|                          | -  | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                   |     | FORM  | ): 09/30/2015<br>1 APPROVED<br>). 0938-0391 |
|--------------------------|--|---|-------------------|-----|---|---|
| STATEMEN                 | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                   |     | PLE CONSTRUCTION (X3) DA  | TE SURVEY<br>MPLETED                        |
|                          |  | 345473  | B. WING           | ;   | 08  | C<br>/ <b>21/2015</b>                       |
| NAME OF                  | PROVIDER OR SUPPLIER   |   |                   |     | STREET ADDRESS, CITY, STATE, ZIP CODE   |   |
|                          | LAKE HEALTHCARE  | CENTER  |                   |     | 6001 WILORA LAKE ROAD   |   |
| WILOKA                   |  | CENTER  |                   |     | CHARLOTTE, NC 28212   |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  | (X5)<br>COMPLETION<br>DATE                  |
| F 281<br>SS=D            |  | VICES PROVIDED MEET<br>TANDARDS   | F 2               | 281 |   | 9/29/15                                     |
|                          |  | led or arranged by the facility onal standards of quality.  |                   |     |   |   |
| ABORATOR                 | by:<br>Based on record rephysician interview<br>order for the collect<br>1 resident (Residen<br>Findings included:<br>Resident #20 was a<br>7/11/2015 and discl<br>on 8/2/2015. Diagno<br>lower limbs, Deep V<br>Failure, Diabetes, V<br>Noninfectious Lymp<br>The MDS dated 7/1<br>was cognitively inta<br>assistance from two<br>mobility and dressir<br>one staff member for<br>assistance from two<br>and transferring (mo<br>occurred only once<br>period. Resident #2<br>admitted with other<br>ulcers, and no veno<br>A record review of t<br>included a focus ca<br>etiology included the<br>ulcers. The care pla<br>and monitor lab/diac<br>care plan goal date<br>resident 's wound v<br>remain free from inter<br>review. | admitted to the facility on<br>harged to an acute care facility<br>oses included Ulcers of the<br>/enous Thrombosis, Heart<br>/enous insufficiency, | NATURE            |     | Resident # 20 no longer resides at the facility.<br>Residents with wounds have the potential to be affected by the alleged deficient practice.<br>The Director of Clinical Services completed a review on 8-28-15 of current residents with wounds to validate that any wound culture orders received within the past 30 days were obtained, collected, documented and results reported to the physician with any new orders carried out as indicated by the licensed nurse. No further deficient practice was identified as a result of the audit.<br>The Director of Clinical Services reeducated licensed nurses currently staffing the facility by 9-28-15 on the policy and procedure of obtaining, collecting, documenting and reporting wound cultures results to the prescribing physician and carrying out new orders timely as indicated by the licensed nurse. Any licensed nurse who did not receive the training by 9-28-15 will receive prior to the next scheduled shift. The Nurse Manager will maintain a log of all wound culture orders to validate that wound |   |

09/14/2015

PRINTED: 09/30/2015

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

**Electronically Signed** 

|                          |  | & MEDICAID SERVICES   |                     |  | OMB NO.   |                           |  |
|--------------------------|--|---|---------------------|--|---|---------------------------|--|
|                          | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | IPLE CONSTRUCTION  | СОМ   | E SURVEY<br>PLETED        |  |
|                          |  | 345473  | B WING              |  |   |                           |  |
|                          |  | 545475  | D. WING             | STREET ADDRESS, CITY, STATE, ZIP C   |   | 21/2015                   |  |
| NAME OF                  | PROVIDER OR SUPPLIER   |   |                     |  | JODE  |                           |  |
| WILORA                   | LAKE HEALTHCARE  | CENTER  |                     | 6001 WILORA LAKE ROAD<br>CHARLOTTE, NC 28212   |   |                           |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COI<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)  | I SHOULD BE   | (X5)<br>COMPLETIC<br>DATE |  |
| F 281                    | Continued From pa  | ae 1  | F 2                 | 81   |   |                           |  |
| F 281                    | 7/24/2015 revealed<br>leg wound culture a<br>The wound care nu<br>interview.<br>On 8/21/2015 at 10<br>corporate staff reve<br>any addition medica<br>wound culture was<br>was not done, the c<br>did not have results<br>A nurse note dated<br>Resident (#20) was<br>confusion. Residen<br>Department for eva<br>communicated with<br>Resident (#20) was<br>care unit (ICU) relation<br>bilaterally.<br>A record review of t<br>8/2/2015 to 8/8/201<br>she presented to the<br>altered mental statu<br>of diabetes type II,<br>edema, and lower ex<br>and was treated at<br>discharged from the<br>a skilled nursing fac<br>on antibiotics in the<br>Emergency Departu-<br>included areas of g<br>right leg wound. Th<br>think that she likely | a physician order dated<br>a laboratory order for a left<br>and sensitivity.<br>rse was unavailable for an<br>:34 AM an interview with<br>aled she was unable to find<br>al records showing that the<br>obtained. She reported the lab<br>order was missed, and the lab | F 28                | <ul> <li>cultures were obtained, coll documented and results rep prescribing physician with a carried out as indicated by t nurse. The Director of Clinic will conduct a weekly wound inclusive of a Nurse Manage Data Set (MDS) Nurse and Manager to review resident to verify that wound cultures completed timely and accur physician orders. The phys wound rounding notes will a reviewed during the weekly meeting to validate that all worders were accurately ident transcribed, as indicated.</li> <li>The Director of Clinical Serr Manager trained Licensed currently working at the faci ¿Red Line¿ system (a systen ight shift audits each recor transcription of orders and by 9/28/15.</li> <li>The Director of Clinical Serr Manager will conduct Qualif Improvement monitoring of records, MARs, and TARs f with appropriate transcription of physician medication/treatment docur the presence of the Red Lin documentation 3 times a we weeks, then 3 records 3 time</li> </ul> | borted to the<br>ny new orders<br>the licensed<br>cal Services<br>d meeting<br>er, Minimum<br>Dietary<br>s with wounds<br>s are<br>rately per<br>licians ¿ weekly<br>also be<br>wound<br>wound culture<br>tified and<br>vices/Nurse<br>nurses<br>lity on the a<br>em where the<br>rd for accurate<br>missed orders)<br>vices or Unit<br>ty<br>5 resident<br>or compliance<br>on and<br>orders and<br>nentation and<br>he<br>eek for 4 |                           |  |

Facility ID: 923567

If continuation sheet Page 2 of 27

|                          |   | E & MEDICAID SERVICES  |                     |   |  | . 0938-039                 |
|--------------------------|---|--|---------------------|---|--|----------------------------|
|                          | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | IPLE CONSTRUCTION   |  | E SURVEY<br>IPLETED        |
|                          |   |  | 7                   |   |  | С                          |
|                          |   | 345473   | B. WING _           |   | 08/  | 21/2015                    |
| NAME OF                  | PROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6001 WILORA LAKE ROAD  |  |                            |
| WILORA                   |   | ECENTER  |                     |   |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPF<br>DEFICIENCY)   | ULD BE   | (X5)<br>COMPLETION<br>DATE |
| F 281                    | and one colony of<br>Methicillin Resistar                       | age 2<br>acter Baumannii (pathogen),<br>Staphylococcus Aureus<br>nt (bacteria). She was admitted<br>shock secondary to wound                               | F 28                | Performance Improvement Mor<br>Tool.<br>The Director of Clinical Services<br>complete Quality Improvement of<br>physicians; orders for reside<br>wounds 5x/week for 4 weeks, 1<br>2 months, then monthly for 3 me<br>validate that any wound cultures<br>residents with wounds were obt<br>collected, documented and resu-<br>reported to the prescribing phys<br>any new orders carried out as in<br>the licensed nurse. The Quality<br>Improvement monitoring will be<br>documented on a Quality Assur-<br>Performance Improvement Mor<br>The Director of Clinical Services<br>report audit results monthly to th<br>Assurance Performance Improv<br>(QAPI) committee for 6 months<br>substantial compliance is obtain<br>QAPI committee will evaluate the<br>effectiveness of the<br>monitoring/observation tools for<br>maintaining substantial complia<br>make changes to the corrective | a will<br>monitoring<br>nts with<br>k/week for<br>onths to<br>for<br>ained,<br>its<br>ician with<br>dicated by<br>ance and<br>itor Tool.<br>will<br>ance and<br>itor Tool.<br>will<br>e Quality<br>ement<br>or until<br>ed. The<br>e |                            |
| F 309<br>SS=G            |   | CARE/SERVICES FOR<br>BEING   | F 30                | necessary.<br>)9  |  | 9/29/15                    |
|                          | provide the necess<br>or maintain the hig<br>mental, and psycho | t receive and the facility must<br>sary care and services to attain<br>hest practicable physical,<br>osocial well-being, in<br>he comprehensive assessment |                     |   |  |                            |

Facility ID: 923567

If continuation sheet Page 3 of 27

| TATEMENT                 |  | & MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    | TIPLE CONSTRUCTION  | (X3) DAT  | 0938-039<br>E SURVEY<br>PLETED |
|--------------------------|--|---|--------------------|---|---|--------------------------------|
| ND PLAN C                | F CORRECTION   | IDENTIFICATION NUMBER.  | A. BUILD           | ING   |   | C                              |
|                          |  | 345473  | B. WING            |   |   | _<br>21/2015                   |
| NAME OF I                | PROVIDER OR SUPPLIER   |   |                    | STREET ADDRESS, CITY, STATE, ZIP COD  |   |                                |
| WILORA                   | LAKE HEALTHCARE  | CENTER  |                    | 6001 WILORA LAKE ROAD<br>CHARLOTTE, NC 28212  |   |                                |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY)  | OULD BE   | (X5)<br>COMPLETIOI<br>DATE     |
| F 309                    | Continued From pa  | ge 3  | F 3                | 09  |   |                                |
|                          | by:<br>Based on record rephysician interview,<br>observation the faci<br>wound care as order<br>residents (Resident<br>infection and hospit<br>to administer a sche<br>(OxyContin) to allev<br>opportunities for 1 of<br>reviewed for well-be<br>Findings Included:<br>1) Resident #20 wa<br>7/11/2015 and discl<br>on 8/2/2015. Diagno<br>lower limbs, Deep V<br>Failure, Diabetes, V<br>Noninfectious Lymp<br>The MDS dated 7/1<br>was cognitively inta<br>assistance from two<br>mobility and dressir<br>one staff member for<br>assistance from two<br>and transferring (mo<br>occurred only once<br>period. Resident #22<br>admitted with other<br>ulcers, and no veno<br>A record review of t<br>included a focus ca<br>etiology included th<br>ulcers. The care pla<br>included 1) The res<br>of healing and rema | s admitted to the facility on<br>harged to an acute care facility<br>oses included Ulcers of the<br>/enous Thrombosis, Heart<br>/enous insufficiency, |                    | Resident # 20 no longer resid<br>facility.<br>A medication error report was<br>by the Director of Clinical Serv<br>8-20-15 for resident #10 and re<br>continue to have medications<br>administered timely per physic<br>orders.<br>Current residents have the pot<br>affected by the alleged deficient<br>A skin assessment was compl<br>each resident by a licensed nu<br>9-23-15 utilizing the Weekly SI<br>Review form. Any identified sk<br>both pressure and non-pressu<br>assessed and documented on<br>Pressure Ulcer Record or Non<br>Skin Condition Record by a lice<br>nurse and reported to the resid<br>physician and new treatment of<br>obtained, implemented and do<br>as appropriate. Residents with<br>and non-pressure wounds wer<br>at a wound meeting on 9-24-19<br>Nurse Manager, the Minimum<br>Nurse and the Dietitian to ensu-<br>necessary treatment and servit<br>promote healing, prevent infec-<br>prevent new sores from develop<br>place for identified residents.<br>The Director of Clinical Service<br>completed a review by 8-21-18 | completed<br>ices on<br>esident will<br>ians;<br>ential to be<br>nt practice.<br>eted on<br>rse by<br>kin Integrity<br>kin issues<br>re were<br>to the<br>-Pressure<br>ensed<br>dents;<br>orders were<br>cumented<br>n pressure<br>e discussed<br>5 with the<br>Data Set<br>ure<br>ces to<br>tion and<br>oping are in |                                |

