for the medication. -The RCC and the ARCC were responsible for contacting the facility's contracted pharmacy within 24 hours of the family not providing the medication. -She was not aware Resident #1 was not administered Metformin HCI on 02/17/24 and 02/18/24. -She did not know why Resident #1's medication was not administered -Checking behind the MA was the function of the medication audit which would now be conducted twice a week. Telephone interview with the on-call provider for the PCP on 03/06/24 at 4:16pm revealed missed doses of Metformin HCI increased the Hemoglobin A1C (test used to measure average blood sugar levels over the past 3 months) and decreased the control of diabetes. e. Review of Resident #1's physician's orders

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ R-C B. WING HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D 358 Continued From page 57 D 358 dated 01/11/24 revealed there was an order for Tamsulosin HCI oral capsule 0.4mg 1 time a day (used to treat urine retention). Review of Resident #1's February 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Tamsulosin HCI oral capsule 0.4mg 1 time a day scheduled for administration at 8:00am. -There was an entry of 09 for Tamsulosin HCl oral capsule 0.4mg on 02/22/24, 02/23/24, 02/24/24, 02/25/24, 02/26/24, 02/27/24, 02/28/24 and 02/29/24. Review of Resident #1's February 2024 facility exception report revealed: -The exception for the 09 entry for Tamsulosin HCI oral capsule 0.4mg on 02/22/24. 02/26/27 and 02/27/24 was "on order". -There was no exception listed for the 09 entry for Tamsulosin HCl oral capsule 0.4mg on 02/23/24, 02/24/24, 02/25/24 and 02/29/24. -The exception for the 09 entry for Tamsulosin HCl oral capsule 0.4mg on 02/28/24 was "not on the cart; on order". Observation of Resident #1's medications on hand on 03/06/24 at 9:22am revealed there was a pack of Tamsulosin HCI oral capsule 0.4mg 30 tablets dispensed on 03/05/24 with 29 left. Interview with Resident #1 on 03/06/24 at 9:40am, 10:50am and 5:10pm revealed: He got his medications on time.

-He had not missed any medications.

been no increased urination needs.

-He had not had any difficulty urinating and had been going to the bathroom the same; there had

PRINTED: 03/27/2024 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R-C HAL047015 B. WING 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D 358 Continued From page 58 D 358 Interview with the Resident Care Coordinator (RCC) on 03/06/24 at 11:30am revealed: -The medication aide (MA) was responsible for ordering medications. -The Assistant Resident Care Coordinator (ARCC) did cart audits weekly. -Medications were to be ordered when they were down to a 7 to 10 day supply. -If family provided the medications, they tried to give 14 days notice of the need for a refill to the family. -The MA was supposed to follow up with the pharmacy if the medication was not received within two days. -If family did not provide the medication on time, they got the medication from the facility's contracted pharmacy and paid for it. -"On order" meant the medication had been ordered, they were awaiting arrival and it had not been administered for that day, -"Not on the cart" meant the medication was not on the cart, had been ordered, they were awaiting arrival and it had not been administered for that dav. -If the medication was not on the cart, the MA should have requested a refill and documented that they called the pharmacy or documented that they borrowed the medication instead of saying that it was not on the cart. -There should have been an explanation for any entry that was documented as "09". -No one checked behind the MA on a daily basis. -She was not aware Resident #1 was not administered Tamsulosin HCI on

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02/22/24-02/29/24.

administered.

-Resident #1 was never out of his medications.
 -She did not know why the medication was not

-Resident #1's family member was supposed to bring all his medications but was having difficulty

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE : COMPL	
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		HAL047015	B. WING			-C 06/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	re, ZIP CODE		
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WICKSHI	RE CREEKS CROSSING	RAEFOR	D, NC 28376			311192
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF	CORRECTION	(X5)
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D 358	Continued From page	59	D 358			
	with the outside phare	nacy.				
		sin HCl doses could have				
	possibly been due to	Resident #1's family				
		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	1			
	pharmacy and she wo	оию рау.				
	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					
	administered Tamsulo 02/22/24-02/29/24.					
		y the medication was not				
	administered.	-				
		nt Resident #1's family a				
		luded all of the prescription it medications needed to be				
	refilled.	it medications needed to be				
		nt #1's family responded				
	stating she was unabl					
	medications.		İ			
	-On 02/08/24, she ask	ked Resident #1's family the				
	name of the medication	ons she was unable to				
		lld get the PCP to write a				
		d allow the facility to obtain				
		neir contracted pharmacy.				
	(The medications were	e not identified.)				
	Interview with the Adn	ninistrator on 03/06/24 at				
	1:00pm revealed:					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE SURVEY			
7111272741	or boracorion	IDENTIFICATION NOMBER:	A. BUILDING:		СОМ	COMPLETED	
		NAL 04704E	B. WING			R-C	
		HAL047015	D. THING		1 03	/06/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE			
WICKSHII	RE CREEKS CROSSING	8398 FA	YETTEVILLE ROAD)			
		RAEFOI	RD, 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO ' DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 358	Continued From page	e 60	D 358				
	-The MA was respons	sible for ordering					
		medication reached a 7 to					
	10 day supply.						
	-It was also the exped						
	checked the medicati	on supply when she did the					
	cart audit weekly.						
		medication, they should					
İ		nen there was a 7 to 10 day					
	supply left.						
		meant the medication had					
	been ordered and wa						
	- Not on the cart mea	ant the medication was not					
	medications or overst	have been in the backup					
	-The MA should have					-	
		on was if they used the code					
	of "09".	was in they used the code					
		n that the MA checked the					
İ	cart thoroughly as we						
		ed to the RCC and ARCC					
	regarding unavailable						
		an out, the MA was to call					
ļ		ne 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						
	-If family did not provid						
		ould order from the facility's					
	for the medication.	and the facility would pay					
1		CC were responsible for					
		contracted pharmacy	1			1	
		family not providing the					
	medication.	not providing the					
	-She was not aware R	esident #1 was not					
	administered Tamsulo						
1	02/22/24-02/29/24.						
	-She did not know why	Resident #1's medication					
	was not administered						
vision of Honl	th Service Pegulation					L	

