STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 07/19/21 through 07/23/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #P9G011.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 07/19/21 through 07/23/21. There were 46 complaint allegations investigated and 8 were substantiated resulting in a deficiency. Event ID# P9G011.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident, and staff interviews, the facility failed to determine whether the self-administration of medications was clinically appropriate for 1 of 1 resident who was observed to have over-the-counter topical medicated anti-itch cream at the bedside (Resident #31). Findings included: Resident #31 was admitted to the facility 12/6/2012 with the most recent readmission date of 5/19/2021. Diagnoses for Resident #31 included heart failure, hypertension and Stiff-man Syndrome (an auto-immune disease that causes neurological symptoms, including itching). The	F 554	A Self-Administration of Medication Assessment was completed for Resident #31.¿Resident #31 determined not to be able to self-administer medication.¿ Anti-itch cream (Hydrocortisone Cream 1 %) immediately removed from Resident #31□s bedside by Director of Nursing M.S. and placed in medication cart. On 7/20/21 Physician notified and ordered received for nurse to apply Hydrocortisone cream 1%. Audit completed by Director of Nursing J.S. and Unit Manager T.S. on 8/11/21 of current resident rooms to ensure there	8/26/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/16/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 554	Continued From page 1 most recent significant change Minimum Data Set assessment dated 5/26/2021 assessed Resident #31 to be moderately cognitively impaired. Physician orders for Resident #31 were reviewed and an order dated 9/7/2020 for anti-itch cream applied topically 2 times per day and as needed was noted to have been discontinued on 5/19/2021. The medical chart was reviewed and there was no assessment related to self-administration of medication for Resident #31. Resident #31 was observed on 7/19/2021 at 11:19 AM. Two tubes of medicated anti-itch cream were noted on her over-the-bed table. Resident #31 reported she had itching "all over" and used the medicated anti-itch cream "wherever I need it on my body." Resident #31 stated her family member sent her care packages and always included medicated anti-itch cream in the care package. Resident #31 was observed again on 7/22/2021 at 11:58 AM. Two tubes of medicated anti-itch cream were noted on her over-the-bed table. Resident #31 was not oriented to interview during that observation. Nurse #1 was interviewed on 7/21/2021 at 11:38 AM. Nurse #1 reported Resident #31's family member sent her care packages with over-the-counter medications, such as the medicated anti-itch cream. Nurse #1 went on to explain the staff would remove the anti-itch cream, but Resident #31 would hide the cream from staff.	F 554	were no unsecured medications at the bedside.¿ Additionally residents that were cognitively intact with BIMS of 13-15 were interviewed regarding their desire to self-administer medication by Director of Nursing and Unit Manager.¿ Any issue identified were addressed and brought into compliance. On 8/10/2021 the Director of Nursing J.S.and Unit Manager T.S. educated Resident #31, on not having family bring over the counter medications in facility. Resident #31, informed that medication brought into facility has to have a physician order and left on medication cart to be administered by licensed nurse. Resident #31 voiced understanding and agreed. Additionally on 8/10/2021 Resident #31□s responsible party received education from the Director of Nursing J.S.and Unit Manager T.S. on not sending over the counter medications to Resident #31. Responsible party voiced understanding and agreed. Current residents and resident representatives will receive a letter via mail by 8/16/2021 informing them of the facility□s policy and procedure for medication storage and self-administration. Members of the Interdisciplinary Team (IDT) to include: ¿Administrator, Director of Nursing, Unit Manager, MDS Nurse, Activities Director, Business Office Manager, Maintenance Director, Admission Coordinator, and Social	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 554	Continued From page 2 Nursing assistant (NA) #1 was interviewed on 7/21/2021 at 3:10 PM. NA #1 reported Resident #31 would complain of itching. NA #1 reported she would assist Resident #31 to apply the medicated anti-itch cream to her back. Nurse #3 was interviewed on 7/21/2021 at 9:56 PM. Nurse #3 reported Resident #31's family member sent in medicated anti-itch cream and Resident #31 would hide the cream from staff. Nurse #3 reported if she saw medicated anti-itch cream on Resident #31's over-the-bed table, she removed it. The Nurse Practitioner (NP) was interviewed on 7/22/2021 at 10:26 AM. The NP reported she was not aware Resident #31 had medicated anti-itch cream at the bedside. The NP reported that because Resident #31 had impaired cognition, she was not safe to have the medicated anti-itch cream at the bedside for self-administration. The Director of Nursing (DON) was interviewed on 7/22/2021 at 4:25 PM. The DON reported Resident #31's family member sent her frequent care packages and staff would remove any over-the-counter creams her sister sent in; however, Resident #31 would hide items from staff. The DON reported it was her expectation that nursing staff removed any over-the-counter medicated creams from Resident #31's room.	F 554	Worker during Mock Survey rounds will observe residents rooms to ensure they are free from unsecured medications.¿¿ IDT members will report findings during morning meeting to Administrator and Director of Nursing. Staff education by Director of Nursing and/or Unit Manager began on 8/10/21 with completion date of 8/26/21 related to Self- Administration of Medication at Bedside and Medication Storage.¿ Residents may request to keep medications at bedside for self-administration, however a self-administration assessment must be completed to determine if the resident meets the criteria both mentally and physically. All new employees will receive education as part of orientation. Current staff will receive education on their next scheduled shift. A member of the Interdisciplinary Team to include:¿ Administrator, Director of Nursing, Unit Manager, MDS Nurse, Activities Director, Business Office Manager, Maintenance Director, Admission Coordinator, and Social Worker will perform a quality review by auditing through observations of 5 residents rooms to ensure they are free from unsecured medications 2 X weekly for 4 weeks then 1 X weekly for 2 months than 1 X monthly for 3 months.¿ The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the DCS or designee for 6 months and/or until	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 554	Continued From page 3	F 554	substantial compliance is obtained.	