Facility ID: 923567

If continuation sheet Page 4 of 27

|                          | OF DEFICIENCIES      | & MEDICAID SERVICES   | (X2) MU             | TIDI                  | E CONSTRUCTION  |         | 0938-039                  |  |
|--------------------------|----------------------|---|---------------------|-----------------------|---|---------|---------------------------|--|
|                          | OF DEFICIENCIES      | IDENTIFICATION NUMBER:  |                     |                       |   |         | PLETED                    |  |
|                          |                      |   |                     |                       |   |         | C                         |  |
|                          |                      | 345473  | B. WING             |                       |   |         | 21/2015                   |  |
| IAME OF I                | PROVIDER OR SUPPLIER |   | <u> </u>            | S                     | TREET ADDRESS, CITY, STATE, ZIP CODE  | 00/1    |                           |  |
|                          |                      |   |                     | 6001 WILORA LAKE ROAD |   |         |                           |  |
| VILORA                   | LAKE HEALTHCARE      | CENTER  | CHARLOTTE, NC 28212 |                       |   |         |                           |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)     | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFI<br>TAG  |                       | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE      | (X5)<br>COMPLETIC<br>DATE |  |
| F 309                    | Continued From pa    |   | F 3                 | 200                   |   |         |                           |  |
| 1 000                    |                      | skin integrity problems or  | га                  | 09                    | Medication Administration Records   | and     |                           |  |
|                          |                      | e next review. The care plan  |                     |                       | medication storage carts to ensure  |         |                           |  |
|                          |                      | ed obtain and monitor   |                     |                       | physician ordered medications wer   |         |                           |  |
|                          |                      | as ordered, administer  |                     |                       | available for administration. Medica  |         |                           |  |
|                          |                      | red, weekly skin checks, and  |                     |                       | were refilled as appropriate to ensu  |         |                           |  |
|                          | administer medicat   |   |                     |                       | availability. Each resident residing  |         |                           |  |
|                          |                      | Resident #20 's treatment   |                     |                       | facility was reassessed for pain and  |         |                           |  |
|                          |                      | ided a treatment order to   |                     |                       | documented on the Pain Assessme   |         |                           |  |
|                          | 5                    | aily to both legs with Normal   |                     |                       | form by a licensed nurse by 8-28-1  |         |                           |  |
|                          |                      | cel and Santyl to both legs with  |                     |                       | unmanaged pain identified was rep   |         |                           |  |
|                          |                      | sion bandages. The treatment  |                     |                       | to the physician and new orders re  |         |                           |  |
|                          |                      | for the 12th of the month and   |                     |                       | by the licensed nurse as appropria  |         |                           |  |
|                          | the 14th of the mor  | ith.  |                     |                       | complete Medication Administration  | n       |                           |  |
|                          |                      | Resident #20 ' s treatment  |                     |                       | Record to medication storage cart   |         |                           |  |
|                          |                      | 2015 through 7/31/2015  |                     |                       | was also completed by the Omnica  | are     |                           |  |
|                          |                      | reatment of Dakin 's solution,  |                     |                       | Nurse on 9-9-15 and any needed  |         |                           |  |
|                          |                      | inate, and a dry protective   |                     |                       | medications were ordered to ensur   |         |                           |  |
|                          |                      | to the 1) right shin, 2) right  |                     |                       | compliance with medication available  | oility. |                           |  |
|                          |                      | lateral shin, 4) left upper shin,   |                     |                       |   |         |                           |  |
|                          |                      | high. In addition give analgesic  |                     |                       | The Director of Clinical Services   | 41      |                           |  |
|                          |                      | wound dressing. The   |                     |                       | reeducated licensed nurses curren   |         |                           |  |
|                          |                      | tialed indicating the task was  |                     |                       | staffing the facility by 9-28-15 on th  |         |                           |  |
|                          |                      | sites for the dates of 15. No indication the wound                                  |                     |                       | accurate completion of and schedu<br>weekly Skin Integrity Reviews and  |         |                           |  |
|                          |                      | on 7/20/2015. The treatments  |                     |                       | initiation of a Pressure Ulcer Reco   | -d      |                           |  |
|                          |                      | 21/2015 -7/24/2015. The treatments  |                     |                       | and/or a Non-Pressure Skin Condi  |         |                           |  |
|                          |                      | dicated the order and   |                     |                       | Record for any wounds identified.   |         |                           |  |
|                          |                      | ontinued on 7/24/2015. There  |                     |                       | education also included timely phys   |         |                           |  |
|                          |                      | atment records or indication  |                     |                       | notification, obtaining and starting i  |         |                           |  |
|                          |                      | been provided in Resident #20   |                     |                       | treatment orders and transcription  |         |                           |  |
|                          |                      | or care from 7/25/2015 until  |                     |                       | the residents¿ Treatment Administ   |         |                           |  |
|                          |                      | insfer to an acute care hospital  |                     |                       | Record (TAR). Any nurses not  |         |                           |  |
|                          | on 8/2/2015.         |   |                     |                       | reeducated by 9-28-15 will be educ  | ated    |                           |  |
|                          |                      | Resident #20 ' s treatment  |                     |                       | prior to reporting to work for their n  | ext     |                           |  |
|                          |                      | )15 through 8/31/2015   |                     |                       | scheduled shift. Residents will have  |         |                           |  |
|                          |                      | ated 7/17/2015. Dakin ' s   |                     |                       | weekly skin assessment completed  |         |                           |  |
|                          |                      | lcium Alginate and dry  |                     |                       | licensed nurse to identify skin conc  |         |                           |  |
|                          |                      | once daily to wounds 1) right   |                     |                       | Any skin issues identified will be re   | ported  |                           |  |
|                          |                      | I thigh, 3) left lateral shin, 4)   |                     |                       | to the physician by the licensed nu   |         |                           |  |

Facility ID: 923567

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|                          |   | & MEDICAID SERVICES   |                      |                               | OMB NO  | . 0930-03                 |
|--------------------------|---|---|----------------------|-------------------------------|---|---------------------------|
|                          | OF DEFICIENCIES                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                               |                      | PLE CONSTRUCTION G            | COM   | e survey<br>Ipleted       |
|                          |   | 345473  | B. WING _            |                               |   | C<br>21/2015              |
|                          | PROVIDER OR SUPPLIER                            |   |                      | STREET ADDRESS, CITY,         |   | 21/2015                   |
|                          |   |   |                      | 6001 WILORA LAKE RO           |   |                           |
| VILORA                   | LAKE HEALTHCARE                                 | CENTER  |                      | CHARLOTTE, NC 282             |   |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                                | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG  | (EACH CORREC<br>CROSS-REFEREN | PLAN OF CORRECTION<br>TIVE ACTION SHOULD BE<br>CED TO THE APPROPRIATE<br>EFICIENCY) | (X5)<br>COMPLETIO<br>DATE |
| F 309                    | Continued From pa                               | ao 5  | Гэс                  | 0                             |   |                           |
| 1 303                    | Continued From pa                               | -   | F 30                 |                               | lara abtainad   |                           |
|                          |   | eft medial thigh. The order was   |                      | new treatment or              |   |                           |
|                          |   | ed for 8/1/2015 and 8/2/2015<br>nent was completed and the                          |                      |                               | transcribed onto the stration Record and  |                           |
|                          |   | as rewritten and no additional  |                      |                               | ecord/Non-Pressure  |                           |
|                          |   | vere found in the Resident #20  |                      |                               | ecord as appropriate. A   |                           |
|                          |   | vith the same handwriting.  |                      |                               | ill make rounds each  |                           |
|                          |   | Physician Orders documented   |                      |                               | und physician to assess,  |                           |
|                          |   | verbal order dated 7/23/2015 included to measure and document                       |                      |                               |   |                           |
|                          | discontinue the Sar                             | ntyl and Dakin 's solution to   |                      |                               | Pressure Ulcer Record   |                           |
|                          |   | and the left medial thigh.  |                      | and Non-Pressure              | e Skin Condition Record.  |                           |
|                          | Continue Calcium A                              | um Alginate and apply protective The Director of Clinica                            | inical Services, the |                               |   |                           |
|                          | dressing once daily. An additional verbal order |   |                      | et Nurse, the Dietary         |   |                           |
|                          |   | cluded Santyl clarification. The  |                      |                               | se Manager will discuss   |                           |
|                          |   | is to be applied directly to  |                      |                               | s during a weekly wound   |                           |
|                          |   | ted on the written verbal order   |                      |                               | e necessary treatment   |                           |
|                          | as directed once da                             |   |                      | and services are              |   |                           |
|                          |   | a physician order dated   |                      |                               | prevent infection and   |                           |
|                          |   | a laboratory order for a left   |                      | prevent new sore              | s from developing.  |                           |
|                          | were found in the m                             | and sensitivity. No results   |                      | The Director of C             | inical Convisoo   |                           |
|                          |   | daily nurse notes dated   |                      | The Director of C             |   |                           |
|                          |   | 7/26/2015 (the dates available  |                      |                               | ed nurses currently<br>by 9-28-15 concerning  |                           |
|                          |   | rd) revealed on 7/13/2015 a   |                      |                               | hister medications timely   |                           |
|                          |   | for treatment to areas, seen  |                      |                               | ne education included   |                           |
|                          |   | antyl, special delivery of  |                      | the reorder proce             |   |                           |
|                          |   | notes dated 7/14/2015,  |                      |                               | oply of medications, the  |                           |
|                          |   | 15, 7/20/2015, 7/22/2015, and   |                      |                               | ication administration,   |                           |
|                          |   | d dressing intact to bilateral  |                      |                               | d use of the back up  |                           |
|                          |   | treatment). The daily note  |                      | pharmacy, notifyir            | ng the physician and  |                           |
|                          |   | cluded dressing intact right  |                      | Director of Clinica           |   |                           |
|                          |   | draining serous bloody  |                      | medication is not             |   |                           |
|                          |   | sings reinforced. The daily   |                      | documentation of              |   |                           |
|                          |   | /2015 included the wound  |                      |                               | physicians order. Any   |                           |
|                          |   | I the wounds and pain   |                      | licensed nurse wh             |   |                           |
|                          |   | ovided prior to the dressing  |                      |                               | 5 will receive prior to the   |                           |
|                          |   | nurse note for 7/24/2015  |                      |                               | hift. The licensed nurse  |                           |
|                          |   | cation was provided prior to  |                      |                               | residents pain upon   |                           |
|                          | the dressing chang order.                       | e and treatment to wound per  |                      | with significant ch           | ission, quarterly and   |                           |
|                          | L OT CIEL                                       |   | 1                    |                               |   |                           |

Facility ID: 923567

If continuation sheet Page 6 of 27

|                          |  | AND HUMAN SERVICES   |                    |     | O   |   | APPROVE<br>0938-039       |
|--------------------------|--|--|--------------------|-----|---|---|---------------------------|
| TATEMENT                 | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |     | E CONSTRUCTION  | (X3) DATE   | E SURVEY<br>PLETED        |
|                          |  |  |                    |     |   | 0   | 2                         |
|                          |  | 345473   | B. WING            |     |   | 08/2  | 21/2015                   |
| NAME OF I                | PROVIDER OR SUPPLIER   |  |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |   |                           |
| WILORA                   | LAKE HEALTHCARE  | CENTER   |                    |     | 001 WILORA LAKE ROAD<br>CHARLOTTE, NC 28212   |   |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)  | BE  | (X5)<br>COMPLETIO<br>DATE |
| F 309                    | Continued From pa  | ae 6   | F 3                | 309 |   |   |                           |
|                          | <ul> <li>F 309 Continued From page 6</li> <li>No weekly skin assessments were found in<br/>Resident #20 ' s medical record.</li> <li>A record review of wound care specialist initial<br/>evaluation dated 7/16/2015. Five Lymphedemic<br/>wound sites were noted 1) right shin 2) right<br/>medial thigh, 3) left lateral shin, 4) left upper shin,<br/>and 5) left medial thigh. Surgical excisional<br/>debridement of subcutaneous tissue was<br/>performed on all 5 sites.</li> <li>A record review of a wound care specialist<br/>evaluation dated 7/23/2015 revealed no change<br/>to the five wound sites. There were treatment<br/>changes made to site 4) left upper shin and 5) left</li> </ul> |  | FJ                 | 009 | condition and report any new uncor<br>pain to the physician to ensure<br>appropriate interventions are imple<br>to alleviate residents pain. The Dire<br>Clinical Services will monitor the<br>controlled emergency kits supply w<br>to ensure adequate back-up medic<br>are available if needed.<br>The Director of Clinical Services or<br>Manager will complete Quality<br>Improvement monitoring of the wee<br>skin assessments, Pressure Ulcer | mented<br>ector of<br>eekly<br>ations<br>Nurse      |                           |
|                          | medial thigh to disc<br>excisional debriden<br>was performed on a<br>A record review of a<br>evaluation dated 7/<br>to wound site 1, 3, 4<br>site 2 for decreased<br>On 8/21/2015 at 2:2   | continuing the Santyl. Surgical<br>nent of subcutaneous tissue<br>all 5 sites.<br>a wound care specialist<br>30/2015 revealed no change<br>4, or 5 and improved noted to<br>d surface area.<br>25 PM an interview with the   |                    |     | Records and/or Non-Pressure Skin<br>Condition Records and Treatment<br>Administration Record if indicated or<br>random residents 3x/week for 4 we<br>x/week for 2 months, then 1x/month<br>months to validate compliance with<br>alleged deficient practice.  | on 5<br>eeks, 1<br>h for 3<br>the                   |                           |
|                          | 7/23/2015 Resident<br>discontinued. She c<br>of Resident #20 ' s<br>She revealed she s<br>facility wound nurse   | list physician revealed on<br>t #20 ' s wound care was not<br>discontinued the Santyl on two<br>Lymphedemic wound sites.<br>pecifically discussed with the<br>e and the facility corporate   |                    |     | The Director of Clinical Services or<br>Manager will complete a Quality<br>Improvement monitoring of 5 reside<br>Medication Administration Records<br>medication storage carts.   | ents¿<br>and  |                           |
|                          | remaining three wo<br>and where on the w<br>the Santyl to conse<br>recalled there being<br>about the price and<br>physician reported<br>enough to determin<br>was providing daily  | #20 's bedside why the<br>und sites needed the Santyl<br>yound the nurse could apply<br>rve supply. The physician<br>g concern from the facility<br>need of the Santyl. The<br>she was not at the facility<br>we whether the nursing staff<br>wound care to Resident #20.<br>urse was unavailable for an |                    |     | 5x/week for 4 weeks, 1 x/week for 3<br>months, then monthly for 3 months<br>ensure compliance with medication<br>administration and availability of a2<br>supply. Quality Improvement monit<br>will be documented on a Quality<br>Assurance and Performance Monit<br>The Director of Clinical Services wi<br>report audit results monthly to the C<br>Assurance Performance Improvem  | to<br>-7 day<br>toring<br>or Tool.<br>II<br>Quality |                           |
|                          | interview.   | 50 PM and interview with the   |                    |     | (QAPI) committee for 6 months or<br>substantial compliance is obtained.   | until   |                           |