PRINTED: 03/27/2024 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R-C B. WING HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 358 Continued From page 61 D 358 -Checking behind the MA was the function of the medication audit which would now be conducted twice a week. Telephone interview with the on-call provider for the PCP on 03/06/24 at 4:16pm revealed missed doses of Tamsulosin HCI increased urinary urgency. f. Review of Resident #1's physician's orders dated 01/11/24 revealed there was an order for Tizanidine HCI oral tablet 2mg 2mg 3 times a day (used to treat pain). Review of Resident #1's February 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Tizanidine HCl oral tablet 2mg 3 times a day scheduled for administration at 8:00am, 2:00pm and 8:00pm. -There was an entry of 09 for Tizanidine HCI 2mg at 8:00am on 02/05/24, 02/06/24, and 02/17/24 at 2:00pm on 02/05/24 and 02/17/24, and at 8:00pm on 02/17/24. Review of Resident #1's February 2024 facility exception report revealed: -The exception for the 09 entry for Tizanidine HCI oral tablet 2mg at 8:00am and 2:00pm on 02/05/24 and 02/06/24 for the 8:00am dose was "on order." - The exception for the 09 entry for Tizanidine HCI oral tablet 2mg at 8:00am, 2:00pm and 8:00pm

on 02/17/24 was "not on the cart".

-The exception for the 09 entry for Tizanidine HCI oral tablet 2mg at 8:00am and 2:00pm on 02/18/24 for the 8:00am was "not on the cart".

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

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER:

(X3) DATE SURVEY COMPLETED

B. WING_

HAL047015

R-C 03/06/2024

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

A. BUILDING: _

8398 FAYETTEVILLE ROAD

RAEFORD, NC 28376						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
D 358	Continued From page 62	D 358				
	3 packs of Tizanidine HCl oral tablet 2mg 30 tablets dispensed in each pack on 02/19/24 with 56 left.					
	Interview with Resident #1 on 03/06/24 at 9:40am, 10:50am and 5:10pm revealed: -He got his medications on timeHe had not missed any medicationsHe had not had any pain other than pain in his heel; no increased pain.					
	Interview with the Resident Care Coordinator (RCC) on 03/06/24 at 11:30am revealed: -The medication aide (MA) was responsible for ordering medicationsThe Assistant Resident Care Coordinator (ARCC) did cart audits weekly.					
	-Medications were to be ordered when they were down to a 7 to 10 day supplyIf family provided the medications, they tried to give 14 days notice of the need for a refill to the family.					
	-The MA was supposed to follow up with the pharmacy if the medication was not received within two days.					
į	-If family did not provide the medication on time, they got the medication from the facility's contracted pharmacy and paid for it"On order" meant the medication had been					
	ordered, they were awaiting arrival and it had not been administered for that day.					
	-"Not on the cart" meant the medication was not on the cart, had been ordered, they were awaiting arrival and it had not been administered for that					
	day. -If the medication was not on the cart, the MA should have requested a refill and documented					
	that they called the pharmacy or documented that they borrowed the medication instead of saying that it was not on the cart.					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL047015	B. WING		R-C 03/06/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	
MUCKELIII	DE CDEEKS ADAGONA	8398 FAY	ETTEVILLE ROAL		
WICKSHII	RE CREEKS CROSSING	RAEFOR	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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETE E APPROPRIATE DATE
D 358	Continued From page	63	D 358		
	-No one checked beh -She was not aware F administered Tizanidi				
	02/06/24, 02/17/24 ar				
		er out of his medications.			
		y the medication was not			
	administered.				
	bring all his medication	member was supposed to ans but was having difficulty			
	with the outside phare				
	-When family was una	able to obtain the			
	medication, the facility				
	the facility would pay	contracted pharmacy and			
		agreed to allow the facility to			
		from the facility's contracted			
	pharmacy and she wo	ould pay.			
	revealed:	CC on 03/06/24 at 11:30am			
	-The MA was respons	ible for ordering			
	medicationsShe did cart audits w	ookly			
		nd the MA on a daily basis.			
		er out of his medications.	}		
	-She was not aware R				
	administered Tizanidir				a II a
	02/06/24, 02/17/24 an	d 02/18/24. y the medication was not			
	administered.	y trie medication was not			
		nt Resident #1's family a			
	text message that incl	uded all of the prescription			
	refilled.	t medications needed to be			
		nt #1's family responded			
	stating she was unable medications.	e to obtain 2 of the			
ļ		ed Resident #1's family the			
	name of the medicatio	ns she was unable to			
	obtain so that she cou	ld get the primary care			

