STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on July 13-15, 2022.	{D 000}		
{D 164}	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 3 of 3 sampled Medication Aides (Staff A, Staff B and Staff C), who	{D 164}		

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	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

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{D 164}	Continued From page 1	{D 164}		

administered insulin and obtained finger stick blood sugars for residents, completed training on the care of diabetic residents prior to the administration of insulin.

The findings are:

Review of the facility's medication administration policy revealed the administration of medications, are ordered by a licensed prescribing practitioner, maintained in the residents' record and administered and prepared by associates who meet the qualifications to do so.

1. Review of Staff A's, medication aide (MA), personnel record revealed:
-There was a hire date of 01/04/22.
-There was no documentation Staff A had completed training on the care of diabetic residents.

Review of a resident's June 2022 electronic medication administration record (eMAR) revealed Staff A documented the administration of insulin on 06/18/22, 06/19/22, 06/21/22, 06/22/22, and 06/23/22.

Review of a resident's July 2022 eMAR revealed Staff A documented the administration of insulin on 07/02/22, 07/03/22, 07/07/22, and 07/11/22.

Attempted telephone interview with Staff A on 07/15/22 at 1:15pm was unsuccessful.

2. Review of Staff B's, medication aide (MA), personnel record revealed:
-There was a hire date of 05/17/22.
-There was no documentation Staff B had completed training on the care of diabetic residents.

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{D 164}	Continued From page 2 Attempted telephone interview with Staff B on 07/15/22 at 1:14pm was unsuccessful. 3. Review of Staff C's, medication aide (MA), personnel record revealed: -There was a hire date of 10/08/21. -There was no documentation Staff C had completed training on the care of diabetic residents. Review of a resident's June 2022 electronic medication administration record (eMAR) revealed Staff C documented the administration of insulin on 06/14/22, 06/24/22, 06/26/22, 06/28/22, and 06/29/22. Attempted telephone interview with Staff C on 07/15/22 at 1:14pm was unsuccessful. Interview with the Business Office Manager (BOM) on 07/14/22 at 4:00pm and on 07/15/22 at 1:47pm revealed: -When new medication aides (MA) were hired she, the Special Care Unit Coordinator (SCC) or the Resident Care Coordinator (RCC) contacted the facility's contracted nurse to provide diabetic training. -The contracted nurse told her that she discussed all the topics related to the care of diabetic residents on the medication skills checklist. -The contracted nurse did not provide a certificate for diabetic training, but she checked off information related to diabetes on the medication skills checklist to indicate that the training was completed. -The SCC and RCC were responsible to ensure the MAs completed the diabetic training prior to administering insulin. -She had a list of things that new hires required in	{D 164}		

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	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

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{D 164}	Continued From page 3 their staff records but diabetic training was not included since it was the clinical team's responsibility. -She had not created a comprehensive list of everything that should be included in the staff records at this time. Interview with the Administrator on 07/14/22 at 4:00pm revealed the contracted nurse who provided the diabetic training documented it on the medication skills checklist. Attempted telephone interview with the contracted nurse on 07/15/22 at 8:55am was unsuccessful. Interview with the RCC on 07/15/22 at 2:29pm revealed: -The facility's contracted nurse was responsible for providing the training on the care of diabetic residents for the MAs. -The BOM was responsible to identify which MAs needed the training. -She was responsible to ensure the diabetic training was completed for the MAs.	{D 164}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by:	{D 358}		

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{D 358}	Continued From page 4 FOLLOW-UP TO TYPE A1 VIOLATION The Type A1 Violation is abated. Non-compliance continues. THIS IS A TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 5 sampled residents (Resident #2, #3, and #5) including a fast acting insulin that was not available for administration to treat high blood sugars, and medications to treat high cholesterol, nausea, vitamin D and vitamin B-12 insufficiency (#3), medications to treat confusion and increased pain, and three medications used to treat muscle spasms (#5), and medications to treat a zinc deficiency and insomnia (#2). The findings are: Review of the facility's medication administration policy revealed: -The administration of medications, prescription and non-prescription are ordered by a licensed prescribing practitioner, which are maintained in the residents' record and administered and prepared by associates who meet the qualifications to do so. -The resident's medication administration record will be accurate and include the following: resident's name; name of medication; strength and dosage; or quantity of medication administered; instructions for administering the medication; date and time of administration; documentation of any omission of medications and the reason for the omission; and name or initials of the person administering the medication.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

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{D 358}	Continued From page 5 1. Review of Resident #3's current FL2 dated 03/15/22 revealed diagnoses included Type II diabetes mellitus, memory deficit, difficulty in walking, and muscle weakness. a. Review of Resident #3's current FL2 dated 03/15/22 revealed: -There was an order for aspart 100units/ml inject 5 units subcutaneously (SQ) before meals. -There was an order for aspart 100units/ml inject SQ per sliding scale: if fingerstick blood sugar (FSBS) 0-100=0, 101-150=1, 151-200=2, 201-250=3, 251-300=4, 301-350=5, 351-400=6, and greater than 401 call MD. -There was no type of insulin solution specified. Review of Resident #3's Primary Care Provider's (PCP) Order Summary Report signed 06/06/22 revealed: -There was an order for insulin aspart (a fast acting insulin to treat high blood sugars) FlexPen 100units/ml inject 5 units SQ before meals related to Type 2 diabetes mellitus. -There was an order for insulin aspart FlexPen 100units/ml inject as per sliding scale: if FSBS 0-100=0 units, 101-150=1 unit, 151-200=2 units, 201-250=3 units, 251-300=4 units, 301-350=5 units, 351-400=6 units, and greater than 401 call MD. Review of Resident #3's June 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for insulin aspart 100units/ml inject 5 units SQ before meals scheduled at 7:30am, 11:30am, and 5:00pm. -Insulin aspart 100units/ml inject 5 units SQ before meals was not documented as administered on 06/15/22 at 5:00pm, 06/16/22 at	{D 358}		

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	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

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{D 358}	Continued From page 6 7:30am, 11:30am and 5:00pm, 06/17/22 at 7:30am, 11:30am, 5:00pm, and on 06/18/22 at 7:30am. -The reason not administered before meals was documented as "09" indicating the medication was not administered and to see the nurse's notes on 06/15/22 at 5:00pm, 06/16/22 at 7:30am, 11:30am and 5:00pm, 06/17/22 at 7:30am, 11:30am, 5:00pm, and on 06/18/22 at 7:30am. -There was an entry for insulin aspart 100units/ml inject as per sliding scale scheduled at 7:30am, 11:30am, and 5:00pm: if FSBS 0-100=0 units, 101-150=1 unit, 151-200=2 units, 201-250=3 units, 251-300=4 units, 301-350=5 units, 351-400=6 units, and greater than 401 call MD. -Insulin aspart FlexPen 100units/ml inject as per sliding scale was not documented as administered at 7:30am on 06/16/22, 06/17/22, and 06/18/22; at 11:30am on 06/16/22 and 06/17/22; and at 1700 on 06/15/22, 06/16/22, and 06/17/22. -The reason not administered per sliding scale was documented as "09" indicating the medication was not administered and to see the nurse's notes on 7:30am on 06/16/22, 06/17/22, and 06/18/22; at 11:30am on 06/16/22 and 06/17/22; and at 5:00pm on 06/15/22, 06/16/22, and 06/17/22. -Resident #3's fingerstick blood sugar (FSBS) ranged from 06/13/22 to 06/30/22 was 104 to 410. Review of Resident #3's July 2022 eMAR revealed: -There was an entry for insulin aspart 100units/ml inject 5 units SQ before meals scheduled at 7:30am, 11:30am, and 5:00pm. -Insulin aspart 100units/ml inject 5 units SQ before meals was not documented as	{D 358}		

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{D 358}	Continued From page 7	{D 358}		

administered on 07/03/22 at 7:30am, 11:30am, and 5:00pm, and on 07/05/22 at 7:30am, 11:30am and 5:00pm.
-The reason not administered before meals was documented as "09" indicating the medication was not administered and to see the nurse's notes on 07/03/22 at 7:30am, 11:30am, and 5:00pm, and on 07/05/22 at 7:30am, 11:30am and 5:00pm.
-There was an entry for insulin aspart 100units/ml inject as per sliding scale scheduled at 7:30am, 11:30am, and 5:00pm: if FSBS 0-100=0 units, 101-150=1 unit, 151-200=2 units, 201-250=3 units, 251-300=4 units, 301-350=5 units, 351-400=6 units, and greater than 401 call MD.
-Insulin aspart FlexPen 100units/ml inject as per sliding scale was not documented as administered at 7:30am on 07/03/22 and 07/05/22; at 11:30am on 07/03/22 and 07/05/22; and at 5:00pm on 07/03/22 and 07/05/22.
-The reason not administered per sliding scale was documented as "09" indicating the medication was not administered, and to see the nurse's notes at 7:30am on 07/03/22 and 07/05/22; at 11:30am on 07/03/22 and 07/05/22; and at 5:00pm on 07/03/22 and 07/05/22.
-Resident #3's FSBS ranged from 07/01/22 to 07/12/22 was 101 to 405.