Facility ID: 923567

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| TATEMENT                 | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULTI                                   | PLE CONSTRUCTION  | (X3) DAT                     | . 0938-039<br>E SURVEY    |  |
|--------------------------|---|--|--|---|------------------------------|---------------------------|--|
| ND PLAN C                | OF CORRECTION   | IDENTIFICATION NUMBER:   | A. BUILDIN                                   | G   |                              | IPLETED                   |  |
|                          |   | 345473   | B. WING                                      |   |                              | C<br>21/2015              |  |
| NAME OF I                | PROVIDER OR SUPPLIER  |  |  | STREET ADDRESS, CITY, STATE, ZIP  |                              | 21/2015                   |  |
| WILORA                   |   | ECENTER  | 6001 WILORA LAKE ROAD<br>CHARLOTTE, NC 28212 |   |                              |                           |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                          | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO TH<br>DEFICIENCY  | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETIO<br>DATE |  |
| F 309                    | knowledge that Re<br>troublesome sites of<br>She reported after<br>the wound nurse to<br>pressure ulcer reco<br>quality improvement<br>vacation. The inter<br>herself had only be<br>and was not sure of<br>On 8/21/2015 at 11<br>Regional Director of<br>the facility was in the<br>current nurse positi<br>with nurses from s<br>staff for Resident #<br>unavailable.<br>On 8/21/2015 at 11<br>corporate nurse re<br>any addition medic<br>wound care treatm<br>Resident #20.<br>A record review of<br>transfer form dated<br>Background, Asset<br>communication for<br>Resident #20 was<br>mental status and<br>evaluation.<br>A nurse note dated<br>Resident (#20) was<br>confusion. Resider<br>Department for eva<br>communicated with<br>Resident (#20) was | Nursing (DON) revealed her<br>sident #20 had some<br>over and above dry dressing.<br>reviewing records she asked<br>o start using the weekly<br>ord and the pressure ulcer<br>int log before she went on<br>im DON only reports she<br>een at the facility for 2 weeks<br>of facility procedure or practice.<br>1:09 PM an interview with the<br>of Human Resources revealed<br>ransition with staffing and<br>tions were being supplemented<br>ister facilities. The primary<br>#20 during her admission was<br>1:44 AM an interview with a<br>vealed she was unable to find<br>cal records showing that daily<br>ents were completed for<br>a nursing home to hospital<br>d 8/2/2015 and a Situation,<br>ssment, Recommendation<br>m dated 8/2/2015 revealed<br>noted to have an altered<br>was sent to the hospital for an<br>4 8/2/2015 included (in part)<br>is noted with increased<br>int (#20) sent to Emergency<br>aluation. At 10:30 PM the nurse<br>in the hospital and documented<br>is being admitted to intensive<br>ated to infection in wounds | F 30   | 9<br>QAPI committee will evalue<br>effectiveness of the<br>monitoring/observation too<br>maintaining substantial co<br>make changes to the corre-<br>necessary. | ols for<br>mpliance, and     |                           |  |

If continuation sheet Page 8 of 27

|                          |   |  | 0.00                |   | · · · · - |                           |
|--------------------------|---|--|---------------------|---|-----------|---------------------------|
|                          | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | PLE CONSTRUCTION  | · · ·     | TE SURVEY<br>MPLETED      |
|                          |   |  | A. DOILDING         |   |           | С                         |
|                          |   | 345473   | B. WING             |   | 08        | /21/2015                  |
| NAME OF                  | PROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP C  |           |                           |
| WILORA                   | LAKE HEALTHCARE   | CENTER   |                     | 6001 WILORA LAKE ROAD<br>CHARLOTTE, NC 28212  |           |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE /<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETIO<br>DATE |
| F 309                    | altered mental statu<br>of diabetes type II, e<br>edema, and lower e<br>of multidrug resista<br>developed lower ex<br>and was treated at<br>discharged from the<br>a skilled nursing fac<br>on antibiotics in the<br>Emergency Departr<br>included areas of g<br>right leg wound. Th<br>think that she likely<br>at her nursing facilit<br>of the right thigh ob<br>resulted on 8/7/201<br>Pseudomonas Aeru<br>growth of Acinetoba<br>and one colony of S<br>Methicillin Resistan<br>to ICU with septic s<br>infections.<br>2) Resident #10 was<br>6/6/2013. Her diagr<br>Insomnia, Upper ar<br>The Minimum Data<br>Resident #10 was s<br>and was totally dep<br>physical assistance<br>living. Resident #10<br>experiencing pain.<br>sleep at night and li<br>The Physician Order<br>through 8/31/2015 | ge 8<br>e acute care hospital with<br>us. Resident #20 had a history<br>chronic lower extremity<br>extremity wounds with a history<br>int pathogens. Resident #20<br>tremity ulcerations in February<br>the burn center. She was<br>a hospital and was residing in<br>cility. Per family she was not<br>nursing facility. The<br>ment records from 8/2/2015<br>reen purulent thick fluid in her<br>e Physician noted he did " not<br>had appropriate wound care<br>ty". The Microbiology culture<br>tained at the hospital and<br>5 included heavy growth of<br>uginosa (bacteria), scant<br>acter Baumannii (pathogen),<br>Staphylococcus Aureus<br>t (bacteria). She was admitted<br>hock secondary to wound<br>s admitted to the facility on<br>noses included Dementia,<br>m Fracture, and Chronic Pain.<br>Set dated 8/17/2015 revealed<br>severely cognitively impaired<br>endent on staff (two person<br>) for her activities of daily<br>0 was assessed as frequently<br>The pain had made it hard to<br>mited her day to day activities.<br>er Sheet dated 8/1/2015<br>for Resident #10 included an<br>in (narcotic pain medication) 10 |                     |   |           |                           |

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|                          | NO FOR MEDICARE   | & MEDICAID SERVICES  | -                   |   |                                | <u>. 0938-039</u>         |
|--------------------------|---|--|---------------------|---|--------------------------------|---------------------------|
|                          | F OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | IPLE CONSTRUCTION   |                                | TE SURVEY<br>MPLETED      |
|                          |   | 345473   | B. WING             |   | 08                             | C<br>/ <b>21/2015</b>     |
| NAME OF                  | PROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIF  |                                | /21/2013                  |
| WILORA                   | LAKE HEALTHCARE   | CENTER   |                     | 6001 WILORA LAKE ROAD<br>CHARLOTTE, NC 28212  |                                |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETIO<br>DATE |
| F 309                    | A record review of t<br>medication utilizatio<br>OxyContin revealed<br>active card stock wa<br>at 9:00 AM.<br>The Medication Adr<br>dated 8/1/2015 thro<br>#10 revealed on 8/1<br>OxyContin was not<br>circled initials. Ther<br>back of the MAR as<br>administered.<br>A Physician Order of<br>for Resident #10 ind<br>10 mg tablet ER for<br>Physician Assistant<br>The MAR dated 8/1<br>Resident #10 revea<br>8/18/2015 the 9:00<br>OxyContin were not<br>circled initials. Ther<br>back of the MAR as<br>administered.<br>The MAR dated 8/1<br>Resident #10 revea<br>of Hydrocodone-Ac<br>medication) 5 mg-3<br>mouth every 4 hour<br>record indicated by<br>doses were adminis<br>back of the MAR the<br>8/17/2015 that read<br>from MD (physician<br>A prescription dated | he pharmacy controlled<br>n record for Resident #10 ' s<br>that the last dose on the<br>as administered on 8/16/2015<br>ninistration Record (MAR)<br>ugh 8/31/2015 for Resident<br>6/2015 the 9:00 PM dose of<br>administered, indicated by<br>e was no indication on the<br>to why the dose was not<br>lated 8/16/2015 at midnight<br>cluded: May hold OxyContin<br>one dose. Follow up with<br>in the morning 8/17/2015.<br>/2015 through 8/31/2015 for<br>led on 8/17/2015 and<br>AM and the 9:00 PM doses of<br>administered indicated by<br>e was no indication on the<br>to why the doses were not<br>/2015 through 8/31/2015 for<br>led an as needed medication<br>etaminophen (narcotic pain<br>25 mg tablet take one by<br>s as needed for pain. The<br>initials that on 8/17/2015 two<br>stered to Resident #10. On the<br>ere was one entry for<br>(in part) waiting for script<br>) for OxyContin.<br>1 8/18/2015 for resident #10 in<br>s was for Oxycodone 10 mg | F 3(                | 09  |                                |                           |

Facility ID: 923567

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|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                    |    |  | FORM             | 09/30/2015<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|--------------------|----|--|------------------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                |    | E CONSTRUCTION   | (X3) DATE<br>COM | E SURVEY<br>PLETED                  |
|                          |   | 345473   | B. WING            |    |  |                  | C<br>21/2015                        |
| NAME OF F                | PROVIDER OR SUPPLIER  |  |                    | S  | TREET ADDRESS, CITY, STATE, ZIP CODE   | -                |                                     |
|                          | LAKE HEALTHCARE   | CENTER   |                    | 60 | 001 WILORA LAKE ROAD   |                  |                                     |
| MEORA                    |   | o Entrenk  |                    | С  | HARLOTTE, NC 28212   |                  |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | x  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE               | (X5)<br>COMPLETION<br>DATE          |
| F 309                    | (RP) revealed Resid<br>fracture in her right<br>operable so she ha<br>reported Resident #<br>for comfort and her<br>She reported reside<br>covered up her righ<br>in her right shoulde<br>filed grievances for<br>her medications. Th<br>facility daily and it w<br>medications ordere<br>to Resident #10.<br>A record review of t<br>medication utilizatio<br>OxyContin revealed<br>and the first dose a<br>8/19/2015.<br>On 8/20/2015 at 4:3<br>#1, a relief nurse fro<br>Resident #10 ' s nu<br>did know the reason<br>8/16/2015.<br>Resident #10 ' s pri<br>8/16/2015 was unar<br>primary nurse for da<br>unavailable. The pr<br>for the evening shiff<br>was a contract nurse<br>On 8/20/2015 at 4:4<br>#2 (a relief nurse fro | dent #10 's Responsible Party<br>dent #10 had a chronic<br>shoulder that was not<br>d chronic pain. The RP<br>#10 needed to be positioned<br>shoulder protected in care.<br>ent #10 rubbed, guarded and<br>t shoulder and verbalized pain<br>r. The RP reported she had<br>Resident #10 not receiving<br>he RP reported she was at the<br>vould take up to a week to get<br>d, in stock, and administered<br>he pharmacy controlled<br>on record for Resident #10 's<br>I it was received on 8/18/2015<br>dministered was on<br>80 PM an interview with Nurse<br>om a sister facility, who was<br>rse on 8/16/2015 reported she<br>in the OxyContin was held on<br>mary nurse the evening of<br>vailable for an interview. The<br>ay shift on 8/17/2015 was<br>imary nurse on the schedule<br>ts for 8/17/2015 and 8/18/2015 | F 3                | 09 | DEFICIENCY)  |                  |                                     |
|                          | did not give Reside<br>18th because it was<br>Nurse #3 processe<br>8/18/2015. She cou<br>was processed bec  | ause she did not have access<br>onic pharmacy ordering   |                    |    |  |                  |                                     |