F 563 SS=E	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on record review, family member interview, and staff interviews, the facility had imposed a schedule which determined not only	F 563	On 8/13/21 the facility Administrator M.C.contacted Resident□s #43□s family to provide update on visitation policy and	8/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 563	Continued From page 4 limited visitation duration, but also limited the opportunity to visit to weekdays during a specified time period, and restricted visitation to supervised visits either outside of the facility in a courtyard or a supervised visit in a common area inside of the facility. This practice impacted a resident receiving hospice services for one of one resident reviewed for visitation (Resident #43). This deficiency was cited at a higher scope and severity, E, due to the potential to impact multiple residents beyond just the sampled resident, Resident #43. Findings included: Resident #43 was admitted to the facility on 12/4/20. The resident was residing in a semi-private room at the time of the recertification. Review of an untitled and undated document revealed a section titled Visitation. The document contained information the facility would follow federal and state regulations on visitation. Further review revealed a second section which documented visitation may occur either outdoor (preferred) or indoor and was followed by multiple bullet points including, but not limited to, screening visitors, performing hand hygiene, wearing a face covering, and maintaining physical distance. Bullet point K stated, "Center will schedule visits and determine the length of the visits." A sixth section provided information for Compassion Care visits and that compassion care visits did not exclusively refer to end of life situations but may also apply to multiple other situations including, but no limited to, a resident who was struggling with a change in environment or lack of physical family support. There was a	F 563	answered any questions/concerns.¿ Current residents have the potential to be affected. ¿ The Interdisciplinary Team which include:¿¿ Administrator, Director of Nursing, Unit Manager, MDS Nurse, Activities Director, Business Office Manager, Maintenance Director, Admission Coordinator, and Social Worker will update current residents on the facility visitation policy during daily rounds and answer any questions by 8/26/21. Additionally on 8/14/21 the facility mailed out a visitation letter to residents families to make them aware of the updated visitation policy in accordance to the NC Department of health s Interim guidance for Skilled Nursing Facilities during COVID-19.¿ this section included part of our policy related to indoor visitation: Visitation may occur either outdoor (preferred) or indoor. All visitors will be screened for signs and symptoms of COVID-19 (including questions about AND observations of signs and symptoms and temperature checks) All visitors will perform hand hygiene prior to visitation All visitor will wear a face covering or mask through-out visit excepted as outlined below Visitors will maintain physical distancing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 563	Continued From page 5 note section at the end of the Compassionate Care visits section which documented Compassionate Care visits and visits required under federal disability rights law are permitted at all times, regardless of the resident's vaccination status, the county rate or outbreak testing. An undated letter provided by the facility which was reported to have been sent to the residents and family of the facility provided updated information to the residents and their families regarding visitation. The letter documented the visitor needed to contact reception during regular business hours to schedule visitation, visitations would be limited to 3 visitors, and the visitation area would either be the covered patio (outdoor) or the indoor activity/living room area. The letter provided no information regarding times when or days of the week when visits may occur and did not provide information regarding compassionate care visits. The Minimum Data Set (MDS) quarterly assessment with an Assessment Reference Date (ARD) of 6/18/21 indicated Resident #43 was unable to be assessed for cognition due to having been rarely/never understood. Further review revealed the resident had a condition or chronic disease that may result in a life expectancy of less than 6 months and was receiving hospice care. Review of Resident #43's care plan revealed a focus area which documented the resident was at risk for alteration in psychosocial well being related to fear of COVID 19, restriction on visitation and social isolation due to COVID 19. Listed interventions included to assure the resident and family the facility is taking all	F 563	during visit except as outlined below If a resident is fully vaccinated they may choose to have close physical contact (including touch)with an unvaccinated visitor while wearing a well-fitted mask and performing hand hygiene before and after If both the resident and visitor(s) (all visitors present) are fully vaccinated, and alone in the room or designated visitation area, they can have close contact and remove source control (mask) Unless otherwise directed by state or local officials The State of Louisiana requires universal mask regardless of vaccination status for residents and visitors Visitors are restricted to the designated visitation area or resident room Visitor will wear mask and physical distance from staff and other residents that not part of their group at all times while in the facility Center will limit the total number of visitors allowed at any one time based on the size and space in the center Facilities will take in consideration how the number of visitors per resident at one time and the total number of visitors in the facility at one time (based on the size of the building and physical space) may affect the ability to maintain the core principles of infection prevention. If	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 563	Continued From page 6	F 563		