Observation of Resident #3's available medications on 07/14/22 at 1:44pm revealed:
-There was no insulin aspart FlexPen 100units/ml available for administration on the medication cart.
-There was one insulin lispro KwikPen 100units/ml (a fast acting insulin used to treat high blood sugars) in a zipper type bag with a pharmacy label with instructions to inject 20 units subcutaneously (SQ) at bedtime.
-The label indicated 2 insulin lispro KwikPens

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{D 358}	Continued From page 8 were dispensed on 06/17/22. Interview with the medication aide (MA) on 07/14/22 at 1:44pm revealed: -She had been administering the insulin lispro 100units/ml KwikPen to Resident #3 according to the insulin aspart 100units/ml FlexPen orders on the eMAR, which included 5 units SQ before each meal and per the sliding scale instructions. -She was unsure why the insulin lispro Kwikpen label had the instructions to administer 20 units SQ at bedtime. -She never questioned the directions on the label, she did not ask the pharmacy about the change in medication, and did not notify the Resident Care Coordinator (RCC) or the primary care provider (PCP). -The insulin lispro medication and instructions were never entered on the eMAR. -The insulin aspart was the only fast acting insulin ordered on the eMAR. Interview with the RCC on 07/14/22 at 2:30pm revealed: -Resident #3 did not have the insulin aspart FlexPen available on the medication cart. -The MAs documented that the medication was not administered, because the medication was not on the cart. -Resident #3 had insulin lispro on the cart, but did not have a physician's order, and it had not been entered on the eMAR. -She did not know about the insulin lispro being on the cart until today (07/14/22), and was not aware the pharmacy label instructed to inject 20 units SQ at bedtime. Telephone interview with a representative from the facility's contracted pharmacy on 07/15/22 at 9:02am revealed:	{D 358}		

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	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

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{D 358}	Continued From page 9	{D 358}		

-Insulin aspart FlexPen was dispensed to the facility on 05/06/22, for a 27-day supply only.
-The facility requested to refill the insulin aspart twice after it was filled on 05/06/22, but there were no refills available.
-The pharmacy received an electronic order from the PCP dated 06/17/22 for insulin lispro KwikPen inject 20 units SQ at bedtime.
-The insulin aspart order was discontinued and insulin lispro was ordered on 06/17/22 due to insurance coverage.
-Insulin lispro, for a quantity of two 28 day KwikPens were dispensed for Resident #3 on 06/17/22.
-The label indicated insulin lispro 20 units SQ at bedtime was to be administered to Resident #3.
-There were no orders to continue the insulin aspart 5 units SQ three times daily with meals and no orders to continue the insulin aspart sliding scale coverage scheduled at 7:30am, 11:30am and 5:00pm.

Interview with the RCC on 07/15/22 at 10:30am revealed:
-She was not aware that the facility's contracted pharmacy had received an electronic order for Resident #3 on 06/17/22 for the insulin lispro.
-She did not have a copy of the order written on 06/17/22 in Resident #3's record.
-She would contact the contracted pharmacy and have them fax the prescription to her today (07/15/22).

Review of a fax sent by the pharmacy for Resident #3 dated 07/15/22 at 10:51am revealed there was a physician's order that was signed on 06/17/22 for insulin lispro KwikPen 100units/ml inject 20 units SQ at bedtime.

Telephone interview with a pharmacist from the

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WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

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{D 358}	Continued From page 10	{D 358}		

facility's contracted pharmacy on 07/15/22 at 11:10am revealed:
-Insulin lispro was typically administered before meals and a FSBS should be obtained prior to administration.
-If this medication was held for several doses it would put the resident at risk for increased FSBS results.

b. Review of Resident #3's current FL2 dated 03/15/22 revealed there was an order for atorvastatin calcium (used to treat high cholesterol levels) 40mg, one tablet at bedtime.

Review of Resident #3's Primary Care Provider's (PCP) Order Summary Report signed 06/06/22 revealed there was an order for atorvastatin calcium 40mg, give one tablet at bedtime for hyperlipidemia.

Review of Resident #3's June 2022 electronic Medication Administration Record (eMAR) from 06/13/22 to 06/30/22 revealed:
-Atorvastatin calcium 40mg was not documented as administered at 6:00pm from 06/14/22 to 06/17/22.
-The reason not administered was documented as "09" indicating the medication was not administered and to see the nurse's notes from 06/14/22 to 06/17/22.
-Atorvastatin calcium 40mg was documented as not administered 4 of 18 opportunities from 06/13/22 to 06/30/22.

Observation of Resident #3's medications on 07/14/22 at 1:44pm revealed:
-There was a bubble pack labeled atorvastatin 40mg, take one tablet at bedtime.
-The label indicated 30 tablets were dispensed on 06/17/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 11 -There were 6 tablets remaining on the bubble pack. Telephone interview with a representative from the facility's contracted pharmacy on 07/15/22 at 9:02am revealed: -Atorvastatin 40mg, for a quantity of 30 were dispensed for Resident #3 on 04/02/22, 06/17/22, and 07/12/22. -The label indicated atorvastatin 40mg, one tablet daily was to be administered to Resident #3. -The pharmacy received the initial prescription from Resident #3's FL2 dated 03/15/22 with no refills and a new prescription on 06/16/22. -The time lapse between the 2 prescriptions caused the delay in refills being dispensed to the facility. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/15/22 at 11:10am revealed when a resident went without atorvastatin for 4 days cholesterol would buildup in the arteries, and puts the resident at increased risk of a heart attack or stroke. Interview with a medication aide (MA) on 07/15/22 at 1:27pm revealed she was not aware Resident #3 had been out of atorvastatin in June 2022. c. Review of Resident #3's current FL2 dated 03/15/22 revealed there was an order for cholecalciferol (used to treat vitamin D insufficiency) 25mcg, one tablet daily. Review of Resident #3's Primary Care Provider's (PCP) Order Summary Report signed 06/06/22 revealed there was an order for cholecalciferol 25mcg, give one tablet daily for vitamin insufficiency.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

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{D 358}	Continued From page 12 Review of Resident #3's June 2022 electronic Medication Administration Record (eMAR) revealed: -Cholecalciferol 25mcg was not documented as administered at 8:00am from 06/13/22 to 06/17/22. -The reason not administered was documented as "09" indicating the medication was not administered and to see the nurse's notes from 06/13/22 to 06/17/22. -Cholecalciferol 25mcg was documented as not administered 5 of 18 opportunities from 06/13/22 to 06/30/22. Observation of Resident #3's medications on 07/14/22 at 1:50pm revealed cholecalciferol 25mcg, 1 tablet daily was not on the medication cart. Interview with the medication aide (MA) on 07/14/22 at 1:50pm revealed Resident #3 was out of cholecalciferol 25mcg, and it would be delivered by the pharmacy tonight. Telephone interview with a representative from the facility's contracted pharmacy on 07/15/22 at 9:02am revealed: -Cholecalciferol 25mcg, for a quantity of 30 were dispensed for Resident #3 on 04/14/22, 06/17/22 and 07/14/22. -The label indicated cholecalciferol 25mcg, one tablet daily was to be administered to Resident #3. -The pharmacy received the initial prescription from the FL2 dated 03/15/22 with no refills and a new prescription on 06/16/22. -The time lapse between the 2 prescriptions caused the delay in refills being dispensed to the facility.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

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{D 358}	Continued From page 13 Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/15/22 at 11:10am revealed when a resident goes without cholecalciferol for 5 days it can result in bone loss, which can put the resident at increased risk of bone weakness and fractures. Interview with a MA on 07/15/22 at 1:27pm revealed she was not aware Resident #3 had been out of cholecalciferol in June 2022. d. Review of Resident #3's current FL2 dated 03/15/22 revealed there was an order for cyanocobalamin (used to treat vitamin B12 insufficiency) 1000mcg, one tablet at bedtime. Review of Resident #3's Primary Care Provider's (PCP) Order Summary Report signed 06/06/22 revealed there was an order for cyanocobalamin 1000mcg, give one tablet at bedtime for vitamin insufficiency. Review of Resident #3's June 2022 electronic Medication Administration Record (eMAR) revealed: -Cyanocobalamin 1000mcg was not documented as administered at bedtime from 06/15/22 to 06/17/22, on 06/19/22, and on 06/28/22. -The reason not administered was documented as "09" indicating the medication was not administered and to see the nurse's notes from 06/15/22 to 06/17/22, on 06/19/22, and on 06/28/22. -Cyanocobalamin 1000mcg was documented as not administered 5 of 18 opportunities from 06/13/22 to 06/30/22. Review of Resident #3's July 2022 eMAR revealed:	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