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|                          | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | IPLE CONSTRUCTION   |        | TE SURVEY<br>MPLETED      |
|--------------------------|--|---|---------------------|---|--------|---------------------------|
|                          |  |   | A. BOILDI           |   |        | С                         |
|                          |  | 345473  | B. WING             |   | 08     | /21/2015                  |
| NAME OF I                | PROVIDER OR SUPPLIER   | ·   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |        |                           |
| WILORA                   | LAKE HEALTHCARE  | CENTER  |                     |   |        |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | JLD BE | (X5)<br>COMPLETIO<br>DATE |
| F 309                    | share with you she<br>Nurse #3 was unaw<br>On 8/20/2015 at 11<br>second shift unit may<br>when a medication<br>nurse was to circle<br>of the MAR the rea<br>medication.<br>On 8/20/2015 at 9:<br>Resident #10 was r<br>was guarding her ri<br>staff to be careful w<br>movement].<br>On 8/21/2015 at 9:<br>pharmacy revealed<br>script (legal prescri<br>filled on 7/21/2015.<br>allowed the pharma<br>supply of a narcotic<br>provided to the faci<br>was filled for OxyCe<br>dispensed to the fa<br>On 8/21/2015 at 9:<br>Resident #10 's face<br>revealed she was r<br>had not been receiv<br>medication. In revise | <ul> <li>eported Resident #10 will<br/>is in pain if you ask her.</li> <li>vailable for an interview.</li> <li>:24 PM an interview with the<br/>anager Nurse #4 revealed<br/>was not administered the<br/>her initials and write on back<br/>son for not giving the</li> <li>15 PM an observation of<br/>made during care where she<br/>ight shoulder, verbalizing to<br/>with her right arm [during</li> <li>34 AM an interview with the<br/>Resident #10 had a hard<br/>ption) for OxyContin 10 mg<br/>The regulatory law only<br/>acy to dispense a 14 day<br/>c medication, 28 tablets were<br/>lity. On 8/18/2015 a hard script<br/>ontin and 28 tablets were</li> </ul> | F 3(                |   |        |                           |
|                          | the order] reported<br>call from the facility<br>she was on call on<br>she felt the facility h<br>ordering and receiv<br>problem never got<br>was no communica<br>disciplines. The NP  | hose name was transcribed on<br>she did not personally get a<br>v staff. She further reported<br>8/16/2015. The NP shared<br>had a big problem with<br>ving medications timely and the<br>corrected. She reported there<br>ation between nurses and other<br>P reported the residents are in<br>cility and a level of care is   |                     |   |        |                           |

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|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                    |   |  | FORM                    | 09/30/2015<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|--------------------|---|--|-------------------------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |   |  | (X3) DATE<br>COM        | E SURVEY<br>PLETED                  |
|                          |   | 345473   | B. WING            |   |  |                         | C<br>21/2015                        |
| NAME OF I                | PROVIDER OR SUPPLIER  |  |                    | S | TREET ADDRESS, CITY, STATE, ZIP CODE   |                         |                                     |
| WILORA                   | LAKE HEALTHCARE   | CENTER   |                    |   | 001 WILORA LAKE ROAD<br>HARLOTTE, NC 28212   |                         |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY)  | BE                      | (X5)<br>COMPLETION<br>DATE          |
| F 309<br>F 314<br>SS=D   | scheduled pain med<br>is not acceptable to<br>medication as a sub<br>chronic pain. "<br>On 8/21/2015 at 11:<br>corporate staff rever<br>in-serviced on the p<br>receiving medication<br>nursing staff was to<br>ordering the medicat<br>acceptable to go 3 of<br>medication. There w<br>nurses write why the<br>on the back of the N<br>483.25(c) TREATM<br>PREVENT/HEAL P<br>Based on the comp<br>resident, the facility<br>who enters the facil<br>does not develop puindividual's clinical of<br>they were unavoida<br>pressure sores rece<br>services to promote<br>prevent new sores f<br>This REQUIREMEN<br>by:<br>Based on record ref<br>facility failed to pror<br>residents (Resident<br>2 pressure ulcer.<br>Findings Included:<br>Resident #20 was a | acusable to be out of a<br>dication for even one dose. It<br>use an as needed pain<br>ostitution for coverage of<br>28 AM an interview with the<br>aled the nursing staff was<br>rocedure for ordering and<br>ns. The expectation for the<br>follow the procedure for<br>ation timely. It was not<br>days without chronic pain<br>was the expectation that the<br>ey did not give a medication<br><i>NAR</i> .<br>ENT/SVCS TO<br>RESSURE SORES<br>rehensive assessment of a<br>must ensure that a resident<br>ity without pressure sores<br>ressure sores unless the<br>condition demonstrates that<br>ble; and a resident having<br>eives necessary treatment and<br>e healing, prevent infection and | F 3                |   | Resident # 20 no longer resides in facility.<br>Current residents have the potential affected by the alleged deficient prata A skin assessment was completed of each resident by a licensed nurse by | l to be<br>ctice.<br>on | 9/29/15                             |

Event ID: N6KV11

Facility ID: 923567

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|                          |   | & MEDICAID SERVICES  |                     |   | OMB NO.   |                           |
|--------------------------|---|--|---------------------|---|---|---------------------------|
|                          | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | PLE CONSTRUCTION<br>G   | COMI  | E SURVEY<br>PLETED        |
|                          |   | 345473   | B. WING             |   | (   |                           |
|                          | PROVIDER OR SUPPLIER  | 545475   | <u> </u>            | STREET ADDRESS, CITY, STATE, ZIP COD  |   | 21/2015                   |
|                          | -ROVIDER OR SUFFLIER  |  |                     | 6001 WILORA LAKE ROAD   | · <b>C</b>  |                           |
| /ILORA                   | LAKE HEALTHCARE   | CENTER   |                     | CHARLOTTE, NC 28212   |   |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY)   | IOULD BE  | (X5)<br>COMPLETIC<br>DATE |
| F 314                    |   | uge 13   | E 21                | 4   |   |                           |
| F 314                    | lower limbs, Deep Y<br>Failure, Diabetes, Y<br>Noninfectious Lymp<br>The MDS dated 7/1<br>was cognitively inta<br>assistance from two<br>mobility and dressin<br>one staff member f<br>assistance from two<br>and transferring (m<br>occurred only once<br>period. Resident #2<br>admitted with other<br>ulcers, and no vend<br>A record review of f<br>included a focus ca<br>care plan goal date<br>resident will not dev<br>problems or wound<br>A record review of 10<br>revealed she was t<br>surfaces 8 out of 10<br>7/30/2015.<br>An admission data<br>7/11/2015 included<br>above the sacrum.<br>A record review of a<br>evaluation dated 7/1<br>Lymphedemic leg wound<br>to the five leg wound | oses included Ulcers of the<br>Venous Thrombosis, Heart<br>Venous insufficiency,<br>ohedema.<br>18/2015 revealed Resident #20<br>act. She required extensive<br>o staff members for bed<br>ng, extensive assistance from<br>or personal hygiene, total<br>o staff members with toileting,<br>oves between surfaces)<br>or twice in the 7 day look back<br>20 was coded on the MDS as<br>open lesions, no pressure<br>ous and arterial ulcers.<br>the Care Plan for Resident #20<br>ategory of skin/wound. The<br>d 7/11/2015 included the<br>velop additional skin integrity<br>is through the next review.<br>Resident #20 ' s ADL report<br>ransferred between two<br>6 days between 7/14/2015 and<br>collection form dated<br>a skin tear drawn in a diagram<br>wound care specialist initial<br>16/2015 included five<br>vound sites.<br>a wound care specialist<br>23/2015 revealed no change<br>ad sites.<br>a wound care specialist | F 31                | 9/23/15 utilizing the Weekly S<br>Review form. Any identified s<br>both pressure and non-pressu<br>assessed and documented or<br>Pressure Ulcer Record or Nor<br>Skin Condition Record by a lic<br>nurse and reported to the resi<br>physician and new treatment of<br>obtained, implemented and do<br>as appropriate. Residents wit<br>and non-pressure wounds we<br>at a wound meeting on 9-24-1<br>Nurse Manager, the Minimum<br>Nurse and the Dietitian to ens<br>necessary treatment and serv<br>promote healing, prevent infect<br>prevent new sores from devel<br>place for identified residents.<br>The Director of Clinical Servic<br>reeducated licensed nurses by<br>the accurate completion of an<br>of weekly Skin Integrity Review<br>initiation of a Pressure Ulcer F<br>and/or a Non-Pressure Skin C<br>Record for any wounds identifi<br>education also included timely<br>notification, obtaining and star<br>treatment orders and transcrip<br>the residents ¿ Treatment Adm<br>Record (TAR). Any nurses no<br>reeducated as of 9-28-15 will<br>prior to reporting to work for th<br>scheduled shift. Residents wil<br>weekly skin assessment comp | kin issues<br>ire were<br>to the<br>h-Pressure<br>eensed<br>dents;<br>orders were<br>ocumented<br>h pressure<br>re discussed<br>5 with the<br>Data Set<br>ure<br>ices to<br>ction and<br>oping are in<br>es<br>y 9-28-15 on<br>d schedule<br>ws and<br>Record<br>condition<br>ied. The<br>physician<br>ting new<br>otion onto<br>hinistration<br>t<br>be educated<br>have a |                           |

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| TATEN/                   |                       |   |                     | יחי  |   | <u>//B NO.</u>    |                           |
|--------------------------|-----------------------|---|---------------------|------|---|-------------------|---------------------------|
|                          | OF DEFICIENCIES       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                               |                     |      | E CONSTRUCTION  | (X3) DATE<br>COMF | SURVEY                    |
|                          |                       |   | A. DOILDII          | - 01 |   | C                 | 2                         |
|                          |                       | 345473  | B. WING             |      |   |                   | 21/2015                   |
| NAME OF I                | PROVIDER OR SUPPLIER  |   | I                   | ST   | TREET ADDRESS, CITY, STATE, ZIP CODE  | 00/2              |                           |
|                          |                       |   |                     | 60   | 001 WILORA LAKE ROAD  |                   |                           |
| WILORA                   | LAKE HEALTHCARE       | CENTER  |                     | С    | HARLOTTE, NC 28212  |                   |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY      | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | (    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | BE                | (X5)<br>COMPLETIC<br>DATE |
| F 314                    | Continued From pa     | ao 14   |                     | 1 4  |   |                   |                           |
| 1 314                    |                       | -   | F 3′                | 14   | implemented and transcribed anto t  | ho                |                           |
|                          | 0                     | as 3.5 X 3.5 X 0.1 centimeters ainage. Dressing: Hydrogel                           |                     |      | implemented and transcribed onto t<br>Treatment Administration Record ar  |                   |                           |
|                          | and dry protective c  |   |                     |      | Pressure Ulcer Record/Non-Pressu  |                   |                           |
|                          |                       | tment records found in  |                     |      | Skin Condition Record as appropria  | -                 |                           |
|                          | Resident #20 " s me   | edical record from 7/30/2015  |                     |      | nurse manager will make rounds ea   |                   |                           |
|                          | to 8/2/2015 when R    | esident #20 ' s discharge to  |                     |      | week with the wound physician to as   |                   |                           |
|                          | acute care.           |   |                     |      | measure and document the wounds   |                   |                           |
|                          |                       | rse was unavailable for an  |                     |      | condition on the Pressure Ulcer Rec   |                   |                           |
|                          | interview.            | 50 PM and interview with the  |                     |      | and Non-Pressure Skin condition Re  |                   |                           |
|                          |                       | So Financi interview with the<br>Jursing (DON) reported after                       |                     |      | The Director of Clinical Services, the<br>Minimum Data Set Nurse, the Dieta                                       |                   |                           |
|                          |                       | he asked the wound nurse to   |                     |      | Manager and Nurse Manager will di   |                   |                           |
|                          |                       | kly pressure ulcer record and   |                     |      | identified residents during a weekly  |                   |                           |
|                          |                       | quality improvement log before  |                     |      | meeting to ensure necessary treatm  |                   |                           |
|                          |                       | on. The interim DON only  |                     |      | and services are being provided to  |                   |                           |
|                          |                       | had only been at the facility for   |                     |      | promote healing, prevent infection a  |                   |                           |
|                          |                       | ot sure of facility procedure or  |                     |      | prevent new sores from developing.  | -                 |                           |
|                          | practice.             | he weekly pressure ulcer  |                     |      | The Director of Clinical Services or  | Nurse             |                           |
|                          | record and the pres   |   |                     |      | Manager will complete Quality   | Nul SC            |                           |
|                          |                       | r Resident #20 included one   |                     |      | Improvement monitoring of the wee   | kly               |                           |
|                          |                       | 15 for Resident #20 ' s 5   |                     |      | skin assessments, Pressure Ulcer  | 5                 |                           |
|                          |                       | ound sites. The stage 2 right   |                     |      | Records and/or Non-Pressure Skin  |                   |                           |
|                          |                       | lcer was not added to the   |                     |      | Condition Records and Treatment   | _                 |                           |
|                          | logs.                 |   |                     |      | Administration Record if indicated o  |                   |                           |
|                          |                       | :09 PM an interview with the  |                     |      | random residents 3x/week for 4 wee  |                   |                           |
|                          |                       | f Human Resources revealed ansition with staffing and                               |                     |      | x/week for 2 months, then 1x/month<br>months to validate compliance with  |                   |                           |
|                          |                       | ons were being supplemented   |                     |      | alleged deficient practice. Quality   |                   |                           |
|                          |                       | ster facilities. [The primary   |                     |      | Improvement monitoring will be  |                   |                           |
|                          | staff for Resident #2 | 20 during her admission was   |                     |      | documented on a Quality Assurance   |                   |                           |
|                          | unavailable]          |   |                     |      | Performance Monitor Tool. The Dire  |                   |                           |
|                          |                       | :44 AM an interview with  |                     |      | Clinical Services will report audit res   | sults             |                           |
|                          |                       | sing] revealed she was unable   |                     |      | monthly to the Quality Assurance  |                   |                           |
|                          |                       | medical records showing that<br>eatments were completed for                         |                     |      | Performance Improvement (QAPI) committee for 6 months or until  |                   |                           |
|                          | Resident #20.         |   |                     |      | substantial compliance is obtained.   | The               |                           |
|                          |                       |   |                     |      | QAPI committee will evaluate the  |                   |                           |
|                          |                       |   |                     |      |   |                   |                           |