necessary precautions to keep them safe, encourage and provide alternate methods of communication with visitors and family, and to update the resident and family as needed. The resident had a focus area for having a terminal prognosis related to dementia and the local hospice agency was being utilized for the agency.

A phone interview was conducted on 7/20/21 at 9:09 AM with a family member of Resident #43. The family member stated she was only allowed to visit the resident between the hours of 8:30 AM and 2:30 PM, Monday through Friday. She stated she had to call the facility to make an appointment to visit the resident and she was only allowed to visit with the resident for 15 minutes. She said she would like to be able to visit the resident more often because she was receiving hospice services but was unable to. She explained with her work schedule, it was difficult to come see the resident during the limited hours. She further explained she would have liked to visit with the resident for a longer period than just the 15 minutes which she was allowed.

An interview was conducted on 7/20/21 at 2:36 PM with Nurse #1. She stated if the resident was passing, the family member was allowed to have compassionate care visits. She said if a family member wanted to visit a resident, they had to call a day ahead of time to reserve the visit. She further explained a family member could visit any day, including weekends, evenings, and some visits were 15 minutes while other visits could last 30 minutes. She stated sometimes visits were in the resident's room but were usually in the snack machine room or outside in the courtyard.

During an interview conducted with the

necessary, the facility will consider scheduling visits for a specified length of time to help ensure all residents are able to receive visitors.

Residents who are suspected or positive for COVID-19 will only receive visitation virtually, window visits, or in-person for compassionate care situations, with adherence to transmission –based precautions.

Visitors will apply PPE prior to visit

The Administrator and/or Director of Nursing will educate facility staff on the visitation policy during COVID-19, the education will be completed by 8/26/21.¿ The facility will continue to follow CDC and CMS guidelines to ensure that we are taking all the appropriate steps in caring for residents and staff and preventing the spread of the virus.¿ All new employees will receive education as part of orientation. Current staff will receive education on their next scheduled shift.

The Administrator or designee will perform Quality Improvement Monitoring by interviewing 5 residents and/or family members about their visits to ensure facility is following the visitation policy 2 X weekly for 4 weeks then 1 X weekly for 2 months than 1 X monthly for 3 months.¿ The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 563	Continued From page 7	F 563		

receptionist on 7/20/21 at 2:44 PM the Receptionist she stated if a family member wanted to visit a resident, the family member needed to call her, and she would make an appointment. She explained visitation was limited to 30 to 60 minutes, and they tried not to restrict the visitation.

An interview was conducted with the Social Worker on 7/20/21 at 3:36 PM. She said visitors had to call the receptionist between 8:30 AM and 2:30 PM to make an appointment to visit with a resident. She said if a family member requested to visit on Saturday or Sunday, the request would have to be accommodated. She further explained the visits were supervised by one staff member to make sure the resident and the family member stayed at least 6 feet apart if one or both were not vaccinated. She said there was a time limit for visitations, but they made accommodations for a resident who was on compassionate care. She said most visits took place in a common area, but some visits could take place in a resident's room. She explained as far as she knew, the facility was following the guidelines from the Centers for Disease Control (CDC) and it was not a corporate or facility policy. She stated they tried not to have more than one visitation taking place at a time due to the need of staff to supervise the visitation and the need to clean and sanitize the area for the next scheduled visitation.