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{D 358}	Continued From page 14 -Cyanocobalamin 1000mcg was not documented as administered at 6:00pm on 07/03/22. -The reason not administered was documented as "09" indicating the medication was not administered and to see the nurse's notes on 07/03/22. -Cyanocobalamin 1000mcg was documented as not administered 1 of 12 opportunities from 07/01/22 to 07/12/22 Observation of Resident #3's medications on 07/14/22 at 1:44pm revealed: -There was a bubble pack of cyanocobalamin 1000mcg, one tablet at bedtime. -The label indicated 26 tablets were dispensed on 06/20/22. -There were 9 tablets remaining on the bubble pack. Telephone interview with a representative from the facility's contracted pharmacy on 07/15/22 at 9:02am revealed: -Cyanocobalamin 1000mcg, for a quantity of 26 was dispensed for Resident #3 on 06/20/22. -Cyanocobalamin 1000mcg, for a quantity of 30 was dispensed for Resident #3 on 04/14/22. -The label indicated cyanocobalamin 1000mcg, one tablet at bedtime was to be administered to Resident #3. -The pharmacy received the initial prescription from the FL2 dated 03/15/22 with no refills and a new prescription on 06/16/22. -The time lapse between the 2 prescriptions caused the delay in refills being dispensed to the facility. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/15/22 at 11:10am revealed when a resident was without cyanocobalamin 1000mcg for 5 days it could	{D 358}		

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	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

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{D 358}	Continued From page 15	{D 358}		

result in low serum levels of vitamin B-12, which could put the resident at increased risk of anemia, weakness, dizziness, and falls.

Interview with a medication aide (MA) on 07/15/22 at 1:27pm revealed she was not aware Resident #3 had been out of cyanocobalamin in June and July 2022.

e. Review of Resident #3's current FL2 dated 03/15/22 revealed there was an order for ondansetron (used to treat nausea) 4mg take one tablet daily.

Review of Resident #3's Primary Care Provider's (PCP) Order Summary Report signed 06/06/22 revealed there was an order for ondansetron 4mg take give one tablet daily for nausea.

Review of Resident #3's June 2022 electronic Medication Administration Record (eMAR) revealed:
-Ondansetron 4mg was not documented as administered at 8:00am from 06/13/22 to 06/24/22.
-The reason not administered was documented as "09" indicating the medication was not administered and to see the nurse's notes from 06/13/22 to 06/24/22.
-Ondansetron 4mg was documented as not administered 12 of 18 opportunities from 06/13/22 to 06/30/22.

Observation of Resident #3's medications on 07/14/22 at 1:44pm revealed:
-There was a bubble pack labeled ondansetron 4mg, take one tablet daily.
-The label indicated 23 tablets were dispensed on 06/24/22.
-There were 5 tablets remaining on the bubble

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

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WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

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{D 358}	Continued From page 16 pack. Telephone interview with a representative from the facility's contracted pharmacy on 07/15/22 at 9:02am revealed: -Ondansetron 4mg, for a quantity of 23 was dispensed for Resident #3 on 06/24/22. -Ondansetron 4mg, for a quantity of 30 was dispensed for Resident #3 on 04/14/22. -The label indicated ondansetron 4mg, one tablet daily was to be administered to Resident #3. -The pharmacy received the initial prescription from the FL2 dated 03/15/22 with no refills and a new prescription on 06/16/22. -The time lapse between the 2 prescriptions caused the delay in refills being dispensed to the facility. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/15/22 at 11:10am revealed when a resident was without ondansetron 4mg for 5 days it could result in increased nausea, feeling uncomfortable, decreased appetite, and unable to move about. Interview with a medication aide (MA) on 07/15/22 at 1:27pm revealed she was not aware Resident #3 had been out of ondansetron in June 2022. Attempted interview with Resident #3 on 07/15/22 at 1:25pm and 2:20pm was unsuccessful. Attempted telephone interview with Resident #3's family member on 07/15/22 at 2:26pm was unsuccessful. Attempted telephone interview with Resident #3's PCP on 07/14/22 at 3:30pm was unsuccessful.	{D 358}		

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{D 358}	Continued From page 17 Refer to interview with the Resident Care Coordinator (RCC) on 07/14/22 at 2:30pm and 4:48pm. Refer to interview with the RCC on 07/15/22 at 11:30am and 1:16pm. Refer to interview with a MA on 07/15/22 at 1:27pm. Refer to interview with the Administrator on 07/15/22 at 2:25pm. Refer to review of the facility's medication administration policy. The findings are: 4. Review of Resident #5's current FL2 dated 07/11/22 revealed diagnoses included mood disorder, conversion disorder with seizures or convulsions and cerebral venous sinus thrombosis. a. Review of Resident #5's current FL2 dated 07/11/22 revealed there was an order for donepezil (used to treat confusion) 5mg one tablet daily. Review of Resident #5's June 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for donepezil 5mg one tablet daily scheduled at 6:30pm. -donepezil was not documented as administered 4 of 18 opportunities from 06/13/22 - 06/30/22. -There were 4 instances the donepezil was documented with a code "09" indicating the medication was not administered and to see Other/See Nurse Note which stated, "awaiting	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 358}	Continued From page 18 pharmacy". Telephone interview with facility's contacted pharmacy representative on 07/14/22 at 10:30am revealed: -donepezil 5mg one tablet daily was dispensed on 05/05/22 for 30 tablets and 07/13/22 for 30 tablets. -donepezil was not filled in month of June. Telephone interview with the facility's contracted Pharmacist representative on 07/14/22 at 11:00am revealed Resident #5 could exhibit increased behaviors, wandering and agitation if not taking donepezil as ordered. b. Review of Resident #5's current FL2 dated 07/11/22 revealed there was an order for atorvastatin (used to lower cholesterol and fats) 10mg one tablet one time daily. Review of Resident #5's June 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for atorvastatin 10mg one tablet one time daily scheduled at 6:00pm. - atorvastatin was not documented as administered 6 of 18 opportunities from 06/13/22 - 06/30/22. -There were 6 instances the atorvastatin was documented with a code "09" indicating the medication was not administered and to see Other/See Nurse Note which stated, "awaiting pharmacy". Telephone interview with facility's contacted pharmacy representative on 07/14/22 at 10:30am revealed: -atorvastatin 10mg one tablet daily was dispensed on 05/05/22 for 30 tablets and	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 358}	Continued From page 19 07/13/22 for 30 tablets. -atorvastatin was not filled in the month of June. Telephone interview with the facility's contracted Pharmacist representative on 07/14/22 at 11:00am revealed Resident #5 could experience artery build up which could cause a potential risk for heart attack if not taking atorvastatin as ordered. c. Review of Resident #5's current FL2 dated 07/11/22 revealed there was an order for melatonin (used to improve sleep) 3mg one capsule daily at bedtime. Review of Resident #5's June 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for melatonin 3mg one capsule daily scheduled at 6:30pm. -melatonin was not documented as administered 5 of 18 opportunities from 06/13/22 - 06/30/22. -There were 5 instances the melatonin was documented with a code "09" indicating the medication was not administered and to see Other/See Nurse Note which stated, "awaiting pharmacy". Telephone interview with facility's contacted pharmacy representative on 07/14/22 at 10:30am revealed: -melatonin 3mg one capsule daily was dispensed on 04/22/22 for 30 capsules and 06/27/22 for 30 capsules. -melatonin was not filled in the month of May. Telephone interview with the facility's contracted Pharmacist representative on 07/14/22 at 11:00am revealed Resident #5 could experience lack of rest, being groggier which could lead to	{D 358}		

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	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