Facility ID: 923567

|                          | OF DEFICIENCIES  | & MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULT           | IPLE CONSTRUCTION  | OMB NO<br>(X3) DAT   | E SURVEY                  |
|--------------------------|--|--|---------------------|--|--|---------------------------|
| ND PLAN C                | F CORRECTION   | IDENTIFICATION NUMBER:   |                     | IG   |  | IPLETED                   |
|                          |  | 345473   | B WING              |  |  | C                         |
| IAME OF I                | PROVIDER OR SUPPLIER   | 040470   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  | 08/  | 21/2015                   |
| VILORA                   | LAKE HEALTHCARE  | CENTER   |                     | 6001 WILORA LAKE ROAD<br>CHARLOTTE, NC 28212   |  |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)  | JLD BE   | (X5)<br>COMPLETIC<br>DATE |
| F 314                    | Continued From pa  | ge 15  | F 31                | 4<br>monitoring/observation tools for<br>maintaining substantial complian<br>make changes to the corrective<br>necessary.  |  |                           |
| F 333<br>SS=G            | 483.25(m)(2) RESII<br>SIGNIFICANT MED  |  | F 33                | -  |  | 9/29/15                   |
|                          | The facility must en any significant med   | sure that residents are free of ication errors.  |                     |  |  |                           |
|                          | by:<br>Based on record re-<br>interview the facility<br>scheduled pain mer<br>opportunities (Resid<br>Findings included:<br>1) Resident #10 was<br>6/6/2013. Her diagr<br>Insomnia, Upper ar<br>Chronic Pain.<br>The Minimum Data<br>Resident #10 was s<br>and was totally dep<br>physical assistance<br>living. Resident #10<br>experiencing pain.<br>sleep at night and li<br>Record review of a<br>concern dated 8/18<br>medications were re<br>The Physician Order<br>through 8/31/2015 f<br>order for OxyContin<br>mg (milligram) table | s admitted to the facility on<br>hoses included Dementia,<br>m Fracture Chronic, and<br>Set dated 8/17/2015 revealed<br>everely cognitively impaired<br>endent on staff (two person<br>) for her activities of daily<br>was assessed as frequently<br>The pain had made it hard to<br>mited her day to day activities.<br>grievance log revealed a<br>/2015 for Resident #10 for |                     | A medication error report was c<br>by the Director of Clinical Service<br>resident #10 on 8-20-15 and res-<br>continue to have pain medication<br>administered timely per physicial<br>All residents with pain medication<br>have the potential to be affected<br>alleged deficient practice. The D<br>Clinical Services completed a re-<br>8-21-15 of the Medication Admin<br>Records and medication storage<br>ensure physician ordered pain<br>medications were available for<br>administration. Medications were<br>as appropriate to ensure available<br>resident residing in the facility w<br>reassessed for pain and docum<br>the Pain Assessment form by a<br>nurse by 8-28-15. Any unmanag-<br>identified was reported to the ph<br>and new orders received by the<br>nurse as appropriate. A complet<br>Medication Administration Reco<br>medication storage cart audit was | es for<br>ident will<br>ns<br>ns orders.<br>by the<br>virector of<br>view on<br>histration<br>e carts to<br>e refilled<br>ility. Each<br>as also<br>ented on<br>licensed<br>ed pain<br>ysician<br>licensed<br>e<br>rd to |                           |

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|                          | RS FOR MEDICARE<br>OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA   | (X2) MUL           | TIPLE CONSTRUCTION   | (X3) DATE  | 0938-039                  |
|--------------------------|--|---|--------------------|--|--|---------------------------|
| ND PLAN C                | OF CORRECTION  | IDENTIFICATION NUMBER:  | A. BUILD           | ING  |  | PLETED                    |
|                          |  | 045470  |                    |  |  | C                         |
|                          |  | 345473  | B. WING            |  |  | 21/2015                   |
| NAME OF                  | PROVIDER OR SUPPLIER   |   |                    | STREET ADDRESS, CITY, STATE, ZI  | PCODE  |                           |
| WILORA                   | LAKE HEALTHCARE  | CENTER  |                    | 6001 WILORA LAKE ROAD<br>CHARLOTTE, NC 28212   |  |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | PROVIDER'S PLAN OF (<br>X (EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC'   | ON SHOULD BE<br>HE APPROPRIATE   | (X5)<br>COMPLETIO<br>DATE |
| F 333                    | Continued From pa  | ae 16   | F 3                | 33   |  |                           |
| F 333                    | The Medication Adr<br>dated 8/1/2015 thro<br>#10 revealed on 8/^<br>OxyContin was not<br>circled initials. Ther<br>back of the MAR as<br>administered.<br>A Physician Order of<br>for Resident #10 ind<br>10 mg tablet ER for<br>Physician Assistant<br>A record review of t<br>medication utilization<br>OxyContin revealed<br>active card stock w<br>at 9:00 AM.<br>The MAR dated 8/1<br>Resident #10 reveal<br>8/18/2015 the 9:00<br>OxyContin were no<br>circled signature ini<br>on the back of the M<br>not administered.<br>A record review of t<br>through 8/31/2015 the<br>sneeded medicat<br>Hydrocodone-Aceta<br>medication) 5 mg-3<br>mouth every 4 hour<br>record indicated by<br>8/17/2015 two dose<br>Resident #10. On th<br>one entry for 8/17/2<br>for script from MD (<br>A prescription dated<br>the physician order) | ministration Record (MAR)<br>bugh 8/31/2015 for Resident<br>16/2015 the 9:00 PM dose of<br>administered indicated by<br>re was no indication on the<br>s to why the dose was not<br>dated 8/16/2015 at midnight<br>cluded: May hold OxyContin<br>one dose follow up with<br>in the morning 8/17/2015.<br>the pharmacy controlled<br>on record for Resident #10 's<br>d that the last dose on the<br>as administered on 8/16/2015<br>1/2015 through 8/31/2015 for<br>aled on 8/17/2015 and<br>AM and the 9:00 PM doses of<br>t administered indicated by<br>tials. There was no indication<br>MAR as to why the dose was<br>the MAR dated 8/1/2015<br>for Resident #10 revealed an |                    | completed by the Omnica<br>9-9-15 and any needed m<br>ordered to ensure compli<br>medication availability.<br>The Director of Clinical S<br>reeducated licensed nurs | ervices<br>es currently<br>9-28-15<br>dminister<br>escribed. The<br>order process,<br>v kit supply of<br>ss of medication<br>bility and use of<br>otifying the<br>Clinical Services<br>ilable and<br>tions not<br>ans order. The<br>eed to timely<br>treatment<br>vel is at a 2-7 day<br>se who did not<br>5 will receive<br>at scheduled<br>will administer<br>ver physicians;<br>ministration by<br>n Administration<br>Clinical Services<br>ontrolled<br>eekly to ensure<br>ation are |                           |