	I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:			E SURVEY PLETED
		HAL047015	B. WING			R-C 3/06/2024
	PROVIDER OR SUPPLIER IRE CREEKS CROSSING	8398 FA	ADDRESS, CITY, STATE YETTEVILLE ROAD RD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	provider (PCP) to wri allow the facility to obtheir contracted pharm were not listed in the Interview with the Adr 1:00pm revealed: -The MA was responsedications once the 10 day supplyIt was also the expectation cart audit weeklyIf family provided the have been notified wrisupply left"On order" probably been ordered and war"Not on the cart" means on the cart but could be medications or overstivas the expectation cart thoroughly as we medications and talke regarding unavailableWhen a medication or the pharmacy to get the a supervisor (RCC their efforts to get the to a supervisor (RCC their efforts to get the to a supervisor (RCC their efforts to get the to a supervisor (RCC their efforts to get the to a supervisor (RCC their efforts to get the to a supervisor (RCC their efforts to get the to a supervisor (RCC their efforts to get the to a supervisor (RCC their efforts to get the to a supervisor (RCC their efforts to get the to a supervisor (RCC their efforts to get the to a supervisor the facility's within 24 hours of the medication.	ite a prescription that would obtain the medication from macy. (The medications message.) ministrator on 03/06/24 at sible for ordering e medication reached a 7 to obtain that the ARCC from supply when she did the emedication, they should then there was a 7 to 10 day meant the medication had as not administered. For another than the MA checked the fill as the overstock and the RCC and ARCC emedications. In that the MA was to call the medication refilled, report and ARCC) and document medication. In up daily with the pharmacy	D 358			

PRINTED: 03/27/2024 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B. WNG HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D 358 Continued From page 65 D 358 missed medication. -She was not aware Resident #1 was not administered Tizanidine HCI on 02/05/24, 02/06/24, 02/17/24 and 02/18/24. -She did not know why Resident #1's medication was not administered -Checking behind the MA was the function of the medication audit which would now be conducted twice a week. Telephone interview with the on-call provider for the PCP on 03/06/24 at 4:16pm revealed missed doses of Tizanidine HCI increased the risk of muscle spasm and pain. g. Review of Resident #1's physician's orders dated 01/11/24 revealed there was an order for Flonase nasal spray 2 sprays in each nostril daily (used to treat allergy symptoms). Review of Resident #1's February 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Flonase nasal spray 2 sprays in each nostril scheduled for administration in the morning at 8:00am. -There was an entry of 09 for Flonase nasal spray on 02/05/24 and on 02/14/24. Review of Resident #1's February 2024 facility exception report revealed the exception for the 09 entry for Flonase nasal spray on 02/05/24 and 02/14/24 was "on order".

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

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

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		1, ,	E SURVEY PLETED
5. 10 to 10	HAL047015	B. WING			R-C / 06/2024
NAME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
WICKSHIRE CREEKS CROSSING		AYETTEVILLE ROAD PRD, NC 28376			
PREFIX (EACH DEFICIENCE	IATEMENT OF DEFICIENCIES CY 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
(RCC) on 03/06/24 a -The medication aide ordering medications -The Assistant Reside (ARCC) did cart auditions were to down to a 7 to 10 day -If family provided the give 14 days notice of family. -The MA was suppose pharmacy if the medication two daysIf family did not provided the goven they got the medication contracted pharmacy -"On order" meant the ordered, they were as been administered for -No one checked behaven and the same of the same	d 5:10pm revealed: ons on time. any medications. allergy symptoms. sident Care Coordinator t 11:30am revealed: o (MA) was responsible for the tare Coordinator ts weekly. be ordered when they were y supply. or medications, they tried to of the need for a refill to the sed to follow up with the cation was not received dide the medication on time, on from the facility's and paid for it. or medication had been waiting arrival and it had not or that day. wind the MA on a daily basis. Resident #1 was not or on 02/05/24 an 02/14/24. wer out of his medications. by 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	D 358			

Division of Health Service Regulation

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R-C HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Continued From page 67 D 358 D 358 pharmacy and she would pay. Interview with the ARCC on 03/06/24 at 11:30am revealed: -The MA was responsible for ordering medications. -She did cart audits weekly. -No one checked behind the MA on a daily basis. -The resident was never out of his medications. -She was not aware Resident #1 was not administered Flonase on 02/05/24 an 02/14/24. -She did not know why the medication was not administered. -On 02/07/24, she sent Resident #1's family a text message that included all of the prescription numbers to show what medications needed to be -On 02/08/24, Resident #1's family responded stating she was unable to obtain 2 of the medications. -On 02/08/24, she asked Resident #1's family the name of the medications she was unable to obtain so that she could get the primary care provider (PCP) to write a prescription that would allow the facility to obtain the medication from their contracted pharmacy. (The medications were not listed in the message.) Interview with the Administrator on 03/06/24 at 1:00pm revealed: -The MA was responsible for ordering medications once the medication reached a 7 to 10 day supply. -It was also the expectation that the ARCC checked the medication supply when she did the cart audit weekly. -If family provided the medication, they should have been notified when there was a 7 to 10 day supply left.

Division of Health Service Regulation

-"On order" probably meant the medication had

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C HAL047015 B. WING 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRFFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY D 358 Continued From page 68 D 358 been ordered and was not administered. -It was the expectation that the MA checked the cart thoroughly as well as the overstock medications and talked to the RCC and ARCC regarding unavailable medications. -When a medication ran out, the MA was to call the pharmacy to get the medication refilled, report to a supervisor (RCC and ARCC) and document their efforts to get the medication. -The MA was to follow up daily with the pharmacy until the medication was obtained -If family did not provide the medication in a timely manner, they would order from the facility's contracted pharmacy and the facility would pay for the medication. -The RCC and the ARCC were responsible for contacting the facility's contracted pharmacy within 24 hours of the family not providing the medication. -She was not aware Resident #1 was not administered Flonase on 02/05/24 an 02/14/24. -She did not know why Resident #1's medication was not administered -Checking behind the MA was the function of the medication audit which would now be conducted twice a week. Telephone interview with the on-call provider for the PCP on 03/06/24 at 4:16pm revealed missed doses of Flonase caused congestion and increased allergies. Telephone interview with Resident #1's responsible person on 03/05/24 at 4:10pm revealed: -She picked Resident #1's medication up from an outside pharmacy. -There was a distribution problem on behalf of Resident #1's pharmacy in February 2024.