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{D 358}	Continued From page 20 possible falls if not taking melatonin as ordered. d. Review of Resident #5's current FL2 dated 07/11/22 revealed there was an order for montelukast (used to treat allergies) 10mg one tablet daily at bedtime. Review of Resident #5's June 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for montelukast 10mg one tablet daily scheduled at 6:30pm. - montelukast was not documented as administered 6 of 18 opportunities from 06/13/22 - 06/30/22. -There were 5 instances the montelukast was documented with a code "09" indicating the medication was not administered and to see Other/See Nurse Note which stated, "awaiting pharmacy". Telephone interview with facility's contacted pharmacy representative on 07/14/22 at 10:30am revealed: -montelukast 10mg one tablet daily at bedtime was dispensed on 05/05/22 for 30 tablets and 07/13/22 for 30 tablets. -montelukast was not filled in the month of June. Telephone interview with the facility's contracted Pharmacist representative on 07/14/22 at 11:00am revealed Resident #5 could experience increased allergy symptoms if not taking montelukast as ordered. e. Review of Resident #5's current FL2 dated 07/11/22 revealed there was an order for baclofen (used to treat muscle spasms) 10mg two tablets three times daily.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

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{D 358}	Continued From page 21 Review of Resident #5's June 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for baclofen 10mg 2 tablets three times daily scheduled at 8:00am, 1:00pm and 6:30pm. -baclofen was not documented as being administered 8 of 18 opportunities from 06/13/22 - 06/30/22. -There was a total of 8 instances the baclofen was documented with a code "09" indicating the medication was not administered and to see Other/See Nurse Note which stated, "awaiting pharmacy". Telephone interview with facility's contacted pharmacy representative on 07/14/22 at 10:30am revealed baclofen 10mg two tablets three times daily was dispensed on 05/05/22 for 180 tablets and 06/27/22 for 180 tablets. Telephone interview with the facility's contracted Pharmacist representative on 07/14/22 at 11:00am revealed Resident #5 could have increased muscle spasms, increased pain and potential for falls if not taking baclofen as ordered. f. Review of Resident #5's current FL2 dated 07/11/22 revealed there was an order for dantrolene (used to treat muscle spasms) 25mg one capsule three times daily. Review of Resident #5's June 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for dantrolene 25mg one capsule three times daily scheduled at 8:00am, 1:00pm and 6:30pm. -dantrolene was not documented as administered	{D 358}		

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	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

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{D 358}	Continued From page 22 10 of 18 opportunities from 06/13/22 - 06/30/22. -There was a total of 10 instances the dantrolene was documented with a code "09" indicating the medication was not administered and to see Other/See Nurse Note which stated, "awaiting pharmacy". Telephone interview with facility's contacted pharmacy representative on 07/14/22 at 10:30am revealed dantrolene 25mg one capsule three times daily was dispensed on 05/05/22 for 90 capsules, 06/28/22 for 54 capsules and 07/15/22 for 90 capsules. Telephone interview with the facility's contracted Pharmacist representative on 07/14/22 at 11:00am revealed Resident #5 could have increased muscle spasms, increased pain and potential for falls if not taking dantrolene as ordered. g. Review of Resident #5's current FL2 dated 07/11/22 revealed there was an order for gabapentin (used to treat pain/seizures) 100mg one capsule three times daily. Review of Resident #5's June 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for gabapentin 100mg one capsule three times daily scheduled at 8:00am, 1:00pm and 6:30pm. -gabapentin was not documented as administered 8 of 18 opportunities from 06/13/22 - 06/30/22. -There was a total of 8 instances the gabapentin was documented with a code "09" indicating the medication was not administered and to see Other/See Nurse Note which stated, "awaiting pharmacy".	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

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{D 358}	Continued From page 23 Telephone interview with facility's contacted pharmacy representative on 07/14/22 at 10:30am revealed gabapentin 100mg one capsule three times daily was dispensed on 05/05/22 for 90 capsules and 06/27/22 for 90 capsules. Telephone interview with the facility's contracted Pharmacist representative on 07/14/22 at 11:00am revealed Resident #5 could experience increased pain, increased spasms which lead to weakness, falls and possible increase of seizures if not taking gabapentin as ordered. h. Review of Resident #5's current FL2 dated 07/11/22 revealed there was an order for fluoxetine (to treat mood disorder) 20mg one capsule three times daily. Review of Resident #5's June 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for fluoxetine 20mg one capsule three times daily scheduled at 8:00am, 1:00pm and 6:30pm. -fluoxetine was not documented as administered 4 of 18 opportunities from 06/13/22 - 06/30/22. -There was a total of 4 instances the fluoxetine was documented with a code "09" indicating the medication was not administered and to see Other/See Nurse Note which stated, "awaiting pharmacy". Telephone interview with facility's contacted pharmacy representative on 07/14/22 at 10:30am revealed fluoxetine 20mg one capsule three times daily was dispensed on 05/05/22 for 90 capsules and 06/27/22 for 90 capsules. Telephone interview with the facility's contracted	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

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WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

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{D 358}	Continued From page 24 Pharmacist representative on 07/14/22 at 11:00am revealed Resident #5 could experience withdrawals symptoms such as irritability, dizziness and headache if not taking fluoxetine as ordered. Interview with the RCC on 07/15/22 at 1:16pm revealed: -She was aware of missed medications for Resident #5. -She expected the MAs to accurately document medication administration and any exception on the residents' MAR. -She expected the MAs to follow up with the pharmacy and notify the her or MCC if a medication was not available. -She expected the MA to notify resident's PCP and responsible party after the first missed dose of medications. -The MA's are responsible for entering appropriate documentation on the electronic Medication Administration Record for any medications not administered with a reason as to why the medications were not administered. -The RCC/MCC to contact MA for any medications not administered if no documentation was entered on the electronic medication administration record. -If medications missed, she and/or the MCC are responsible for contacting the MA responsible for not administrating the medication to obtain the reason why the medication was not administrated and responsible for documenting in the electronic medications administration record the MA interview and reason medication was not administered. -Medication carts are audited every week on night shift by MA who completes a medication cart review form which is reviewed weekly by Administrator, RCC and MCC.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 25 Interview with the Administrator on 07/15/22 at 2:25pm revealed: -He was aware there were issues with Resident #5's medications. -He expected the MAs to accurately document medication administration and any exception on the residents' MAR. -He expected the MAs to follow up with the pharmacy and notify the RCC or MCC if a medication was not available. -He expected the MA or the RCC/MCC to notify resident's PCP and responsible party after the first missed dose of medications. -The MA's are responsible for entering appropriate documentation on the electronic Medication Administration Record for any medications not administered with a reason as to why the medications were not administered. -He stated a missing medication report was printed and reviewed every morning by the Administrator, MCC and RCC. -The MCC/RCC to contact MA for any medications not administered if no documentation was entered on the electronic medication administration record. -The MCC/RCC are responsible for entering interview with MA as to why no documentation was entered on the electronic medication administration record and the reason the medication was not administered. -Medication carts are audited every week on night shift by MA who completes a medication cart review form which is reviewed by Administrator, MCC and RCC weekly. Interview with Resident #5's POA on 07/15/22 at 8:25am revealed: -He was aware that resident had not been receiving some medications as ordered but did	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

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

not know how many or for what time period resident had not received medications.
-He stated he left messages for the RCC to return his call but did not receive a call back.
-He stated the Administrator did call him late in June about resident not having medications.

3. Review of Resident #2's current FL2 dated 11/29/21 revealed:
-Diagnoses included dementia, delirium, cerebrovascular accident of unspecified mechanism and stage three chronic kidney disease.
-The level of care was Special Care Unit (SCU).

Telephone interview with Resident #2's family member on 07/14/22 at 2:44pm revealed she had Resident #2's medications filled at an outside pharmacy and brought the medications to the facility.

a. Review of Resident #2's current FL2 dated 11/29/21 revealed there was an order for Melatonin 1mg with instructions to take two tablets at bedtime.

Review of Resident #2's Physician's orders dated 07/15/22 revealed an order for Melatonin 1mg with instructions to take two tablets at bedtime.

Review of Resident #2's June 2022 electronic medication administration record (eMAR) revealed:
-An entry for Melatonin 3mg tablet scheduled for 10:00pm.
-Melatonin 3mg was documented as administered from 06/13/22- 06/16/22 and 06/18/22- 06/30/22.
-Melatonin was not documented as administered on 06/17/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

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{D 358}	Continued From page 27 Review of Resident #2's July 2022 eMAR revealed: -An entry for Melatonin 3mg tablet scheduled for 10:00pm. -Melatonin 3mg was documented as administered from 07/01/22- 07/10/22 and on 07/12/22. -There was documentation that Resident #2 was in the hospital on 07/11/22. Observation of Resident #2's medications on hand on 07/14/22 at 10:15am revealed: -A over the counter bottle of Melatonin 3mg was available for administration. -The bottle had a sticker with Resident #2's name and barcode on it. -There was not prescription label on the bottle. Interview with a medication aide (MA) on 07/14/22 at 10:15am revealed she looked at the eMAR to know how much Melatonin to give Resident #2. Interview with the SCU Coordinator (SCC) on 07/15/22 at 10:25 am revealed she was not aware that Resident #2's Melatonin was entered incorrectly on the eMAR. Review of the order details on Resident #2's eMAR revealed the previous SCC entered the order Melatonin 3mg give 1 tablet at bedtime on 12/01/21. Interview with the Administrator on 07/15/22 at 2:25pm revealed he was not aware that Resident #2 had an incorrect medication order on his eMAR. Resident #2 was not available for interview on	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{D 358}	Continued From page 28	{D 358}		

07/14/22 and 07/15/22 due to being out of the facility.