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|                          | -   | AND HUMAN SERVICES  |                     |    |   | FORM  | 09/30/2019<br>APPROVEE<br>0938-0391 |
|--------------------------|---|---|---------------------|----|---|---|-------------------------------------|
|                          | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     |    | E CONSTRUCTION (  | COM   | E SURVEY<br>PLETED                  |
|                          |   | 345473  | B. WING             |    |   | (<br>08/2                                   | )<br>21/2015                        |
| NAME OF                  | PROVIDER OR SUPPLIER  |   |                     | S  | TREET ADDRESS, CITY, STATE, ZIP CODE  |   |                                     |
| WILORA                   | LAKE HEALTHCARE   | CENTER  |                     |    | 001 WILORA LAKE ROAD<br>HARLOTTE, NC 28212  |   |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | ×  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)  | BE  | (X5)<br>COMPLETION<br>DATE          |
| F 333                    | and the first dose a<br>8/19/2015.<br>On 8/20/2015 at 4:3<br>#1 (a relief nurse from<br>Resident #10 's nut<br>did not know the resion<br>8/16/2015.<br>Resident #10 's pri<br>8/16/2015 was unar<br>primary nurse for da<br>unavailable. The pri<br>for the evening shift<br>was a contract nurse<br>On 8/20/2015 at 4:4<br>#2 (a relief nurse from<br>Resident #10 's nut<br>did not give Reside<br>18th because it was<br>Nurse #3 processed<br>8/18/2015. She cout<br>was processed bect<br>to the facility electron<br>system. Nurse #2 ro<br>share with you she<br>Nurse #3 was unary<br>On 8/20/2015 at 11<br>second shift unit mat<br>process for reorder<br>stock card became<br>medications in the of<br>the pharmacy. The<br>have been complete<br>stock was out of me<br>before 5:00 PM the<br>the same day. After<br>for a stat delivery if<br>facility does not kee | d it was received on 8/18/2015<br>dministered was on<br>80 PM an interview with Nurse<br>om a sister facility) who was<br>rse on 8/16/2015 reported she<br>ason the OxyContin was held<br>mary nurse the evening of<br>vailable for an interview. The<br>ay shift on 8/17/2015 was<br>imary nurse on the schedule<br>ts for 8/17/2015 and 8/18/2015 | F 3                 | 33 | medication storage carts.<br>5 x/week for 4 weeks, 1 x/week for 2<br>months, then monthly for 3 months t<br>ensure compliance with medication<br>administration and availability of the<br>day supply. Quality Improvement<br>monitoring will be documented on a<br>Quality Assurance and Performance<br>Improvement Monitor Tool. The Dire<br>of Clinical Services will report audit r<br>monthly to the Quality Assurance<br>Performance Improvement (QAPI)<br>committee for 6 months or until<br>substantial compliance is obtained.<br>QAPI committee will evaluate the<br>effectiveness of the<br>monitoring/observation tools for<br>maintaining substantial compliance,<br>make changes to the corrective action<br>necessary. | to<br>2-7<br>ector<br>results<br>The<br>and |                                     |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION       (X) PROVIDERSUPPLERCIAN<br>IDENTIFICATION NUMBER       (X) MULTIPLE CONSTRUCTION<br>A BUILDING       (X) MULTIPLE CONSTRUCTION<br>A BUILDING       (X) MULTIPLE CONSTRUCTION<br>A BUILDING       (X) MULTIPLE CONSTRUCTION<br>A BUILDING       (X) MULTIPLE CONSTRUCTION<br>BUILDING       (X) MULTIPLE CONSTRUCTION<br>A BUILDING       (X) MULTIPLE CONSTRUCTION<br>BUILDING       (X) MULTIPLE CONSTRUCTION<br>BUIL   |           |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |         |     |   | FORM             | 09/30/2015<br>APPROVED<br>0938-0391 |
|--|-----------|---|---|---------|-----|---|------------------|-------------------------------------|
| 345473         B: WING         08/21/2015           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, UP CODE           WILORA LAKE HEALTHCARE CENTER           SUMMARY STATEMENT OF DEFICIENCIES         STREET ADDRESS, CITY, STATE, UP CODE           SUMMARY STATEMENT OF DEFICIENCIES         STREET ADDRESS, CITY, STATE, UP CODE           SUMMARY STATEMENT OF DEFICIENCIES         STREET ADDRESS, CITY, STATE, UP CODE           SUMMARY STATEMENT OF DEFICIENCIES         DEFICIENCIES           STREET ADDRESS, CITY, STATE, UP CODE           SUMMARY STATEMENT OF DEFICIENCIES           STREET ADDRESS, CITY, STATE, UP CODE           SUMMARY STATEMENT OF DEFICIENCIES           SUMMARY STATEMENT OF DEFICIENCIES           PROVIDER PLANCA CORRECTION           (FACI DEFICIENCIES)           TAGE           F 333           Continued From page 18           REPORT PLANCA         F 333           F 333           F 344 AD an interview with the pharmacy, ording system, after [Dusiness] hours the nurses fax medication         F address defined factor addres address address address addres address address a   | STATEMENT | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA   | . ,     |     |   | (X3) DATI<br>COM | E SURVEY<br>PLETED                  |
| WILORA LAKE HEALTHCARE CENTER         B01 WILORA LAKE ROAD<br>CHARLOTTE, NC 28212           PHEFX<br>TAG         SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICENCY MUST BE PRECEDED BY FULL<br>REACH DEFICENCY MUST BE PRECEDED BY FULL<br>TAG         IPREFIX         REOUNDER'S PLAN OF CORRECTION<br>(EACH DEFICENCY MUST BE PRECEDED BY FULL<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)         IPREFIX         Continued From page 18         F 333           Nurse would have to call the pharmacy. If a<br>medication was missing for 3 days it meant the<br>nurse did not request the order in time. The unit<br>manager reported he did not have access to the<br>facility electronic pharmacy ordering system, after<br>[business] hours the nurses fax medication<br>orders to the pharmacy. The unit manager<br>reported when a medication was not administered<br>the nurse was to circle her initials and write on<br>back of the MAR the reason for not giving the<br>medication. On 8/21/2015 at 9:34 AM an interview with the<br>pharmacy revealed Resident #10 had a hard<br>script (legal prescription) for CxyContin 10 mg<br>filled on 7/21/2015. The regulatory law only<br>allowed the pharmacy to dispense a 14 day<br>supply of a narcotic medication, 28 tablets were<br>dispensed to the facility. On 8/2015 a hard script<br>was filled for CxyContin and 28 tablets were<br>dispensed to the facility.<br>On 8/21/2015 at 9:45 AM an interview with<br>Resident #10 had a chronic fracture in<br>her right shoulder. The RP reported Resident #10<br>needed to be positioned for comfort and her<br>shoulder. The RP reported Resident #10<br>needed to be positioned for comfort and her<br>shoulder. The RP reported she had<br>filed grievances for Resident #10 not receiving<br>her medications ordered, in stock, and administered<br>to Resident #10.         Here administered<br>the regional Director of Human Resources revealed  |           |   | 345473  | B. WING |     |   |                  |                                     |
| WILDRA LAKE HEALTHCARE CENTER     CHARLOTTE, NC 28212       (W) ID<br>TAG     SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEEDED BY FUL<br>RECOULTIONY OR LSC DENTIFYING INFORMATION)     ID<br>PREFIX<br>RECOULTIONY OR LSC DENTIFYING INFORMATION)     ID<br>PROVIDERS INAN OF CORRECTIVE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY MUST BE PRECEEDED BY FUL<br>RECOULTIONY OR LSC DENTIFYING INFORMATION)     ID<br>PROVIDERS INAN OF CORRECTIVE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY     OWE IT<br>OWE IT<br>PREFIX       F 333     Continued From page 18<br>nurse would have to call the pharmacy. If a<br>medication was missing for 3 days it meant the<br>nurse dui not request the order in time. The unit<br>manager reported he did not have access to the<br>facility electronic pharmacy ordering system, after<br>[business] hours the nurses fax medication<br>orders to the pharmacy. The unit manager<br>reported when a medication was not administered<br>the nurse was to circle her initials and write on<br>back of the MAR the reason for not giving the<br>medication.<br>On 8/21/2015 at 9:34 AM an interview with the<br>pharmacy revealed Resident #10 had a hard<br>script (legal prescription) for OxyContin 10 mg<br>filled or 702/2015. The regulatory law only<br>allowed the pharmacy to dispense a 14 day<br>supply of a narcotic medication, 28 tablets were<br>provided to the facility.<br>On 8/21/2015 at 9:45 AM an interview with<br>Resident #10 had a chronic fracture in<br>her right shoulder that was not operable so she<br>had chronic pain. The RP reported Resident #10<br>needed to be positioned for comfort and her<br>shoulder protected in care. She reported resident<br>#10 rubs, guards, covers up, and verbalized pain<br>to her right shoulder. The RP reported she was at the<br>facility daily and it would take up to a week to get<br>medications ordered, in stock, and administered<br>to Resident #10.<br>On 8/21/2015 at 11:09 PM an interview with the<br>Regional Director of Human Resources revealed | NAME OF F | PROVIDER OR SUPPLIER  |   |         | S   | STREET ADDRESS, CITY, STATE, ZIP CODE                           |                  |                                     |
| PREFIX<br>TXG       (EACH CORRECTIVE ACTION SHOULD BE<br>REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX<br>TAG       (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCE)       COMPLETIC<br>DEFICENCY         F 333       Continued From page 18<br>nurse would have to call the pharmacy. If a<br>medication was missing for 3 days it meant the<br>nurse did not request the order in time. The unit<br>manager reported he did not have access to the<br>facility electronic pharmacy ordering system, after<br>[business] hours the nurses fax medication<br>orders to the pharmacy. The unit manager<br>reported when a medication was not administered<br>the nurse was to circle her initials and write on<br>back of the MAR the reason for not giving the<br>medication.       F 333         On 8/21/2015 at 9:34 AM an interview with the<br>pharmacy revealed Resident #10 had a hard<br>script (lega) prescription) for OxyContin 10 mg<br>filled on 7/21/2015. The regulatory law only<br>allowed the pharmacy to dispense a 14 day<br>supply of a narcolic medication. 28 tablets were<br>dispensed to the facility.<br>On 8/21/2015 at 9:45 AM an interview with<br>Resident #10 ms do parable seription<br>her right shoulder That was not operable so she<br>had chronic pain. The RP reported Resident #10<br>needed to be positioned for comfort and her<br>shoulder protected in care. She reported she had<br>filed grievances for Resident #10 not receiving<br>her medications. The RP reported she had<br>filed grievances for Resident #10 not receiving<br>her medications. The RP reported she had<br>filed grievances for Resident #10 not receiving<br>her medications. The RP reported she was the<br>facility daily and it would take up to a week to get<br>medications ordered, in stock, and administered<br>to Resident #10.<br>On 0/21/2015 at 11:09 PM an interview with the<br>Regiona Director of Human Resources revealed   | WILORA    | LAKE HEALTHCARE   | CENTER  |         |     |   |                  |                                     |
| nurse would have to call the pharmacy. If a<br>medication was missing for 3 days it meant the<br>nurse did not request the order in time. The unit<br>manager reported he did not have access to the<br>facility electronic pharmacy ordering system, after<br>[business] hours the nurses fax medication<br>orders to the pharmacy. The unit manager<br>reported when a medication was not administered<br>the nurse was to circle her initials and write on<br>back of the MAR the reason for not giving the<br>medication.<br>On 8/21/2015 at 9:34 AM an interview with the<br>pharmacy revealed Resident #10 had a hard<br>script (legal prescription) for OxyContin 10 mg<br>filled on 7/21/2015. The regulatory law only<br>allowed the pharmacy to dispense a 14 day<br>supply of a narcotic medication. 28 tablets were<br>provided to the facility.<br>On 8/21/2015 at 9:45 AM an interview with<br>Resident #10 's Responsible Party (RP)<br>revealed Resident #10 had a chronic fracture in<br>her right shoulder that was not operable so she<br>had chronic pain. The RP reported Resident #10<br>needed to be positioned for comfort and her<br>shoulder protected in care. She reported resident<br>#10 rubs, guards, covers up, and verbalized pain<br>to her right shoulder. The RP reported she had<br>filed grievances for Resident #10 neceiving<br>her medications. The RP reported she had<br>filed grievances for Resident #10 nuceiving<br>her medications. The RP reported she was at the<br>facility daily and it would take up to a week to get<br>medications ordered, in stock, and administered<br>to Resident #10.<br>On 8/21/2015 at 11:09 PM an interview with the<br>Regional Director of Human Resources revealed   | PRÉFIX    | (EACH DEFICIENCY  | MUST BE PRECEDED BY FULL  | PREF    |     | (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF | ) BE             | COMPLETION                          |
| because of staffing changes the nurses<br>scheduled to work at the facility were from sister<br>facilities. Corporate policies and practices are   | F 333     | nurse would have to<br>medication was miss<br>nurse did not reque<br>manager reported h<br>facility electronic ph<br>[business] hours the<br>orders to the pharm<br>reported when a me<br>the nurse was to cir<br>back of the MAR th<br>medication.<br>On 8/21/2015 at 9:3<br>pharmacy revealed<br>script (legal prescrip<br>filled on 7/21/2015.<br>allowed the pharma<br>supply of a narcotic<br>provided to the facil<br>was filled for OxyCo<br>dispensed to the facil<br>on 8/21/2015 at 9:4<br>facility daily and it w<br>medications ordere<br>to Resident #10.<br>On 8/21/2015 at 11<br>Regional Director o<br>because of staffing<br>scheduled to work a | <ul> <li>a call the pharmacy. If a sing for 3 days it meant the st the order in time. The unit he did not have access to the armacy ordering system, after enurses fax medication have access to the armacy ordering system, after enurses fax medication have access to the armacy ordering system, after enurses fax medication access. The unit manager edication was not administered the relation was not administered access for not giving the and the relation of the regulatory law only bey to dispense a 14 day medication, 28 tablets were ity. On 8/18/2015 a hard script ontin and 28 tablets were cility.</li> <li>b AM an interview with the sponsible Party (RP) #10 had a chronic fracture in the reported Resident #10 oned for comfort and her in care. She reported resident overs up, and verbalized pain r. The RP reported she had Resident #10 not receiving the RP reported she was at the fould take up to a week to get d, in stock, and administered at the facility were from sister</li> </ul> | F       | 333 |   |                  |                                     |

Facility ID: 923567

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|                          |  |  |                     |   |                              | 0. 0938-039               |
|--------------------------|--|--|---------------------|---|------------------------------|---------------------------|
|                          | OF DEFICIENCIES                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                |                     | IPLE CONSTRUCTION   | · · ·                        | TE SURVEY<br>MPLETED      |
|                          |  |  | A. BOILDII          |   |                              | С                         |
|                          |  | 345473   | B. WING             |   | 08                           | /21/2015                  |
| NAME OF F                | PROVIDER OR SUPPLIER                         |  | 1                   | STREET ADDRESS, CITY, STATE, ZIP  |                              |                           |
|                          | LAKE HEALTHCARE                              | CENTER   |                     | 6001 WILORA LAKE ROAD   |                              |                           |
| WILOKA                   |  | CENTER   |                     | CHARLOTTE, NC 28212   |                              |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                             | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THI<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETIO<br>DATE |
| F 333                    | Continued From pa                            | ae 19  | F 33                | 33  |                              |                           |
|                          | •  | cilities. Her expectation would  |                     |   |                              |                           |
|                          | be the nurse on staff would be familiar with |  |                     |   |                              |                           |
|                          |  | t the building would need to   |                     |   |                              |                           |
|                          |  | ecific orientation. The nurses had building specific                                 |                     |   |                              |                           |
|                          |  | y access. They had the ability   |                     |   |                              |                           |
|                          |  | ere were nursing supervisors   |                     |   |                              |                           |
|                          |  | available to order the   |                     |   |                              |                           |
|                          |  | Director of Nursing was  |                     |   |                              |                           |
|                          |  | ering house stock medications  |                     |   |                              |                           |
|                          | and narcotics.                               | 30 AM an interview with  |                     |   |                              |                           |
|                          |  | cility Nurse Practitioner (NP)   |                     |   |                              |                           |
|                          |  | not aware that Resident #10  |                     |   |                              |                           |
|                          |  | ving her scheduled pain  |                     |   |                              |                           |
|                          |  | ewing the order written on   |                     |   |                              |                           |
|                          |  | er was managed by the on call hose name was transcribed on                           |                     |   |                              |                           |
|                          |  | she did not personally get a   |                     |   |                              |                           |
|                          |  | staff. She further reported  |                     |   |                              |                           |
|                          |  | 8/16/2015. The NP shared   |                     |   |                              |                           |
|                          | she felt the facility h                      | had a big problem with   |                     |   |                              |                           |
|                          |  | ring medications timely and the  |                     |   |                              |                           |
|                          |  | corrected. She reported there<br>ation between nurses and other                      |                     |   |                              |                           |
|                          |  | reported the residents are in  |                     |   |                              |                           |
|                          |  | cility and a level of care is  |                     |   |                              |                           |
|                          |  | xcusable to be out of a  |                     |   |                              |                           |
|                          |  | dication for even one dose. It   |                     |   |                              |                           |
|                          |  | o use an as needed pain<br>bstitution for coverage of                                |                     |   |                              |                           |
|                          | chronic pain. "                              | ballution for coverage of  |                     |   |                              |                           |
|                          |  | :28 AM an interview with the   |                     |   |                              |                           |
|                          | corporate staff reve                         | ealed the nursing staff was  |                     |   |                              |                           |
|                          |  | 15 on the procedure for  |                     |   |                              |                           |
|                          |  | ring medications. The  |                     |   |                              |                           |
|                          |  | nursing staff was to follow the ring the medication timely.                          |                     |   |                              |                           |
|                          | When the medication                          |  | 1                   |   |                              |                           |