The Director of Nursing (DON) stated during an interview conducted on 7/22/21 at 10:13 AM the way they did their visitation was changed during the previous week. She said there was not a current restriction on visitation times and visitation could occur at any time, including weekends.

the DCS or designee for 6 months and/or until substantial compliance is obtained.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 563	Continued From page 8 The DON noted they had been communicating information about family members visiting residents to family members through robo calls (an automated system which contacts family members with a recorded message via a voice message on the phone). She said up until last week, visitation was not as wide open as it was at the time of the interview. She explained the week prior, the visitation by a family member was restricted by a certain amount of time and to restricted areas. She further explained those restrictions no longer applied. She said the facility was currently able to accommodate visits on the unit or in the resident's room. During an interview conducted with the Administrator on 7/22/21 at 4:09 PM he stated the visiting hours for family members at the facility had not changed. He said family members were able to visit resident 7 days a week, there were not time limitations on the length of the visits, and it had been that way for at least 3 or 4 months. He did state visitations were limited to about 30 minutes for the common area they used for visitation because of the need to clean the room between visitations, but visitation time for family members who visited with residents outside was unlimited.	F 563		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and	F 582		8/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 582	Continued From page 9	F 582		

for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 582	Continued From page 10 date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a CMS-10055 SNF ABN (Centers for Medicare and Medicaid Services Skilled Nursing Facility Advanced Beneficiary Notice) prior to discharge from Medicare Part A skilled services to 1 of 1 resident reviewed for beneficiary protection notification review (Resident #34). Findings included: Resident #34 was admitted to the facility on 3/5/21 with diagnosis that included anemia, unspecified. A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was given to Resident #34 on 6/1/21 which indicated Medicare Part A coverage for skilled services would end on 06/3/21. Resident #34 remained in the facility. A review of the medical record revealed a CMS-10055 SNF ABN (SNF ABN) was not provided to Resident #34. An interview was conducted with the Business Office Manager (BOM) and the Traveling BOM on 7/21/21 at 2:42 PM. The Traveling BOM stated that she did not realize the SNF ABN form was needed.	F 582	Resident #34 was given a copy of the SNF ABN form and explained the delay on 7/26/21. On 8/13/21 Business Office Manager N.A. performed an audit for the month of July to ensure that all affected residents were issued a proper SNF ABN form if needed. Business Office N.A. and Social Worker S.K. were educated by executive Director on the proper process and regulation of issuing ABN notices on 7/26/21. The Business Office Manager will be conducting weekly audit x 4 weeks to ensure that form was issued when appropriate. Then Bi weekly for 1 month and then monthly x 1 month. Business office to bring audit result to quality assurance meeting on monthly basis to report result of audit. Correction will be made if needed to ensure continuous compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 582	Continued From page 11 An interview was completed on 7/22/21 at 1:48 PM with the Social Worker who stated that she fills out the NOMNC form and will give this to the resident and the BOM is the one that fills out the SNF ABN form. An interview was completed with the Administrator on 7/22/21 at 2:18 PM who stated that it is his expectation that the facility gives the proper documents according to regulation.	F 582		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Nurse Practitioner and physician interview, the facility failed to document blood glucose results for 1 of 3 residents reviewed for change of status (Resident #253). Resident #253 was admitted to the hospital 4/24/2021 with diagnoses to include hyperglycemia (elevated blood glucose), with a blood glucose result of 677 (normal 80-150). Elevated blood glucose can contribute to dehydration, which resulted in Resident #253 diagnoses of hypernatremia (high blood sodium level), lactic acidosis (high lactic acid blood level, a result of low oxygen levels in the blood) and altered mental status.	F 684	Resident #253 no longer resides in facility, discharged from facility on 4/24/21.