Division of Health Service Regulation

-She was not aware of Resident #1 running out of

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING: __ R-C B. WNG_ HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD **WICKSHIRE CREEKS CROSSING**

	RAEFOR	RD, NC 28376		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE
D 358	Continued From page 69	D 358		
	any medications.			
	-Resident #1 should not have run out of any			
	medications.			
	-The facility was supposed to inform her 2 weeks			
	in advance of Resident #1 needing medication refills.			
	Interview with a MA on 03/06/24 at 9:40am revealed:			
	-The MA was responsible for ordering			
	medications.			
	-Medication was supposed to be ordered when			
	there were 7 to 10 pills left.			
	-If family provided the medication, the MA was			
	supposed to inform the family that the medication			
- 1	was running low when there were 7 to 10 pills left.			
	-Carts were audited every couple of weeks by the			
	RCC and the ARCC to make sure they had			
	enough medication.			
	-"On order" on the eMAR meant a request for a			
	refill had been faxed to the pharmacy and the			
	medication was not on the cart or in overstock and was not administered.			
	-She was unsure why Resident #1 had several			
	medications that were "on order".			
	-If a medication was not available, the MA was			
	supposed to select "09" and write a progress note			
	as to why the medication was not available.			
	-She was not aware of any policies regarding			}
	getting a resident's medication when it ran out			
	and family had not provided a refill.			
	-She was not aware of the use of a back up			
	pharmacy.			
	-She did not recall reporting any medications not			
;	available or not being administered to anyone.			
	Attempted interview with Resident #1's pharmacy			
	on 03/06/24 at 3:20pm was unsuccessful.			
'	The same of the sa			
:	The facility failed to administer medications as			

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C HAL047015 B. WNG 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 358 Continued From page 70 D 358 ordered to 3 of 4 residents observed during the medication passes on 03/05/24 and 03/06/24 resulting in a 55% medication error rate. Resident #2 missed at least 7 doses of a medication for acid reflux and had a hospital visit after missing the doses and was diagnosed with gastrointestinal bleed and esophagitis. Resident #2 was administered a crushed Ferrous Sulfate tablet and did not receive a new medication for acid reflux on 03/05/24 putting the resident at increased risk for gastrointestinal irritation and precipitating a gastrointestinal bleed. Resident #8's blood pressure medication was not held for a systolic blood pressure less than 130 on 03/05/24 putting the resident at risk of low blood pressure and increased falls. Resident #1 missed multiple doses of several medications due to the medications being unavailable including a blood thinner, medications for diabetes, high blood pressure, and a muscle relaxer putting the resident at increased risk of blood clots. decreased blood sugar control, increase risk of high blood pressure, muscles spasms and pain. The failure of the facility to administer medications as ordered placed the residents at substantial risk of serious physical harm and neglect and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/05/24 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 5, 2024. D 364 10A NCAC 13F .1004(g) Medication D 364 Administration

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B. WING HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 364 Continued From page 71 D 364 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. It shall always be the This Rule is not met as evidenced by: policy of the Community to ensure that medications 3/21/24 Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered within one hour before or after the scheduled times for 3 of 5 residents observed are administered to residents (#11, #13, #14) in the assisted living (AL) side of within one hour before or the facility on 3/05/24 resulting in medications ordered multiple times a day being administered one hour after the prescribed too close to the next scheduled administration or scheduled time Linless time and medications not being administered at consistent time intervals to ensure therapeutic precluded by emergency situations. effectiveness. The community had an RN The findings are: consultant to come in to the Review of the facility's Medication Administration Community and Inservice 3/21/24 Policies and Procedures with effective date of 10/01/20 revealed the facility would ensure that Med tech's and MCC/RCC medications were administered to the residents within one hour before or one hour after the on Medication Administrator prescribed or scheduled time unless precluded by emergency situations. time frames, parameters, meds not available, leaving meds at 3/21/24 Review of the facility's census report dated 03/05/24 revealed: bedside, reading orders on the -The facility's current in-house census was 66 MAR, reording meds process residents. -There were 40 residents currently residing in the and timely and meds not available. assisted living (AL) side of the facility. -There were 26 residents currently residing in the That training was completed 3/21/24 special care unit (SCU). on 3/21/24 by the RN Consultant BSN, RN. Observation of the assisted living (AL) side of the The RCCIMCCIARCGOISO facility on 03/05/24 at 9:55am revealed a

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: R-C HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD **WICKSHIRE CREEKS CROSSING** RAEFORD, NC 28376 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Separated all treatments from pills to ensure that D 364 Continued From page 72 D 364 medication aide (MA) was administering medications on 100 hall. all scheduled medications and treatments are given within the timeframe Interview with the MA on 03/05/24 at 9:55am revealed: -She was still administering the 8:00am medications to the residents on the 100 hall in the allotted and ordered. As new orders come in -There was usually one MA assigned to administer medications to all residents in the AL the RCC MCC | ARCC WILL on first shift -She usually started administering medications at ensure that all medications 7:00am and she usually finished around including treatment are -She had finished administering medications to scheduled according to the the residents who lived on the 200 hall in the AL Medication Administration rule but she still have 5 more residents to administer 8:00am medications on the 100 hall in the AL. of I hour before or one hour -There had not been any emergencies that morning that slowed down her medication pass. after its schedule. Observation of the AL on 03/05/24 at 10:05am The community has also 4/19/24 staffed 3 medication cides revealed the Assistant Resident Care Coordinator (ARCC) went to the 100 hall medication cart with a second laptop computer and started helping the on 1st shift to ensure there MA administer medications to the residents on the 100 hall. is ample time and help to Observation of the AL on 03/05/24 at 10:32am pass the medication. revealed the MA and ARCC finished The community has also changed the administration times of many medications administering medications in the AL side of the facility. Interview with the ARCC MA on 03/05/24 at 10:32am revealed she had just finished that can be administered by administering morning medications to the last resident in the AL side of the facility. 3rd shift therefore allowing A second interview with the MA on 03/05/24 at ample time to administer 2:09pm revealed:

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R-C HAL047015 B. WNG 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 364 D 364 scheduled medications and Continued From page 73 treatments within the hour -She was the only MA assigned to administer before and hour after rule. medications in the AL side of the facility. -She was responsible for administering medications to residents on the 100 hall and 200 The RCC MCC/ARCC Designee will check the missed 4/17 medication report daily to hall. -It was a big medication pass and she ran late sometimes because there were so many residents and medications to administer. -She started working as a MA independently ensure that medications dreabout the second week of February 2024. given within the time -She started with the fingerstick blood sugars, then went to 200 hall and then to 100 hall. allotted and the residents -She had told the ARCC in the past that it was a big medication pass and they needed more MAs. are recieving their medications -The ARCC would sometimes help her administer medications when the ARCC was not busy. the ED Designee will complete -The ARCC helped her finish administering weekly and as needed 41 missed med reports to ensure that medications are being given within the time allotted medications that morning, 03/05/24. Interview with the ARCC on 03/05/24 at 2:42pm revealed: -She was not aware the MA was running late with the morning medications on 03/05/24 until she noticed the MA was still at the medication cart administering medications (could not recall the and residents are receiving time). -She started helping the MA administer the rest of their medications, 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)

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during first shift.

7:30am - 11:30am.

-The first shift MAs were also responsible for administering treatments such as topical medications that were scheduled between

-Today, 03/05/24, was not a good day and the

Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ R-C 03/06/2024 HAL047015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 364 Continued From page 74 D 364 medication pass in the AL side of the facility was running late. -If a MA was running late with a medication pass, the MA was supposed to notify her or the RCC and they would help or get help. Interview with the Administrator on 03/05/24 at 4:02pm revealed: -There was usually 1 MA in the Al and 1 in the -Some of the early medications (6:00am and 7:00am) were administered by third shift to help decrease the amount of morning medications for first shift. -The MAs should let the ARCC, Resident Care Coordinator (RCC), or Memory Care Director (MCD) know if they were running late with the medication pass so they could get help for them. Review of the March 2024 electronic medication administration records (eMARs) for the 3 residents in the AL who received late medications ordered more than once daily on 03/05/24 revealed all 3 residents had medications ordered twice a day and/or 3 times a day. [For medications with multiple administrations, consistent time intervals are necessary to prevent side effects and adverse reactions.] a. Review of Resident #11's current FL-2 dated 09/18/23 revealed diagnoses included essential hypertension, constipation, hypothyroidism, seizures, Parkinson's disease, and cerebrovascular disease. Observation of the medication aide (MA) in the assisted living (AL) side of the facility administering morning medications on 03/05/24 revealed the MA administered Resident #11's medications scheduled for 8:00am at 10:30am, 1

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL047015	B. WNG			R-C /06/2024
	ROVIDER OR SUPPLIER RE CREEKS CROSSING	8398 FA	DDRESS, CITY, STATE YETTEVILLE ROAL 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 AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 364	hour and 30 minutes frame.	e 75 beyond the allowed time 11's March 2024 electronic	D 364			
	scheduled 3 times a c 8:00pm.	Parkinson's disease) was day at 8:00am, 2:00pm, and				
	care provider (PCP) of revealed: -Resident #11's medicadministered on time effectiveness. -Receiving Sinemet la					
	12/05/23 revealed dia hemiplegia, insomnia disorder, gastroesoph	t #13's current FL-2 dated gnoses included , hypertension, bipolar lageal reflux disease, less leg syndrome, retention				
	assisted living (AL) side administering morning revealed the MA adminedications schedule	edication aide (MA) in the de of the facility g medications on 03/05/24 inistered Resident #13's d for 8:00am at 10:18am, 1 beyond the allowed time				
	medication administrative revealed: -There were 5 medications	utions, Famotidine (for acid vizures or mood disorders),				

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R-C B. WING HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 364 Continued From page 76 D 364 constipation), and Trileptal (for seizures) scheduled twice a day at 8:00am and 8:00pm. -Tylenol Arthritis (for pain) was scheduled twice a day for 8:00am and 4:00pm. -Ferrous Gluconate (iron supplement) was scheduled 3 times a day at 8:00am, 2:00pm, and 5:00pm. Telephone interview with Resident #13's primary care provider (PCP) on 03/05/24 at 3:52pm revealed: -Resident #13's medications should be administered on time to ensure therapeutic effectiveness. -Administering medications used to treat seizures late, could lower the seizure threshold and put the resident at risk of having seizures. -Administering medications used to treat mood disorders late, could cause the resident to have increased behaviors. -A delay in getting pain medication could cause the resident to have breath through pain. c. Review of Resident #14's current FL-2 dated 108/31/23 revealed diagnoses included metabolic encephalopathy, overactive bladder, insomnia, traumatic brain injury, constipation, and hyperlipidemia. Observation of the medication aide (MA) in the assisted living (AL) side of the facility administering morning medications on 03/05/24 revealed the MA administered Resident #14's medications scheduled for 8:00am at 10:07am, 1 hour and 7 minutes beyond the allowed time frame. Review of Resident #14's March 2024 electronic medication administration record (eMAR) revealed there were 2 medications. Zonisamide