If continuation sheet Page 20 of 27

|                          | OF DEFICIENCIES                          | & MEDICAID SERVICES   | (X2) MI II T        | IPLE CONSTRUCTION   | (Y3) האח (                   | TE SURVEY                 |
|--------------------------|--|---|---------------------|---|------------------------------|---------------------------|
|                          | OF CORRECTION                            | IDENTIFICATION NUMBER:  |                     | NG  |                              | MPLETED                   |
|                          |  | 345473  | B. WING             |   |                              | С                         |
|                          | PROVIDER OR SUPPLIER                     | 545475  | D: WING _           | STREET ADDRESS, CITY, STATE, ZIP  |                              | /21/2015                  |
|                          | FROMBER OR SUFFEIER                      |   |                     | 6001 WILORA LAKE ROAD   | CODE                         |                           |
| WILORA                   | LAKE HEALTHCARE                          | CENTER  |                     | CHARLOTTE, NC 28212   |                              |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                         | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CC<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETIO<br>DATE |
| F 333                    | Continued From pa                        | ae 20   | F 3                 | 22  |                              |                           |
| 1 000                    |  | -   | гэ                  | 55  |                              |                           |
|                          |  | hysician for a hard script and o the pharmacy. The                                  |                     |   |                              |                           |
|                          |  | the new prescription to be in   |                     |   |                              |                           |
|                          | the building before                      | the medication card stock was   |                     |   |                              |                           |
|                          |  | cceptable to go 3 days without  |                     |   |                              |                           |
|                          |  | ation. There was the  |                     |   |                              |                           |
|                          |  | e nurses write why they did not   |                     |   |                              |                           |
| F 514                    | -  | n the back of the MAR.  | F 5                 | 14  |                              | 0/20/15                   |
| SS=D                     |  | LETE/ACCURATE/ACCESSIB  | ГЭ                  | 14  |                              | 9/29/15                   |
| 33-D                     | LE                                       |   |                     |   |                              |                           |
|                          | The facility must ma                     | aintain clinical records on each  |                     |   |                              |                           |
|                          |  | nce with accepted professional  |                     |   |                              |                           |
|                          |  | tices that are complete;  |                     |   |                              |                           |
|                          | accurately docume<br>systematically orga | nted; readily accessible; and nized.  |                     |   |                              |                           |
|                          |  | must contain sufficient   |                     |   |                              |                           |
|                          |  | ify the resident; a record of the   |                     |   |                              |                           |
|                          | services provided; 1                     | ents; the plan of care and  |                     |   |                              |                           |
|                          | •  | ening conducted by the State;   |                     |   |                              |                           |
|                          | and progress notes                       |   |                     |   |                              |                           |
|                          |  |   |                     |   |                              |                           |
|                          |  | NT is not met as evidenced  |                     |   |                              |                           |
|                          | by:<br>Based on record re                | eview and staff interview the   |                     | Resident #10 continues to   | receive                      |                           |
|                          |  | ntain a complete medical  |                     | OxyContin twice daily as so   |                              |                           |
|                          |  | menting the reason for  |                     | Hydrocodone continues to  |                              |                           |
|                          | medication omissio                       | ns on two medications   |                     | administered on an as nee   | ded basis per                |                           |
|                          |  | ro) and by not documenting  |                     | physicians; orders with the   |                              |                           |
|                          |  | inistering a pain medication  |                     | needed documented in the  |                              |                           |
|                          |  | ered on an as needed basis<br>Resident #10) in line with the                        |                     | record. The licensed nurse<br>order on 8-21-15 to discon                                  |                              |                           |
|                          |  | ce and the documentation tool   |                     | #10 Muro eye drops.   |                              |                           |
|                          |  | stration Record) provided by  |                     |   |                              |                           |

Facility ID: 923567

If continuation sheet Page 21 of 27

|                          | OF DEFICIENCIES                          | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA                                     | (X2) MUL            | TIPLE | E CONSTRUCTION  |          | 0938-039<br>E SURVEY      |
|--------------------------|--|---|---------------------|-------|---|----------|---------------------------|
| ID PLAN C                | OF CORRECTION                            | IDENTIFICATION NUMBER:  |                     |       |   | `́сом    | PLETED                    |
|                          |  |   |                     |       |   | (        | 0                         |
|                          |  | 345473  | B. WING             |       |   | 08/2     | 21/2015                   |
| IAME OF I                | PROVIDER OR SUPPLIER                     |   |                     | SI    | TREET ADDRESS, CITY, STATE, ZIP CODE  |          |                           |
|                          | LAKE HEALTHCARE                          | CENTER  |                     |       | 001 WILORA LAKE ROAD  |          |                           |
|                          |  | OENTER  |                     | С     | HARLOTTE, NC 28212  |          |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                         | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | K     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE     | (X5)<br>COMPLETIC<br>DATE |
| F 514                    | Continued From pa                        | ae 21   | F 5                 | 14    |   |          |                           |
|                          | the facility.                            |   | 1.5                 |       | All residents have the potential to   | ho       |                           |
|                          | Findings included:                       |   |                     |       | affected by the alleged deficient p   |          |                           |
|                          |  | admitted to the facility on   |                     |       |   | 201001   |                           |
|                          | 6/6/2013. Her diagr                      | noses included Dementia.  |                     |       | A review of all Medication Adminis  | tration  |                           |
|                          |  | grievance log revealed a  |                     |       | Records (MARs) and Treatment  |          |                           |
|                          |  | /2015 regarding Resident #10  |                     |       | Administration Records (TARs) fo  |          |                           |
|                          | receiving her medic                      | cation late.<br>Resident #10 ' s Medication   |                     |       | current month was completed by to<br>Director of Clinical Services and the                                      |          |                           |
|                          |  | ord (MAR) dated 8/1/2015 to   |                     |       | Nurse Manager by 9-10-15. Other   |          |                           |
|                          |  | an order for Muro-128 2%  |                     |       | of missed documentation were no   |          |                           |
|                          |  | both eyes twice daily (for  |                     |       | corrected when possible within cu   |          |                           |
|                          |  | n 8/17/2015 the 9:00 PM dose  |                     |       | standards of practice.  |          |                           |
|                          |  | ed as indicated by circled  |                     |       |   |          |                           |
|                          |  | 15 the 9:00 AM and the 9:00   |                     |       | The Director of Clinical Services   |          |                           |
|                          |  | were not administered as  |                     |       | reeducated licensed nurses by 9-2   |          |                           |
|                          |  | initials. There was no written ack of the MAR as to why the                         |                     |       | the need to maintain accurate, co medical records. This education in  |          |                           |
|                          | doses were missed                        |   |                     |       | appropriate documentation of the  |          |                           |
|                          |  | ministration Record (MAR)   |                     |       | for as needed medication adminis  |          |                           |
|                          |  | ough 8/31/2015 for Resident   |                     |       | and appropriate documentation of  |          |                           |
|                          |  | 16/2015 the 9:00 PM dose of   |                     |       | medication omissions. Any licens  |          |                           |
|                          |  | milligram) tablet Extended  |                     |       | nurse not educated by 9-28-15 wi  |          |                           |
|                          |  | ice daily every 12 hours  |                     |       | educated prior to their next workin   |          |                           |
|                          |  | cation) was not administered led initials. There was no                             |                     |       | It is expectation that the licensed will document administration of or  |          |                           |
|                          |  | ack of the MAR as to why the  |                     |       | medication by initialing on the Me  |          |                           |
|                          | dose was not admir                       | ,   |                     |       | Administration Record (MAR). For  |          |                           |
|                          |  | 30 PM an interview was  |                     |       | needed medications, the licensed  |          |                           |
|                          | conducted with Nur                       | se #1 (a relief nurse from a  |                     |       | will document in the medical reco   | d the    |                           |
|                          |  | vas Resident #10 ' s nurse for  |                     |       | reason for administration. When a   |          |                           |
|                          |  | 015. Nurse #1 reported she did  |                     |       | medication is not given as ordered  |          |                           |
|                          |  | e OxyContin was held in the   |                     |       | licensed nurse will indicate this by<br>his/her initial on the front of the M                                   |          |                           |
|                          | PM on 8/16/2015.<br>Resident #10 ' s pri | mary nurse during the evening   |                     |       | document the reason for omission  |          |                           |
|                          |  | navailable for an interview.  |                     |       | medical record.   |          |                           |
|                          |  | 1/2015 through 8/31/2015 for  |                     |       |   |          |                           |
|                          |  | aled on 8/17/2015 and   |                     |       | The Director of Clinical Services of  | or Nurse |                           |
|                          |  | AM and the 9:00 PM doses of   |                     |       | Manager will conduct Quality  |          |                           |
|                          |  | administered as indicated by  |                     |       | Improvement monitoring of Medic   |          |                           |

Facility ID: 923567

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| TATEMENT                 | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MI II T        | IPLE CONSTRUCTION   |  | SURVEY                    |
|--------------------------|--|--|---------------------|---|--|---------------------------|
|                          | F CORRECTION   | IDENTIFICATION NUMBER:   |                     | NG  |  | PLETED                    |
|                          |  |  |                     |   | 0  | )                         |
|                          |  | 345473   | B. WING _           |   |  | 21/2015                   |
| NAME OF                  | PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE,  | ZIP CODE   |                           |
| WILORA                   | LAKE HEALTHCARE  | CENTER   |                     | 6001 WILORA LAKE ROAD<br>CHARLOTTE, NC 28212  |  |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN O<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN   | CTION SHOULD BE  | (X5)<br>COMPLETIO<br>DATE |
| F 514                    | Continued From pa  | -  | F 51                |   | for accuracy and   |                           |
|                          | back of the MAR as<br>administered.<br>A record review of t<br>through 8/31/2015<br>order for Hydrocode<br>pain medication) 5<br>mouth every 4 hour<br>record indicated, by<br>doses were adminis<br>back of the MAR th<br>8/17/2015 that was<br>waiting for script fro<br>OxyContin.<br>The primary nurse<br>on 8/17/2015 that was<br>waiting for script fro<br>OxyContin.<br>The primary nurse<br>on 8/17/2015 was a<br>con 8/20/2015 at 4:4<br>conducted with Nur<br>sister facility who w<br>8/18/2015. She rep<br>Resident #10 her C<br>it was not available<br>reason on the back<br>On 8/20/2015 at 11<br>conducted with the<br>Nurse #4. The nur<br>was not administer<br>initials and write on<br>reason for not givin<br>On 8/21/2015 at 11<br>Regional Director of<br>because of staffing | for Resident #10 on the<br>rening shifts for 8/17/2015 and<br>ontract nurse and unavailable.<br>40 PM an interview was<br>rse #2 a relief nurse from a<br>vas Resident #10 ' s nurse on<br>ported she did not give<br>Dxycontin on the 18th because<br>. She did not document the<br>a of the MAR.<br>:24 PM an interview was<br>second shift unit manager<br>se reported when a medication<br>ed the nurse was to circle her<br>the back of the MAR the |                     | Administration Records<br>completeness of medic<br>documentation 5x/ wee<br>1x/week for 2 months, t<br>months. The Quality Im<br>monitoring will be docur<br>Quality Assurance and<br>Improvement Monitor T<br>of Clinical Services will<br>monthly to the Quality A<br>Performance Improvem<br>committee for 6 months<br>substantial compliance<br>QAPI committee will ev<br>effectiveness of the<br>monitoring/observation<br>maintaining substantial<br>make changes to the co<br>necessary. | ation<br>k for 4 weeks,<br>then 1x/month for 3<br>provement<br>mented on a<br>Performance<br>ool. The Director<br>report audit results<br>assurance<br>nent (QAPI)<br>s or until<br>is obtained. The<br>aluate the<br>tools for<br>compliance, and |                           |