¿ Nurse #1 V.H. reeducated by Director of Nursing M.S. on 7/20/21, regarding monitoring blood glucose as ordered by the Medical Director and /or Nurse Practitioner and to record the results and insulin administered in electronic record. A quality review/observation was completed on 8/16/21 by the Director of Nursing J.S. and Unit Manager T.S. to ensure current diabetic residents with	8/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 684	Continued From page 12 Findings included: Resident #253 was admitted to the facility 4/19/2021 with diagnoses to include stroke, diabetes, and hypertension. Resident #253 was discharged from the facility to the hospital on 4/24/2021. A physician order dated 4/19/2021 ordered blood sugar monitoring to be completed 3 times per day at 8:00 AM, 11:00 AM and 5:00 PM and sliding scale insulin was to be used for blood glucose results more than 200. The sliding scale insulin was ordered to be administered 2 units of insulin for results between 201 to 250; 4 units of insulin for results between 251 and 300; 6 units of insulin for results between 301 and 350; 8 units of insulin for results between 351 and 400; 12 units of insulin for results between 401 and 450; 14 units of insulin for results 501 and 550 and instructions to call the physician (MD) for results over 501. Physician orders dated 4/19/2021 were reviewed and Resident #253 had an order for Humalog (quick acting insulin) 16 units to be injected daily at 8:00 AM, 24 units to be injected daily at 1:00 PM and 18 units to be injected daily at 5:00 PM. Additionally, Humalog N (intermediate acting insulin) was ordered on 4/19/2021 to administer 18 units daily at 8:00 AM. Resident #253's medication administration record for April 2021 was reviewed. Blood glucose results were documented and sliding scale insulin documented as administered 4/19-23/2021 at 8:00 AM, 1:00 PM and 5:00 PM.	F 684	orders for blood glucose level monitoring are being monitored as prescribed by the Medical Director and /or Nurse Practitioner. An additional quality review/observation was also completed on 8/16/21 by the Director of Nursing and Unit Manager of current diabetic residents Medication Administration Records (MARS) to ensure blood glucose results are documented as well as administered insulin.¿ Any issue identified were addressed and brought into compliance. The Director of Nursing J.S. and Unit Manager T.S. will reeducate licensed nurses and medication aides regarding Diabetes Management to include:¿ Blood Glucose Monitoring, Signs/Symptoms of Hyperglycemia and Hypoglycemia, and Insulin Administration with emphasis to record/document blood glucose results and/or administered insulin immediately in the electronic record this education will be completed by 8/26/21.¿ During shift change Licensed Nurses will review MARS together to ensure blood glucose results and administered insulin are documented. New admissions/readmissions will be reviewed in the Daily Clinical Meeting by Director of Nursing and Unit Manager to ensure all orders are entered into Electronic Record to include parameters required with medication administration monitoring of blood glucose with low and high parameters for notification to the physician.¿ Also, if resident has an order	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 684	Continued From page 13 The last documented blood glucose was 101 on 4/23/2021 at 5:00 PM. Blood glucose levels were not documented on 4/24/2021 for 8:00 AM or 11:00 AM. Sliding scale insulin for 8:00 AM and 1:00 PM were not documented. A late entry (made on 7/21/2021 for 4/24/2021) documented the blood glucose as "Hi" and the administration of 14 units of Humalog insulin at 5:00 PM. A nursing note dated 4/24/2021 at 11:33 AM was reviewed. No blood glucose results were documented in the note. A nursing note dated 4/24/2021 at 6:55 PM written by Nurse #1 was reviewed. The note documented Resident #253 had a "Hi" blood glucose result and she was clammy and lethargic. The note documented an order by the Nurse Practitioner (NP) to send Resident #253 to the hospital for evaluation. A facility to hospital transfer form dated 4/24/2021 at 6:45 PM was reviewed. The form documented Resident #253 had a blood glucose result of "Hi". The note further documented Resident #253 had received insulin: Humalog N 18 units at 8:00 AM, Humalog 16 units at 8:00 AM, Humalog 24 units at 1:00 PM and Humalog 18 units at 5:00 PM. Hospital records for Resident #253 were reviewed. The emergency room history and physical admitting note dated 4/24/2021 included diagnoses of probable sepsis (blood infection), acute kidney injury (related to dehydration), hypernatremia (high blood sodium, related to dehydration), uncontrolled diabetes, and acute	F 684	to administer sliding scale insulin, validation by the clinical team that the orders contain low and high parameters.¿ The Director of Nursing or designee will perform Quality Improvement Monitoring of 5 diabetic residents□ Medication Administration Records (MARS) to ensure blood glucose levels are being monitored as prescribed by the Medical Director and /or Nurse Practitioner with documentation on MARS of blood glucose level results and administered insulin 2 X weekly for 4 weeks then 1 X weekly for 2 months than 1 X monthly for 3 months.¿ The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the DCS or designee for 6 months and/or until substantial compliance is obtained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 684	Continued From page 14	F 684		

metabolic encephalopathy (altered mental status related to hypernatremia and uncontrolled diabetes). Additionally, the emergency room note documented Resident #253's high lactic acid blood level was thought to be a result of the possible sepsis and dehydration.