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B. WNG HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE 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. Telephone interview with Resident #14's primary care provider (PCP) on 03/05/24 at 3:52pm revealed: -Resident #14's medications should be administered on time to ensure therapeutic effectiveness. -Administering medications used to treat seizures late, could lower the seizure threshold and put the resident at risk of having seizures. D 366 10A NCAC 13F .1004 (i) Medication D 366 Administration It shall always be the 4/20/24 policy of the community that the recording of administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication on the medication administration immediately following administration of the record shall be by the staff medication to the resident and observation of the resident actually taking the medication and prior person who administers the to the administration of another resident's medication immediately following medication. Pre-charting is prohibited. administration of the medication This Rule is not met as evidenced by: to the resident and observation Based on observations, interviews and record reviews, the facility failed to ensure medication of the resident actually taking staff who administered medications actually the medication and prior to the administration of another residents observed 2 of 4 residents (#2, #9) taking their medications during the morning medication passes observed on 03/05/24 and 03/06/24. medication. Pre-charting is The findings are: prohibited. Review of the facility's Medication Administration The community hired

Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ R-C B. WING 03/06/2024 HAL047015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) RN Consultants, BSN, RN D 366 | Continued From page 78 D 366 who trained and Inserviced Policies and Procedures with effective date of 10/01/20 revealed the recording of the med techs on Medication administration on the medication administration Administration, time frames record (MAR) shall be by the staff person who administered the medication immediately parameters, meds not available and following administration of the medication to the leaving meds at bedside. resident and observation of the resident actually taking the medication prior to the administration of another resident's medication. All new med aides are inserviced on Medication Administration 420/24 1. Review of Resident #9's current FL-2 dated 01/07/24 revealed: time frames, parameters, meds -Diagnoses included frontotemporal neurocognitive disorder, essential hypertension, not available and leaving meds and hyperlipidemia. -There was an order for Norvasc 5mg 1 tablet at preside. daily. (Norvasc is used to lower blood pressure.) The RCC/MCC/ARCC will complete weekly routine passes to 4/20/24 -There was an order for Depakote DR 250mg 1 tablet twice a day. (Depakote DR is a delayed-release medication that can be used to treat mood disorders.) observe and ensure that med aides are watching residents take their medication and not left Review of Resident #9's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Norvasc 5mg 1 tablet The ED Designer will 4/20/24 complete PRN passes to once daily scheduled at 8:00am. -Norvasc was documented as administered from 03/01/24 - 03/06/24. -There was an entry for Depakote DR 250mg 1 observe and ensure that med tablet two times a day for mood stabilization aides are watching residents takes their medication and scheduled for 8:00am and 4:00pm. -Depakote DR was documented as administered from 03/01/24 - 03/06/24 (8:00am). not being left bedside Observation of the 8:00am medication pass in the special care unit (SCU) on 03/06/24 revealed: -Resident #9 was sitting alone at the bar attached to the serving station in the SCU dining room eating breakfast.

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HAL047015 B. WING	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY STATE 7th CODE	72024
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 CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366 Continued From page 79 D 366	
-There were 23 other SCU residents sitting at multiple tables throughout the dining room eating breakfastThe medication aide (MA) prepared morning medications for Resident #9, including one Depakote DR 250mg tablet and one Norvasc 5mg tabletThe MA crushed both tablets and mixed them in a whole cup of yogunt and administered one spoonful from the top of the yogurt cup to the resident at 8:34amThere were pieces of crushed pills left around the rim of the yogurt cup and in the yogurt inside the cupThe MA did not attempt to have the resident eat anymore yogurt with the crushed pieces of medicationThe MA sat the yogurt cup on the table beside the resident's breakfast plate and walked out of the SCU dining roomThe MA did not stay in the dining room to observe the residentThe MA went to the nurses' station outside of the dining room and worked sitting at the deskThe MA did not attempt to go back to Resident #9's table to see if she had eaten the yogurtAt 8:57am, the resident picked up the cup of yogurt and ate a few spoonfuls but there was still crushed medication particles in the yogurtAt 8:59am, a personal care aide (PCA) stopped at Resident #9's table and provided feeding assistance with some of her breakfast, including 2 spoonfuls of yogurtAt 9:02am, the residents started eating some of the yogunt again but did not finish itAt 9:02am, a second MA was walking by and stopped to assist Resident #9 with eating her breakfast including feeding the remainder of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		СОМР	(X3) DATE SURVEY COMPLETED R-C	
		HAL047015	B. WING			06/2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376						
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 366	revealed: -She usually crushed and opened any cap applesauceShe usually handed the resident take the applesauce herselfThat morning on 03 crushed medications and tried to keep all at the top of the yog -She gave the resident receive medications becaus -She did not think all Interview with the M on 03/06/24 at 12:5 -If medications were supposed to mix the small amount of applastic medication or yogurt, to make sum medications were a -Once the MAs adm medications from the cup to a resident, the dispose of it in the totartAll residents in the medications should any residentThe MAs were suptake all their medications the cup to a the total cartThe MAs were suptake all their medications the cup to a the total cart.	A on 03/06/24 at 12:32pm d all of Resident #9's tablets issules and mixed in d the resident a spoon and let ecrushed medication in b/06/24, she mixed the is in the whole cup of yogurt of the crushed medications urt cup. ent one spoonful of yogurt ations, but she was not sure if d all of the crushed is she forgot to check. bout it until "after the fact". demory Care Director (MCD) 7pm revealed: e crushed, the MAs were e crushed medications in a colesauce or yogurt in the small oup, not the whole cup of e all of the crushed dministered. Ininistered crushed in esmall plastic medication in the MAs were supposed to crash can on the medication. SCU were confused so and beginning the sidents.	D 366			
	1:09pm revealed:	n trained and should observe				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		СОМ	(X3) DATE SURVEY COMPLETED	
		HAL047015	B. WING		03	3/06/2024
	ROVIDER OR SUPPLIER RE CREEKS CROSSING	8398 FA	DDRESS, CITY, STATE			
			RD, NC 28376			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 366	Continued From page	e 81	D 366			
		the SCU and the MA should sident take all the yogurt				
		ns, interviews, and record ined that Resident #9 was				
	02/29/24 revealed: -Diagnoses included disease, polyneuropa-There was an order	at #2's current FL-2 dated chronic ischemic heart athy, and spinal stenosis. for Miralax give 1 packet ay for constipation. (Miralax creat and prevent				
	assisted living (AL) sirevealed: -The medication aide (17gm) of Miralax por 8-ounce styrofoam or 1-the MA took the styrothe resident's room at table at 9:37am. -The resident asked it MA indicated it was Marthe MA left the residents observing or asking the Miralax. Review of Resident # medication administrative revealed: -There was an entry it in the resident # medication administrative revealed:	rofoam cup with Miralax to nd sat it on the bedside If that was Miralax and the Miralax. Ident's room without the resident to take the Ident's March 2024 electronic ation record (eMAR) Ident's Miralax give 1 packet				
:	for 8:00am	ay for constipation scheduled ented as administered daily				