Attempted telephone interview with Resident #2's PCP on 07/15/22 at 8:38am was unsuccessful.

b. Review of Resident #2's current FL2 dated 11/29/21 revealed there was not an order for Zinc 50mg with instructions to take once daily.

Review of Resident #2's signed Physician's orders dated 07/15/22 revealed there was not an order for Zinc 50mg with instructions to take once daily.

Review of Resident #2's June 2022 electronic medication administration record (eMAR) revealed:
-An entry for Zinc 50mg tablet scheduled once daily at 8:00am.
-Zinc 50mg was documented as administered from 06/13/22 to 06/30/22.

Review of Resident #2's July 2022 eMAR revealed:
-An entry for Zinc 50mg tablet scheduled once daily at 8:00am.
-Zinc 50mg was documented as administered from 07/01/22 to 07/13/22.

Observation of Resident #2's medications on hand on 07/14/22 at 10:15am revealed:
-An over the counter bottle of Zinc 50mg was available for administration.
-The bottle had a sticker with Resident #2's name and barcode on it.
-There was not prescription label on the bottle.

Interview with a medication aide (MA) on 07/14/22 at 10:15am revealed she gave Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

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{D 358}	Continued From page 29 #2 one pill of the Zinc as scheduled. Interview with the SCU Coordinator (SCC) on 07/15/22 at 10:25am revealed she was not aware that Resident #2 did not have a physician's order for Zinc. Review of the order details on Resident #2's eMAR revealed the previous SCC entered the order Zinc 50mg give 1 tablet one time per day. Interview with the SCC on 07/13/22 at 2:10pm revealed: -Resident #2's family member took him to all of his PCP's appointments and brought in his medications. -Resident #2 did not use the facility's contracted PCP and it had been very difficult to get signed orders. -She had been waiting weeks for Resident #2's PCP to send updated signed medication orders. -The PCP's office said they faxed the orders yesterday (07/14/22) but they had not arrived until this morning (07/15/22). -She requested that Resident #2's family member turn in all of the paperwork and prescriptions from his PCP's appointments. -Resident #2 had not had any changes to his medications since she started in March 2022. -She would not put any of Resident #2's medication on the eMAR if she did not have any order for it. -Medication cart audits were completed for every resident once a week in the SCU. -She or one of the MAs would compare the medications on the medication cart to the entries on the eMAR and make sure that they match. -If there are any errors the MAs would leave her a note and she would follow up.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 30 Interview with a MA on 07/15/22 at 1:27pm revealed: -Resident #2's wife brought his medications to him twice weekly. -She had to ask the SCC for a prescription for Resident #2 before the medication could be entered on the eMAR. -She or the SCC were responsible to enter the order into the eMAR once the order was received. -Resident #2's medication should be stored in the medication room until the order is received. -Medications should not be on the medication cart or administered to residents until the order has been entered on the eMAR. Interview with the Administrator on 07/15/22 at 2:25pm revealed: -He was not aware that Resident #2 did not have a physician's order for Zinc. -Zinc should not have been entered into the eMAR and given to Resident #2 without a signed physician's order. Resident #2 was not available for interview on 07/14/22 and 07/15/22 due to being out of the facility. Attempted telephone interview with Resident #2's PCP on 07/15/22 at 8:38am was unsuccessful. Refer to interview with the Resident Care Coordinator (RCC) on 07/14/22 at 2:30pm and 4:48pm. Refer to interview with the RCC on 07/15/22 at 11:30am and 1:16pm. Refer to interview with a MA on 07/15/22 at 1:27pm.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

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{D 358}	Continued From page 31 Refer to interview with the Administrator on 07/15/22 at 2:25pm. Refer to review of the facility's medication administration policy. _____ Interview with the RCC on 07/14/22 at 2:30pm and 4:48pm revealed: -The process for completing weekly cart audits included comparing the printed eMAR to the medications on the cart. -She would print a complete eMAR for each resident on a specific cart and the MA compared the medications on the cart to the printed eMAR. -The MAs did not compare medications on the cart or the eMARs to the actual orders in the residents' record. -The facility had four medication carts, and the audit process was to perform one cart audit on Monday, a second cart audit on Tuesday, a third cart audit on Wednesday, and the fourth cart audit on Thursday or each week. -The cart audits were performed weekly by the medication aides (MAs), then the RCC or SCC checked off on the cart audits once completed. -eMARs for each resident were printed and were compared to each residents' medications on hand. -The MAs were responsible to document when a medication did not match the eMAR or vice versa. -Cart audits were normally performed by the night shift MAs. -Each MA was responsible to audit their entire medication cart during the shift. -She thought because a medication was listed on the eMAR, then there was an order for it. -When there was no order available, the medication should not be placed on the cart and the MA, RCC or SCC should contact the PCP	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

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{D 358}	Continued From page 32	{D 358}		

directly to get a valid prescription for the residents' record.
-Medication's that arrived in the facility (from the pharmacy or family members) without orders should be stored in the medication room until a signed physician's order was received.
-She and/or the SCC were responsible to enter medication order information into the eMAR's.
-A second check was completed by the RCC, SCC or Business Office Manager (BOM) after the medication order information was entered into the eMARs to verify accuracy.
-She, the SCC and the Administrator reviewed the Missed Medication Report every morning and reviewed the eMAR exceptions located on the facility's Progress Notes "sporadically".
-The MAs should request refills for a medication when there were 7 medications remaining in a bubble pack or bottle.
-The refill request should be entered in Point Click Care (PCC) or could be requested on the Refill Order Form (ROF) and faxed to the pharmacy.
-The MA should notify the RCC/SCC and call the pharmacy the following day if the medication had not arrived at the facility.

Interview with the RCC on 07/15/22 at 11:30am and 1:16pm revealed:
-The facility's contracted pharmacy had performed quarterly medication reviews on 07/07/22 for 67 residents, and did not identify any issues with Resident #2, #3 and #5's medications.
-She expected the MAs to accurately document medication administration and any exception on the residents' MAR.
-She expected the MAs to follow up with the pharmacy and notify the her or the SCC if a medication was not available.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{D 358}	Continued From page 33 -She expected the MA to notify the resident's PCP and responsible party after the first missed dose of medications. -The MA's were responsible for entering appropriate documentation on the eMAR for any medications not administered with a reason as to why the medications were not administered. -The RCC and SCC were responsible to contact the MA for any medications documented as not administered, or if no documentation was entered on the eMAR. -If medications were missed, she and/or the SCC were responsible for contacting the MA responsible for not administrating the medication to obtain the reason why the medication was not administrated and responsible for documenting in the electronic medications administration record the MA interview and reason medication was not administered. -Medication carts were audited every week on night shift by the MA who completed a medication cart review form which was reviewed weekly by the Administrator, RCC and SCC. Interview with a MA on 07/15/22 at 1:27pm revealed: -She worked in the SCU and the Assisted Living unit in the facility. -She had to ask the RCC or SCC for a physician's order for certain residents who had medications, without an order, before the medication could be entered on the eMAR. -She or the RCC/SCC were responsible to enter the order into the eMAR once the order was received. -Residents' medication that arrived without an order should be stored in the medication room until the order is received. -Medications should not be placed in the medication cart or administered to residents until	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

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

the order was entered into the eMAR.
-When a medication was received and did not match the current eMAR, the MA had to request a signed physician's order before it could be entered into the eMAR or administered to a resident.
-The MAs should perform a 3 step check prior to administering all medications: Step 1. check the eMAR, Step 2. Compare eMAR to the medication, and Step 3. Compare the medication back to the eMAR , if a problem was identified, the MA should go find the actual order to verify accuracy.
-The process to request refills was to call the pharmacy and ask if the resident had a refill on file or needed a new physician order.
-The MA should then complete the refill order form (ROF) and fax to the pharmacy or electronically request the refill on the PCC software.
-When a resident needed a new prescription, she would leave a note in the unit's red binder for the PCP to review on the next visit.
-Refills could be requested electronically on the PCC software, but she preferred to fax in the ROF.
-When refills were requested before 11:00am on weekdays, the medication would be delivered to the facility that evening.
-When refills were requested on a Saturday, it was "hit or miss" and may not be delivered that day.
-When refills were requested on a Sunday, the medication would be delivered the following Monday afternoon.