|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                    |     | FOF  | ED: 09/30/2015<br>RM APPROVED<br>IO. 0938-0391 |
|--------------------------|--|---|--------------------|-----|--|--|
|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |     |  | OATE SURVEY<br>OMPLETED                        |
|                          |  | 345473  | B. WING            |     |  | C<br>08/21/2015                                |
|                          | PROVIDER OR SUPPLIER   | CENTER  |                    | 6   | TREET ADDRESS, CITY, STATE, ZIP CODE<br>001 WILORA LAKE ROAD<br>HARLOTTE, NC 28212                                       |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE                     |
| F 514<br>F 520<br>SS=G   | corporate staff rever<br>expectation that the<br>give a medication of<br>483.75(o)(1) QAA<br>COMMITTEE-MEM<br>QUARTERLY/PLAN<br>A facility must main<br>assurance committ<br>nursing services; a<br>facility; and at least<br>facility's staff.<br>The quality assess<br>committee meets a<br>issues with respect<br>and assurance actin<br>develops and imple | 28 AM an interview with the<br>ealed there was the<br>e nurses write why they did not<br>in the back of the MAR.<br>IBERS/MEET<br>NS<br>tain a quality assessment and<br>ee consisting of the director of<br>physician designated by the<br>3 other members of the<br>ment and assurance<br>t least quarterly to identify<br>to which quality assessment<br>wities are necessary; and<br>ments appropriate plans of |                    | 514 |  | 9/29/15  |
|                          | A State or the Sect<br>disclosure of the re<br>except insofar as si<br>compliance of such<br>requirements of this<br>Good faith attempts<br>and correct quality<br>a basis for sanction<br>This REQUIREMEN   | s by the committee to identify<br>deficiencies will not be used as  |                    |     | The facility will follow all regulations   |  |
|                          |  | lement an appropriate plan of   |                    |     | related to the maintenance of an effectiv  | /e   |

Facility ID: 923567

If continuation sheet Page 24 of 27

|                              | OF DEFICIENCIES   |   |                            |                                |   |                               |                           |
|------------------------------|---|---|----------------------------|--------------------------------|---|-------------------------------|---------------------------|
|                              | ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA<br>ID PLAN OF CORRECTION IDENTIFICATION NUMBER:                                       |   | (X2) MULTIPLE CONSTRUCTION |                                |   | (X3) DATE SURVEY<br>COMPLETED |                           |
| 345473                       |   | A. BUILDING   |                            |                                | C<br>08/21/2015   |                               |                           |
|                              |   | B. WING   |                            |                                |   |                               |                           |
| JAME OF PROVIDER OR SUPPLIER |   |   |                            |                                | TREET ADDRESS, CITY, STATE, ZIP CODE  |                               |                           |
|                              |   |   |                            |                                | 001 WILORA LAKE ROAD  |                               |                           |
| /ILORA                       | LAKE HEALTHCARE   | CENTER  |                            | С                              | HARLOTTE, NC 28212  |                               |                           |
| (X4) ID<br>PREFIX<br>TAG     | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG        | (                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI/<br>DEFICIENCY) |                               | (X5)<br>COMPLETIC<br>DATE |
| F 520                        |   |   |                            |                                |   |                               |                           |
| F 520                        | Continued From pa   | -   | F 52                       | 20                             |   |                               |                           |
|                              | action to correct 1 of 4 identified quality deficiency<br>in a plan of correction for failure to administer<br>scheduled pain medication. |   |                            |                                | Quality Assessment and Process<br>Improvement committee.  |                               |                           |
|                              | Findings included:  |   |                            |                                | All residents have the potential to be  |                               |                           |
|                              | Cross reference F3  | 09  |                            |                                | affected by the alleged deficient prac  |                               |                           |
|                              | On 7/17/2015 the fa   | acility received a citation for   |                            |                                | The Quality Assurance and Process   |                               |                           |
|                              |   | scheduled pain medication.  |                            |                                | Improvement (QAPI) committee; incl  |                               |                           |
|                              |   | ed a plan of correction on  |                            |                                | of the Executive Director, Director of  | -                             |                           |
|                              |   | completion date for 8/12/2015.  |                            |                                | Clinical Services, Medical Records  |                               |                           |
|                              |   | on included re-education of   |                            |                                | Coordinator, Business Office Manage   |                               |                           |
|                              |   | rking at the facility on  |                            |                                | Maintenance Director, Human Resou<br>Director, Minimum Date Set Nurse,  | urces                         |                           |
|                              | 7/23/2015 on the need to follow up on resident issues affecting their wellbeing such as pain.   |   |                            |                                | Recreational Director and Nurse   |                               |                           |
|                              | A record review of the plan of correction   |   |                            |                                | Practitioner conducted a QAPI meeti   | ina on                        |                           |
|                              | in-services included (in part) Understand the   |   |                            |                                | 8-25-15 to discuss the deficient pract  |                               |                           |
|                              | need to be diligent to prevent medication errors,   |   |                            |                                | identified during the survey revisit an   | nd                            |                           |
|                              | understand the nee  |   |                            | discussed implementation of an |   |                               |                           |
|                              |   | e the need to complete RED  |                            |                                | immediate plan of correction.   |                               |                           |
|                              |   | ght, understands that the RED   |                            |                                | The feelity will follow all regulations   |                               |                           |
|                              |   | uality check of the days '<br>sian order are checked nightly,                       |                            |                                | The facility will follow all regulations<br>related to the maintenance of an effe                                     | octivo                        |                           |
|                              |   | nding of the need to notify   |                            |                                | quality assessment and process  | scuve                         |                           |
|                              |   | es, understand how to order   |                            |                                | improvement program. The QAPI   |                               |                           |
|                              |   | tions per physician orders,   |                            |                                | committee members were reeducate  | ed on                         |                           |
|                              |   | in which medications must   |                            |                                | 9-10-15 by the Regional Vice Preside  |                               |                           |
|                              |   | stand how to request items  |                            |                                | Operations on the need to meet reg  | ularly                        |                           |
|                              |   | armacy, and understand that   |                            |                                | and to review the results and   | _                             |                           |
|                              |   | idered medication errors.   |                            |                                | effectiveness of all audits completed   |                               |                           |
|                              |   | acility was recited for F309 for  |                            |                                | to revise the plan of correction as de  |                               |                           |
|                              |   | scheduled pain medication treatments as ordered.                                    |                            |                                | necessary by the committee to obtain<br>maintain substantial compliance.  | n anu                         |                           |
|                              |   | :28 AM an interview with the  |                            |                                |   |                               |                           |
|                              |   | aled the nursing staff was  |                            |                                | The Quality Assurance and Performa  | ance                          |                           |
|                              |   | procedure for ordering and  |                            |                                | Improvement Committee will meet   |                               |                           |
|                              |   | ns. The expectation for the   |                            |                                | monthly and/or more frequently as   |                               |                           |
|                              |   | follow the procedure for  |                            |                                | deemed necessary to review the Qua  |                               |                           |
|                              |   | ation timely. When the  |                            |                                | Improvement Monitoring and audit re   | esults                        |                           |
|                              |   | vels got low they were to<br>for a hard script and fax the                          |                            |                                | to ensure continued substantial<br>compliance. The Executive Director   |                               |                           |

Facility ID: 923567

|  |                     |  |                          |   | OMB NO. 0938-039              |                           |  |
|--|---------------------|--|--------------------------|---|-------------------------------|---------------------------|--|
| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br>345473 |                     |  | (X2) MULTI<br>A. BUILDIN |   | (X3) DATE SURVEY<br>COMPLETED |                           |  |
|  |                     | The DOILDING   |                          | С   |                               |                           |  |
|  |                     | B. WING  |                          |   | 08/21/2015                    |                           |  |
| NAME OF PROVIDER OR SUPPLIER   |                     |  |                          | STREET ADDRESS, CITY, STATE, ZIP COD  |                               |                           |  |
| WILORA   | LAKE HEALTHCARE     | CENTER   |                          | 6001 WILORA LAKE ROAD<br>CHARLOTTE, NC 28212  |                               |                           |  |
|  |                     | ATEMENT OF DEFICIENCIES  |                          | -   |                               |                           |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)    | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | IOULD BE                      | (X5)<br>COMPLETIC<br>DATE |  |
| F 520  | Continued From pa   | age 25   | F 52                     | 0   |                               |                           |  |
|  |                     | harmacy. The expectation was   | . 02                     | serve as the QAPI coordinato  | r and be                      |                           |  |
|  |                     | ption to be in the building  |                          | responsible for the ongoing m   |                               |                           |  |
|  | before the medicat  | ion card stock was empty. It   |                          | and improvement process.  | Ŭ                             |                           |  |
|  |                     | e to go 3 days without chronic   |                          |   |                               |                           |  |
|  |                     | here was the expectation that  |                          |   |                               |                           |  |
|  |                     | ny they did not give a<br>back of the medication   |                          |   |                               |                           |  |
|  |                     | ord. In addition there was an  |                          |   |                               |                           |  |
|  |                     | kit (e kit) in the building that   |                          |   |                               |                           |  |
|  |                     | was in process. We did the   |                          |   |                               |                           |  |
|  |                     | some reason there was a  |                          |   |                               |                           |  |
|  |                     | I started with a full house audit  |                          |   |                               |                           |  |
|  |                     | ts and it was decreased to a   |                          |   |                               |                           |  |
|  |                     | ne relief nurses should have   |                          |   |                               |                           |  |
|  | the backup pharma   | pharmacy procedure, using  |                          |   |                               |                           |  |
|  |                     | 2:20 PM the corporate nurse  |                          |   |                               |                           |  |
|  |                     | y Improvement (QI) committee   |                          |   |                               |                           |  |
|  | consisted of the ma |  |                          |   |                               |                           |  |
|  |                     | Medical Director. The  |                          |   |                               |                           |  |
|  | committee met mo    |  |                          |   |                               |                           |  |
|  |                     | 2:54 PM an interview with the  |                          |   |                               |                           |  |
|  |                     | chair of the QI committee  |                          |   |                               |                           |  |
|  |                     | ittee met on the last Thursday   |                          |   |                               |                           |  |
|  |                     | QI committee meeting was not   |                          |   |                               |                           |  |
|  |                     | ursday of July (7/30/2015)   |                          |   |                               |                           |  |
|  |                     | ct with the physician on the   |                          |   |                               |                           |  |
|  |                     | The Administrator reported he  |                          |   |                               |                           |  |
|  |                     | the committee meeting  |                          |   |                               |                           |  |
|  |                     | was working on the Plan of   |                          |   |                               |                           |  |
|  |                     | orted the staff was in-serviced for a staff was in-service |                          |   |                               |                           |  |
|  |                     | e pharmacy helped facilitate   |                          |   |                               |                           |  |
|  |                     | agement created memos with   |                          |   |                               |                           |  |
|  |                     | aining medications after hours.  |                          |   |                               |                           |  |
|  | The process for ob  | taining medications after hours  |                          |   |                               |                           |  |
|  |                     | backup pharmacy. He  |                          |   |                               |                           |  |
|  | reported managem    |  | 1                        |   |                               | 1                         |  |

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|                               |   | AND HUMAN SERVICES   |  |     |  | FORM                               | 09/30/2015<br>APPROVED<br>0938-0391 |  |  |
|-------------------------------|---|--|--|-----|--|------------------------------------|-------------------------------------|--|--|
|                               |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING       |     |  | (X3) DATE SURVEY<br>COMPLETED<br>C |                                     |  |  |
|                               |   | 345473   | B. WING                                      |     |  |                                    | _<br>21/2015                        |  |  |
| NAME OF PROVIDER OR SUPPLIER  |   |  |  | •   |  |                                    |                                     |  |  |
| WILORA LAKE HEALTHCARE CENTER |   |  | 6001 WILORA LAKE ROAD<br>CHARLOTTE, NC 28212 |     |  |                                    |                                     |  |  |
| (X4) ID<br>PREFIX<br>TAG      | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIZ<br>TAG                          |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE                                 | (X5)<br>COMPLETION<br>DATE          |  |  |
| F 520                         | included face to face<br>demonstration. The<br>expectation was that<br>and staff training th<br>the procedure for o<br>and accurately. He | nge 26<br>ation. The staff in-service<br>ce education and return<br>e administrator reported his<br>at after the plan of correction<br>e staff would be able to follow<br>rdering and receiving correctly<br>reported, it was not<br>dents to miss a dose of | F 5  | ;20 |  |                                    |                                     |  |  |

Facility ID: 923567