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Division of Health Service Regulation (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: R-C B. WING HAL047015 03/06/2024 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 366 D 366 Continued From page 82 from 03/01/24 - 03/05/24. Observation of Resident #2's room on 03/05/24 at 10:01am revealed: -The styrofoam cup with Miralax was still sitting on the corner of the bedside table. -There were approximately 2 ounces of water with Miralax remaining in the cup. Interview with Resident #2 on 03/05/24 at 10:01am revealed: -He had not finished drinking the water with Miralax. -The MAs usually left the cup with water and Miralax in his room and he usually drank it during the day until it was gone. Observation of Resident #2's room on 03/05/24 at 1:05pm revealed the styrofoam cup with water and Miralax was no longer sitting on the bedside table. Interview with Resident #2 on 03/05/24 at 1:05pm revealed he thought he had finished drinking the Miralax earlier, but he could not recall a time. Interview with the MA on 03/05/24 at 2:09pm revealed: -There were certain residents she had to observe take their medications and some residents she did not observe because they would take the medications on their own. -She did not usually observe Resident #2 take the Miralax because he would drink it on his own. -She saw a styrofoam cup in Resident #2's trash can today, 03/05/24, around 1:00pm so she thought he drank the Miralax from this morning's medication pass. -There was one resident in the AL side of the

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facility who was confused and had wandering

PRINTED: 03/27/2024 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B. WING HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 366 Continued From page 83 D 366 behaviors but that resident was currently in the hospital. Interview with the Assistant Resident Care Coordinator (ARCC) on 03/05/24 at 2:42pm revealed: -The MAs were supposed to wait and observe residents take all of their medications. -The MA should have waited and observed Resident #2 drink all of the Miralax. Interview with the Administrator on 03/05/24 at 4:02pm revealed the MA should have observed Resident #2 take all of his medication, including the Miralax to make sure the resident did not spit it out or pour it out. D 377 10A NCAC 13F .1006(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

The findings are:

lubricant eye drop, a topical pain relief spray, and

a foam for relief of muscle cramps.

Review of the facility's Medication Storage

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		HAL047015	B. WNG		03/06/2024
	ROVIDER OR SUPPLIER	8398 FA	ADDRESS, CITY, ST YETTEVILLE RO RD, NC 28376		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 377	10/01/20 revealed: -Medications that are stored in the resident safe and secure man-Medications must be within the resident's in the resident's in the resident's in the resident's in the resident's in the resident's in the resident's in the resident's in the resident's in the resident's in the resident's in the resident's in the resident's in the resident's bedside to the residen	eself-administered and eself-administered and est room shall be stored in a ener. estored behind lock and key room. #2's current FL-2 dated chronic ischemic heart athy, and spinal stenosis. for Aspercreme Maximum Spray apply topically at leg pain; may self-administer ercreme is used to treat ins.) for Theraworx apply topically at feet for pain; may bervised. (Theraworx is a treat muscle cramps.) for Refresh Plus eye drops in eye every 4 hours as (Refresh Plus is a lubricant at dry eyes.) dent #2's room in the assisted of facility on 03/05/24 at in a private room with no estions sitting on top of the able. Aspercreme Maximum Spray with the resident's can; a bottle of Theraworx supply of Refresh Plus unit	D 377	It shall continue the policy of the of to ensure that Medithat are self adminant stored in the reservoir shall be store safe and secure ma as specified in the or care home's medication policy and procedure. The community pullock boxes for any that self administ medication, with a ensure that their in being stored correct. The Rec/Mec/ARCC the Self administration and contract.	cations 4/20/24 nistered nistered sidents din a nner duit on storage s. rchased 4/20/2 y resident ers their key to neds are y. will check ation residents
	A second observation	n of Resident #2's room on		meds weekly to en	1Sure that

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 377 Continued From page 85 D 377 medications are being stored 4/20/24 03/05/24 at 10:01am revealed: appropriately. -Resident #2 was in his room. -The Aspercreme, Theraworx, and Refresh Plus The ED/ Designee will 4/20/24 were sitting on top of the resident's bedside table. check self-administration A third observation of Resident #2's room on 03/05/24 at 1:05pm revealed: medication residents medication -Resident #2 was in his room. -The Aspercreme, Theraworx, and Refresh Plus to ensure that the meds are were sitting on top of the resident's bedside table. being stored correctly. Interview with Resident #2 on 03/06/04 at 4:56pm The community will purchase -He self-administered the 3 medications he kept on his bedside table. lock boxes for all residents -He did not usually lock the door to his room who have been deemed able 4/20/24 when he left the room. -He had not been instructed to put the to self administer their medications in a locked area. medications. Interview with a medication aide (MA) on 03/05/24 at 2:09pm revealed: -She was not sure how medications were to be stored when a resident self-administered medications. -There was one resident in the AL side of the facility who was confused and had wandering behaviors but that resident was currently in the hospital. Interview with the Resident Care Coordinator (RCC) on 03/06/24 at 5:52pm revealed: -She thought the facility's policy allowed residents to store self-administered medications at bedside. -The residents did not have a locked drawer to store the medications in their rooms. -The facility did not usually have residents with wandering behaviors living in the AL side of the -There were no current residents with wandering

Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ R-C B. WNG HAL047015 03/06/2024 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LISC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 377 Continued From page 86 D 377 behaviors in the AL to her knowledge. Interview with the Administrator on 03/06/24 at 6:11pm revealed: -The facility's policy for storage of self-administered medications was those medications should be stored in a locked area in the resident's room. -The self-administered medications should not be accessible to other residents or staff. -Resident #2's self-administered medications should be stored in a locked area in his room. The community shall 4/20/24 continue to ensure that D 611 D 611 10A NCAC 13F .1801(b) Infection Prevention & Control Policies & Pro it's policies and procedures 10A NCAC 13F .1801 INFECTION are implemented by the PREVENTION AND CONTROL POLICIES AND **PROCEDURES** facility and shall address (b) The facility's infection and control policies and procedures shall be implemented by the facility Standard and transmission and shall address the following: Standard and transmission-based (1) precautions, respirator/hygiene precautions, including: and cough ettiquette, environmenta respiratory hygiene and cough (A) etiquette: Cleaning and disinfection, repocessing (B) environmental cleaning and disinfection: and disinfection of reusable (C) reprocessing and disinfection of medical equipment, hard hydrene reusable resident medical equipment; (D) hand hygiene; accessibility and proper use accessibility and proper use of (E) of PPE and types of transmission. personal protective equipment (PPE); and types of transmission-based (F) based precautions and when each precautions and when each type is indicated. including contact precautions, droplet type is indicated, including precautions, and airborne precautions; contact, droplet precautions and (2)When and how to report to the local health department when there is a suspected or airborne precautions. When and

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: R-C B. WNG HAL047015 03/06/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8398 FAYETTEVILLE ROAD WICKSHIRE CREEKS CROSSING RAEFORD, NC 28376 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY D 611 Continued From page 87 how to report to the local D 611 health Departmentwhen there confirmed reportable communicable disease is a suspected or confirmed 4/20/24 case or condition, or communicable disease outbreak in accordance with Rule .1802 of this reportable communicable Section: disease case or condition, (3) Measures for the facility to consider taking in the event of a communicable disease communicable disease outbreak. outbreak to prevent the spread of illness, such as isolating infected residents; limiting or stopping It is further the policy of wickshire to implement group activities and communal dining; limiting or restricting outside visitation to the facility; screening staff, residents, and visitors for signs of its infection control pulicy illness; and use of source control as tolerated by that is consistent with the the residents; and (4) Strategies for addressing potential Federal Centers for Disease staffing issues and ensuring staffing to meet the Control and Prevention quidelines needs of the residents during a communicable disease outbreak. in order to prevent transmission This Rule is not met as evidenced by: of any bloodborne patnogens TYPE B VIOLATION and take all measures to prevent Based on observations, interviews, and record and limit the spread of disease reviews, the facility failed to ensure recommendations and guidance established by and reduce illness by modifying the federal Centers for Disease Control and Social interaction, maintaining Prevention (CDC) and guidelines established in Spatial separation and allowing the facility's infection control policies and procedures were followed for 2 of 2 sampled associates with communicable residents with a positive COVID-19 diagnosis. diseases to stay at home at the The findings are: first sign of symptoms and or Review of the federal Centers for Disease Control mirror the current CDC quidelines and Prevention (CDC) Interim Infection or recommendations. Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus The community Concierge/Designee Disease 2019 (COVID-19) Pandemic dated any visitor upon arrival 05/08/23 revealed: -Facilities should ensure that everyone is aware of recommended infection prevention of recommended infection prevention and control

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Set up monthly Infection protection, gown, gloves). -If caring for COVID-19 positive and symptomatic residents as well as non-COVID-19 positive residents in other areas of the building, staff need Control Inservices with the to wear at minimum, a procedure mask in non-COVID-19 positive resident rooms only in the the RN Consultant to ensure event of an outbreak (2 or more individuals positive for COVID-19). that everyone has been trained in Infection control. -Staff members should clean hands often, after removing gloves and after contact with an ill person, by washing hands with soap and water for 20 seconds. If soap and water are not The ED | Designee will complete weekly and provable audits to ensure that 4/20/24 processes are being followed. available and hands are not visibly dirty, an alcohol-based hand sanitizer containing at least 60% alcohol may be used. -In the event of a confirmed positive COVID-19 case with a resident or associate, the Administrator and Health and Wellness Director should contact the local health department and follow the local health department's recommendations. Observation of the entrance of the facility on 03/05/24 at 8:45am revealed: -There were two undated signs posted on either side of the front entrance door that read "please wear a facemask". -There was no signage which indicated there were current positive COVID-19 cases in the building. Observation of the reception area at the front

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entrance of the facility on 03/05/24 at 8:46am

-There was a box of disposable surgical masks

and a hand sanitizer station.

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benign essential hypertension.

kidney disease stage 4 due to Type 2 diabetes mellitus, coronary artery disease, carotid atherosclerosis, carotid artery disorder, and

Review of Resident #15's discharge summary from a local hospital dated 03/04/24 revealed: -Resident #15 went to the emergency room on

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medications.

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-Resident #13 and Resident #15 had both returned to the facility from the hospital yesterday,

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