Interview with the Administrator on 07/15/22 at 2:25pm revealed:
-He expected the MAs to accurately document medication administration and any exception on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 35	{D 358}		

the residents' eMAR.
-He expected the MAs to follow up with the pharmacy and notify the RCC or SCC if a medication was not available.
-He expected the MA or the RCC/SCC to notify resident's PCP and responsible party after the first missed dose of a medication.
-The MA's were responsible for entering appropriate documentation on the eMAR for any medications not administered with a reason as to why the medications were not administered.
-A missed medication report for all residents was printed and reviewed every morning by the Administrator, SCC and RCC.
-The SCC and RCC were responsible to contact the MA for any medications not administered, or if no documentation was entered on the eMAR.
-The SCC and RCC were responsible for entering information reported by the MA as to why no documentation was entered on the eMAR and the reason the medication was not administered.
-Medication carts were audited every week on night shift by the MA who completed a medication cart review form, which was reviewed by Administrator, SCC and RCC weekly.
-He expected the RCC or SCC to have an order for a medication before it was put on the medication cart and eMAR.
-Recently the facility implemented a two step order verification system that involved the RCC checking orders that the SCC put on the eMARs and the SCC checking orders that the RCC put on the eMARs.
-He expected staff to enter orders on the eMAR correctly.

_____

The facility failed to ensure medications were administered as ordered for 4 of 5 sampled residents including a resident who was at risk for hyperglycemia by receiving the incorrect type of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 36 insulin and by not receiving it as frequently as ordered; and at increased risk of heart attack or stroke from not receiving a scheduled cholesterol lowering medication (#3); and a resident who was at risk for wandering and agitation from not receiving a scheduled medication used to treat confusion and increased pain or potential falls, and from not receiving three medications used to treat muscle spasms (#5). This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection on 07/14/22 in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 29, 2022.	{D 358}		
{D 367}	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

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{D 367}	Continued From page 37	{D 367}		

medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure medication administration records were complete and accurate for 3 of 5 sampled residents (Resident #3, #1 and #5) related to a medication used to decrease blood sugar levels (#3), medications to regulate thyroid hormones, blood sugar, prevent nerve pain and muscle pain (#1), and medications to prevent blood clotting, memory loss, insomnia, allergies, nerve pain, seizures, anxiety, and for muscle spasms (#5).

The findings are:

Review of the facility's medication administration policy revealed:
-The administration of medications, prescription and non-prescription are ordered by a licensed prescribing practitioner, which are maintained in the residents' record and administered and prepared by associates who meet the qualifications to do so.
-The resident's medication administration record will be accurate and include the following: resident's name; name of medication; strength and dosage; or quantity of medication administered; instructions for administering the medication; date and time of administration; documentation of any omission of medications and the reason for the omission; and name or initials of the person administering the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

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{D 367}	Continued From page 38	{D 367}		

medication.

1. Review of Resident #3's current FL2 dated 03/15/22 revealed diagnoses included Type II diabetes mellitus, memory deficit, difficulty in walking, and muscle weakness.

a. Review of Resident #3's current FL2 dated 03/15/22 revealed:
-There was an order for insulin solution 100units/ml inject 5 units subcutaneously (SQ) before meals.
-There was no type of insulin solution specified.

Review of Resident #3's Primary Care Provider's (PCP) Order Summary Report signed 06/06/22 revealed there was an order for insulin aspart (a fast acting insulin to treat high blood sugars) FlexPen 100units/ml inject 5 units SQ before meals related to Type 2 diabetes mellitus.

Review of Resident #3's June 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for insulin aspart 100units/ml inject 5 units SQ before meals scheduled at 7:30am, 11:30am, and 5:00pm.
-Insulin aspart 100units/ml inject 5 units SQ before meals was documented as administered 44 of 54 opportunities from 06/13/22 to 06/30/22.
-Resident #3's fingerstick blood sugar (FSBS) range from 06/13/22 to 06/30/22 was 104 to 410.

Review of Resident #3's July 2022 eMAR revealed:
-There was an entry for insulin aspart 100units/ml inject 5 units SQ before meals scheduled at 7:30am, 11:30am, and 5:00pm.
-Insulin aspart 100units/ml inject 5 units SQ before meals was documented as administered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 367}	Continued From page 39 for 32 of 38 opportunities from 07/01/22 at 7:00am to 07/13/22 at 11:30am. -Resident #3's FSBS range from 07/01/22 to 07/12/22 was 101 to 405. Observation of Resident #3's medications on 07/14/22 at 1:44pm revealed: -There was no insulin aspart FlexPen 100units/ml inject 5 units SQ before meals scheduled at 7:30am, 11:30am, and 5:00pm available for administration on the medication cart. -There was one insulin lispro KwikPen 100units/ml (a fast acting insulin used to treat high blood sugars) in a zipper type bag with a pharmacy label with instructions to inject 20 units subcutaneously (SQ) at bedtime. -The label indicated 2 insulin lispro KwikPens were dispensed on 06/17/22. b. Review of Resident #3's current FL2 dated 03/15/22 revealed: -There was an order for insulin solution 100units/ml inject SQ per sliding scale: if FSBS 0-100=0, 101-150=1, 151-200=2, 201-250=3, 251-300=4, 301-350=5, 351-400=6, and greater than 401 call MD. -There was no type of insulin solution specified. Review of Resident #3's Primary Care Provider's (PCP) Order Summary Report signed 06/06/22 revealed there was an order for insulin aspart FlexPen 100units/ml inject as per sliding scale: if FSBS 0-100=0 units, 101-150=1 unit, 151-200=2 units, 201-250=3 units, 251-300=4 units, 301-350=5 units, 351-400=6 units, and greater than 401 call MD. Review of Resident #3's June 2022 electronic Medication Administration Record (eMAR) revealed:	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

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{D 367}	Continued From page 40 -There was an entry for insulin aspart 100units/ml inject as per sliding scale scheduled at 7:30am, 11:30am, and 5:00pm: if FSBS 0-100=0 units, 101-150=1 unit, 151-200=2 units, 201-250=3 units, 251-300=4 units, 301-350=5 units, 351-400=6 units, and greater than 401 call MD. -Insulin aspart FlexPen 100units/ml inject as per sliding scale was documented as administered for 44 of 54 opportunities from 06/13/22 to 06/30/22. -Resident #3's fingerstick blood sugar (FSBS) ranged from 06/13/22 to 06/30/22 was 104 to 410. Review of Resident #3's July 2022 eMAR revealed: -There was an entry for insulin aspart 100units/ml inject as per sliding scale scheduled at 7:30am, 11:30am, and 5:00pm: if FSBS 0-100=0 units, 101-150=1 unit, 151-200=2 units, 201-250=3 units, 251-300=4 units, 301-350=5 units, 351-400=6 units, and greater than 401 call MD. -Insulin aspart FlexPen 100units/ml inject as per sliding scale was documented as administered for 32 of 38 opportunities from 07/01/22 at 7:00am to 07/13/22 at 11:30am. -Resident #3's FSBS ranged from 07/01/22 to 07/12/22 was 101 to 405. Observation of Resident #3's medications on 07/14/22 at 1:44pm revealed: -There was no insulin aspart FlexPen 100units/ml inject per sliding scale at 7:30am, 11:30am, and 5:00pm: if FSBS 0-100=0 units, 101-150=1 unit, 151-200=2 units, 201-250=3 units, 251-300=4 units, 301-350=5 units, 351-400=6 units, and greater than 401 call MD available for administration on the medication cart. -There was one insulin lispro KwikPen 100units/ml (a fast acting insulin used to treat	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

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{D 367}	Continued From page 41	{D 367}		

high blood sugars) in a zipper type bag with a pharmacy label with instructions to inject 20 units subcutaneously (SQ) at bedtime.
-The label indicated 2 insulin lispro KwikPens were dispensed on 06/17/22.

Interview with the medication aide (MA) on 07/14/22 at 1:44pm revealed:
-She had been administering the insulin lispro 100units/ml KwikPen to Resident #3 according to the insulin aspart 100units/ml FlexPen orders on the eMAR, which included 5 units SQ before each meal and per the sliding scale instructions.
-She was unsure why the insulin lispro KwikPen label had the instructions to administer 20 units SQ at bedtime.
-She never questioned the directions on the label, she did not ask the pharmacy about the change in medication, and did not notify the Resident Care Coordinator (RCC) or the primary care provider (PCP).
-The insulin lispro medication and instructions were never entered on the eMAR.
-The insulin aspart was the only fast acting insulin currently ordered on the eMAR.

Interview with the RCC on 07/14/22 at 2:30pm revealed:
-Resident #3 did not have the insulin aspart FlexPen currently available on the medication cart.
-Most of the MAs documented that the medication was administered, because of the insulin lispro KwikPen that was on the cart.
-Resident #3 had insulin lispro KwikPen on the cart, but did not have a physician's order, and it had not been entered on the eMAR.
-She did not know about the insulin lispro being on the cart until today (07/14/22), and was not aware the pharmacy label instructed to inject 20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

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{D 367}	Continued From page 42	{D 367}		

units SQ at bedtime.
-She was responsible to enter new or changed medication orders in the eMAR.

Telephone interview with a representative from the facility's contracted pharmacy on 07/15/22 at 9:02am revealed:
-The pharmacy received an electronic order from the PCP dated 06/17/22 for insulin lispro KwikPen inject 20 units SQ at bedtime.
-The insulin aspart order was discontinued and insulin lispro was ordered on 06/17/22 due to insurance coverage.
-Insulin lispro, for a quantity of two 28 day KwikPens were dispensed for Resident #3 on 06/17/22.
-The label indicated insulin lispro 20 units SQ at bedtime was to be administered to Resident #3.
-There were no orders to continue the insulin aspart 5 units SQ three times daily with meals and no orders to continue the insulin aspart sliding scale coverage scheduled at 7:30am, 11:30am and 5:00pm.

Interview with the RCC on 07/15/22 at 10:30am revealed:
-She was not aware that the facility's contracted pharmacy had received an electronic order for Resident #3 on 06/17/22 for the insulin lispro.
-She did not have a copy of the order written on 06/17/22 in Resident #3's record.
-She would contact the contracted pharmacy and have them fax the prescription to her today (07/15/22).
-She contacted the PCP today (07/15/22) to request clarification orders for all insulin types for Resident #3.

Refer to interview with the Resident Care Coordinator (RCC) on 07/14/22 at 2:30pm and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

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{D 367}	Continued From page 43 4:48pm. Refer to interview with the RCC on 07/15/22 at 11:30am and 1:16pm. Refer to interview with a MA on 07/15/22 at 1:27pm. Refer to interview with the Administrator on 07/15/22 at 2:25pm. Refer to review of the facility's medication administration policy. 2. Review of Resident #1's current FL2 dated 01/25/22 revealed diagnoses included Alzheimer's disease and vascular dementia. a. Review of Resident #1's current FL2 dated 01/25/22 revealed there was an order for levothyroxine (used to treat hypothyroidism) 75mcg one tablet daily. Review of Resident #1's June 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for levothyroxine 75mcg one tablet daily scheduled at 9:00am. -The levothyroxine was documented administered as ordered on 06/15/22, 06/17/22, 06/20/22 to 06/23/22, 06/25/22 to 06/27/22 and 06/30/22. -The levothyroxine entry was left blank on 06/13/22, 06/16/22, 06/18/22, 06/19/22, 06/24/22, 06/28/22 and 06/29/22. Telephone interview with the facility's contracted Pharmacist representative on 07/15/22 at 11:00am revealed Resident #1 could experience fatigue or muscle weakness, nervousness and anxiety if not taking levothyroxine as ordered.	{D 367}		

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	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

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WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

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{D 367}	Continued From page 44 b. Review of Resident #1's current FL2 dated 01/25/22 revealed there was an order for carvedilol (used to treat high blood pressure) 12.5mg one tablet two times daily. Review of Resident #1's June 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for carvedilol 12.5mg one table two times daily scheduled at 9:00am and 9:00pm. -The carvedilol entry was left blank at 9:00pm on 06/17/22. Telephone interview with the facility's contracted Pharmacist representative on 07/15/22 at 11:00am revealed Resident #1 could experience chest pain, irregular heartbeat and possible heart attack if not taking carvedilol as ordered. c. Review of Resident #1's current FL2 dated 01/25/22 revealed there was an order for memantine (used to treat dementia) 10mg one tablet two times daily. Review of Resident #1's June 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for memantine 10mg one table two times daily scheduled at 9:00am and 9:00pm. -The memantine entry was left blank at 9:00pm on 06/17/22. Telephone interview with the facility's contracted pharmacy representative on 07/15/22 at 10:30am revealed Resident #1 could experience increased restlessness, insomnia and confusion if not taking memantine as ordered.	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

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{D 367}	Continued From page 45 d. Review of Resident #1's current FL2 dated 01/25/22 revealed there was an order for metformin (used to treat high blood sugar levels) 500mg one tablet two times daily. Review of Resident #1's June 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for metformin 500mg one table two times daily scheduled at 8:00am and 8:00pm. -The metformin entry was left blank at 8:00pm on 06/17/22. Telephone interview with the facility's contracted pharmacy representative on 07/15/22 at 10:30am revealed Resident #1 could experience increased blood sugars, impaired vision, neuropathy if not taking metformin as ordered. e. Review of Resident #1's current FL2 dated 01/25/22 revealed there was an order for gabapentin (used to treat nerve pain) 300mg one capsule three times daily. Review of Resident #1's June 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for gabapentin 300mg one capsule three times daily scheduled at 6:00am, 3:00pm and 9:00pm. -The gabapentin entry was left blank at 6:00 am on 06/13/22, 06/16/22, 06/18/22, 06/19/22, 06/24/22, 06/28/22 and 06/29/22. -The gabapentin entry was left blank at 9:00pm on 06/17/22. Telephone interview with the facility's contracted pharmacy representative on 07/15/22 at 10:30am revealed Resident #1 could experience pain,	{D 367}		

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	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{D 367}	Continued From page 46	{D 367}		

dizziness and falls if not taking gabapentin as ordered.

f. Review of Resident #1's current FL2 dated 01/25/22 revealed there was an order for diclofenac sodium gel (used to treat pain) 1%, apply to both knees four times daily.

Review of Resident #1's June 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for diclofenac sodium gel 1%, apply to both knees four times daily scheduled at 8:00am, 12:00pm, 4:00pm and 10:00pm.
-The diclofenac sodium gel entry was left blank at 10:00pm on 06/17/22.

Telephone interview with the facility's contracted pharmacy representative on 07/15/22 at 10:30am revealed Resident #1 could experience increased pain which could lead to falls if not using diclofenac sodium gel as ordered.

Interview with the RCC on 07/15/22 at 1:16pm revealed she was unaware of missed medications for Resident #1.

Interview with a medication aide (MA) on 07/15/22 at 1:27pm revealed:
-She was aware that Resident #1 was out of some medications in June 2022.
-The blanks on the eMAR meant that the MA did not document whether the medications were administered or not.

Interview with the Administrator on 07/15/22 at 2:25pm revealed he was unaware of medications not being administered to Resident #1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{D 367}	Continued From page 47 Refer to interview with the Resident Care Coordinator (RCC) on 07/14/22 at 2:30pm and 4:48pm. Refer to interview with the RCC on 07/15/22 at 11:30am and 1:16pm. Refer to interview with a MA on 07/15/22 at 1:27pm. Refer to interview with the Administrator on 07/15/22 at 2:25pm. Refer to review of the facility's medication administration policy. _____ Interview with the RCC on 07/14/22 at 2:30pm and 4:48pm revealed: -The process for completing weekly cart audits included comparing the printed eMAR to the medications on the cart. -She would print a complete eMAR for each resident on a specific cart and the MA compared the medications on the cart to the printed eMAR. -The MAs did not compare medications on the cart or the eMARs to the actual orders in the residents' record. -eMARs for each resident were printed and were compared to each residents' medications on hand. -The MAs were responsible to document when a medication did not match the eMAR or vice versa. -Cart audits were normally performed by the night shift MAs. -Each MA was responsible to audit their entire medication cart during the shift. -When there was no order available, the medication should not be placed on the cart and the MA, RCC or SCC should contact the PCP directly to get a valid prescription for the	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

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{D 367}	Continued From page 48	{D 367}		

residents' record.
-Medication's that arrived in the facility (from the pharmacy or family members) without orders should be stored in the medication room until a signed physician's order was received.
-She and/or the SCC were responsible to enter medication order information into the eMAR's.
-She, the SCC and the Administrator reviewed the Missed Medication Report every morning and reviewed the eMAR exceptions located on the facility's Progress Notes "sporadically".

Interview with the RCC on 07/15/22 at 11:30am and 1:16pm revealed:
-She expected the MAs to accurately document medication administration and any exception on the residents' MAR.
-The MA's were responsible for entering appropriate documentation on the eMAR for any medications not administered with a reason as to why the medications were not administered.
-The RCC and SCC were responsible to contact the MA for any medications documented as not administered, or if no documentation was entered on the eMAR.
-If medications were missed, she and/or the SCC were responsible for contacting the MA responsible for not administrating the medication to obtain the reason why the medication was not administrated and responsible for documenting in the electronic medications administration record the MA interview and reason medication was not administered.
-Medication carts were audited every week on night shift by the MA who completed a medication cart review form which was reviewed weekly by the Administrator, RCC and SCC.

Interview with a MA on 07/15/22 at 1:27pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

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{D 367}	Continued From page 49 -She had to ask the RCC or SCC for a physician's order for certain residents who had medications, without an order, before the medication could be entered on the eMAR. -She or the RCC/SCC were responsible to enter orders into the eMAR once an order was received. -Residents' medication that arrived without an order should be stored in the medication room until the order was received. -Medications should not be on the medication cart or administered to residents until the order has been entered on the eMAR. -When a medication was received and did not match the current eMAR, the MA had to request a signed physician's order before it could be entered onto the eMAR or administered to a resident. -The MAs should perform a 3 step check prior to administering all medications: Step 1. check the eMAR, Step 2. Compare eMAR to the medication, and Step 3. Compare the medication back to the eMAR , if a problem arises, the MA should go find the actual order to verify accuracy. Interview with the Administrator on 07/15/22 at 2:25pm revealed: -He expected the MAs to accurately document medication administration and any exception on the residents' eMAR. -The MA's were responsible for entering appropriate documentation on the eMAR for any medications not administered with a reason as to why the medications were not administered. -A missed medication report for all residents was printed and reviewed every morning by the Administrator, SCC and RCC. -The SCC and RCC were responsible to contact the MA for any medications not administered, or if no documentation was entered on the eMAR.	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

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{D 367}	Continued From page 50 -The SCC and RCC were responsible for entering information reported by the MA as to why no documentation was entered on the eMAR and the reason the medication was not administered. -Medication carts were audited every week on night shift by the MA who completed a medication cart review form, which was reviewed by Administrator, SCC and RCC weekly. -He expected the RCC or SCC to have an order for a medication before it was put on the medication cart and eMAR. -He expected staff to enter orders on the eMAR correctly.	{D 367}		
{D 464}	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities.	{D 464}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 464}	Continued From page 51	{D 464}		

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure a Special Care Unit Resident Profile and Care Plan was completed within 30 days of admission for 3 of 3 sampled residents (Resident #1, #2 and #4).

The findings are:

1. Review of Resident #1's current FL2 dated 01/25/22 revealed:
-Diagnoses included Alzheimer's disease and vascular dementia.
-The resident was intermittently disoriented.
-The recommended level of care was Special Care Unit (SCU).

Review of Resident #1's record revealed there was no documented SCU Resident Profile and Care Plan completed within 30 days of admission.

Attempted telephone interview with the Special Care Unit Coordinator on 07/15/22 at 2:45pm was unsuccessful.

Refer to interview with a SCU personal care aide (PCA) on 07/15/22 at 10:44am.

Refer to interview with a second SCU PCA on 07/15/22 at 10:53am.

Refer to interview with a third SCU PCA on 07/15/22 at 10:57pm.

Refer to interview with a SCU medication aide (MA) on 07/15/22 at 11:05am.

Refer to interview with the Resident Care Coordinator (RCC) on 07/15/22 at 11:00am and

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	HAL060166	A. BUILDING: _____ B. WING _____	R 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 464}	Continued From page 52	{D 464}		

1:16pm.

Refer to interview with the Administrator on 07/15/22 at 2:25pm.

2. Review of Resident #2's current FL2 dated 11/29/21 revealed:
-Diagnoses included dementia and delirium.
-The recommended level of care was the SCU (Special Care Unit).
-He was intermittently disoriented.
-He required assistance with bathing and dressing.

Review of Resident #2's record revealed there was no documented SCU Resident Profile and Care Plan completed within 30 days of admission.

Attempted telephone interview with the Special Care Unit Coordinator on 07/15/22 at 2:45pm was unsuccessful.

Refer to interview with a SCU personal care aide (PCA) on 07/15/22 at 10:44am.

Refer to interview with a second SCU PCA on 07/15/22 at 10:53am.

Refer to interview with a third SCU PCA on 07/15/22 at 10:57pm.

Refer to interview with a SCU medication aide (MA) on 07/15/22 at 11:05am.

Refer to interview with the Resident Care Coordinator (RCC) on 07/15/22 at 11:00am and 1:16pm.

Refer to interview with the Administrator on

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{D 464}	Continued From page 53 07/15/22 at 2:25pm. 3. Review of Resident #4's current FL2 dated 01/31/22 revealed: -Diagnoses included dementia. -The recommended level of care was the Special Care Unit (SCU). -He was a wanderer and constantly disoriented. -He required assistance with bathing and dressing. Review of Resident #4's record revealed there was no documented SCU Resident Profile and Care Plan completed within 30 days of admission. Attempted telephone interview with the Special Care Unit Coordinator on 07/15/22 at 2:45pm was unsuccessful. Refer to interview with SCU personal care aide (PCA) on 07/15/22 at 10:44am. Refer to interview with a second SCU PCA on 07/15/22 at 10:53am. Refer to interview with a third SCU PCA on 07/15/22 at 10:57pm. Refer to interview with SCU medication aide (MA) on 07/15/22 at 11:05am. Refer to interview with the Resident Care Coordinator (RCC) on 07/15/22 at 11:00am and 1:16 pm. Refer to interview with the Administrator on 07/15/22 at 2:25pm. _____ Interview with a SCU PCA on 07/15/22 at	{D 464}		

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{D 464}	Continued From page 54 10:44am revealed: -She was new to the facility and did not know the residents in the SCU very well. -She was told that you must get to know the residents to know what kind of assistance they required. -Her coworkers were very helpful in letting her know what kind of assistance each resident required. -Some of the residents were able to tell you that they needed to use the restroom. -Two of the residents always sat in wheelchairs so she assumed that they were totally dependent on staff for assistance with their activities of daily living (ADLs). -The facility's computer program had a document that gave information on residents' ADL needs such as assistance with bathing, toileting and transferring in and out of bed. -The document also stated which residents ate in their room and if they required their trash to be taken out by staff. Interview with a second SCU PCA on 07/15/22 at 10:53am revealed: -She had worked at the facility for one year and knew what kind of assistance residents required based on getting to know them. -If a new resident was admitted, the MA was supposed to inform the PCAs what kind of assistance with ADLs that resident required. -There was a document on the computer that showed which residents required assistance with grooming. -When the PCAs provided assistance to a resident it was recorded on the 24-hour sheet. -Resident behaviors were not recorded on the 24-hour sheet. Interview with a third SCU PCA on 07/15/22 at	{D 464}		

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{D 464}	Continued From page 55 10:57am revealed: -When a new resident was admitted, the SCC met with staff to discuss what kind of assistance they required. -She thought there was a "Resident Profile" book but could not find it. Interview with the SCU MA on 07/15/22 at 11:05am revealed: -The SCC told the MAs what kind of assistance each resident required. -The MAs were responsible for sharing this information with the PCAs. -The resident's required level of assistance with ADLs was not documented anywhere. Interview with the RCC on 07/15/22 at 11:00am and 1:16pm revealed: -The SCC completed the SCU Resident Profile and Care Plan for residents in the SCU. -She and the SCC discussed starting a "Resident Profile" binder but had not started one at this time. Interview with the Administrator on 07/15/22 at 2:25pm revealed: -He did not know Resident #1, Resident #2 and Resident #4 did not have completed Resident Profiles or Care Plans. -He and the SCC were responsible for ensuring the Resident Profile and Care Plans were completed on every SCU resident. -He was aware that the residents in the SCU required a resident profile and the resident profile needed to be updated quarterly. -He was not aware that an appropriate Care Plan was not being used. -When asked how staff knew the needs of the resident on the SCU, he stated a weekly risk meeting was held with managers including dietary	{D 464}		

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{D 464}	Continued From page 56 and activity staff to review SCU residents needs and then managers reported to staff.	{D 464}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration. The findings are: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 5 sampled residents (Resident #2, #3, and #5) including a fast acting insulin that was not available for administration to treat high blood sugars, and medications to treat high cholesterol, nausea, vitamin D and vitamin B-12 insufficiency (#3), medications to treat confusion and increased pain, and three medications used to treat muscle spasms (#5), and medications to treat a zinc deficiency and insomnia (#2). [Refer to Tag 0358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	{D912}		