The emergency room note of 4/24/2021 documented Resident #253 presented with acute metabolic encephalopathy felt to be multifactorial (due to multiple issues) and secondary to hypernatremia and hyperglycemia. The emergency room note documented Resident #253 had a history of diabetes mellitus type 2 with markedly elevated blood sugars at presentation.

Hospital laboratory blood work for Resident #253 documented blood glucose results of 677 (normal 80-150) on 4/24/2021 at 7:53 PM.

Nurse #1 was interviewed on 7/21/2021 at 11:38 AM. Nurse #1 reported she provided care to Resident #253 on 4/24/2021. Nurse #1 reported Resident #253 became lethargic and could not state her name on 4/24/2021. Nurse #1 reported Resident #253's blood glucose at 5:00 PM registered "Hi" on the glucometer and Nurse #1 called the NP to report the results. Nurse #1 reported the NP ordered Resident #253 to go to the emergency room for evaluation.

A follow-up interview was conducted with Nurse #1 on 7/21/2021 at 2:25 PM. Nurse #1 reported she did not remember the blood glucose results from 8:00 AM or 1:00 PM on 4/24/2021 for Resident #253. Nurse #1 reported she was not certain why she did not document the blood glucose results from earlier in the day on 4/24/2021. Nurse #1 further reported she did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 684	Continued From page 15	F 684		

remember if she gave the sliding scale insulin to Resident #253 on 4/24/2021 at 8:00 AM or 1:00 PM.

The NP was interviewed on 7/22/2021 at 10:26 AM. The NP reported she thought the facility contacted her on 4/24/2021 regarding Resident #253's elevated blood glucose, but because she did not make a physical visit, the NP did not write a note. The NP reported she gave verbal orders to the facility and it was the receiving nurse's responsibility to write the verbal order. The NP reported she expected the blood glucose results to be documented to track blood glucose trends.

The Director of Nursing (DON) was interviewed on 7/22/2021 at 1:15 PM. The DON reported she thought Nurse #1 had forgotten to document the blood glucose at 8:00 AM and 1:00 PM on 4/24/2021. The DON reported she expected blood glucose to be monitored as ordered.

The facility physician (MD) was interviewed on 7/22/2021 at 1:40 PM. The MD reported he had not assessed Resident #253 during her stay at the facility. The MD reported without documented blood glucose results, it was difficult to determine what care Resident #253 received and if she had elevated blood glucose prior to 5:00 PM on 4/24/2021. The MD reported the blood glucose results and sliding scale insulin should have been documented on 4/24/2021. The MD felt the elevated lactic acid was due to dehydration and this also caused the extreme elevated blood glucose results.

A follow-up interview was conducted with the DON on 7/22/2021 at 4:33 PM. The DON reported she expected all blood glucose levels to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 684	Continued From page 16 be documented as well as administered insulin.	F 684		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with the nurse practitioner, registered dietician, staff and record review, the facility failed to provide 1 of 2 sampled residents a diabetic enteral formula at the prescribed rate as ordered by the physician. This resulted in a loss of calories and free water (Resident #103). The findings included:	F 693	Resident #103 no longer resides in the facility as of 7/31/21, however enteral feeding rate was corrected by Licensed Nurse V.H. on 7/21/2021 from 54cc/hr to the correct rate 65cc/hr. The Licensed Nurse notified Nurse Practitioner T.A., no new orders received. Director of Nursing J.S.and Unit Manager T.S.will conduct a quality review of current	8/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 693	Continued From page 17 Resident #103 was admitted to the facility on 5/20/21. Diagnoses included gastrostomy status, dysphagia (impaired swallowing) oropharyngeal phase following cerebral infarction, elevated BMI (basal metabolic index), chronic edema and diabetes mellitus (DM), adult onset, among others. An admission minimum data set (MDS) dated 5/26/21 assessed Resident #103 as rarely/never understood/understands, unclear speech, severely impaired cognition, received 51% or more of calories via a therapeutic enteral formula and an average of 501 cc (cubic centimeters) of fluid per day by enteral feeding The MDS documented the weight for Resident #103 as 396 pounds. A nutrition Care Area Assessment (CAA), completed by the registered dietitian (RD), dated 5/26/21 indicated Resident #103 had increased energy needs due to open areas to her skin. The CAA documented that due to an elevated BMI, Resident #103 would benefit from desired/planned weight loss for overall optimal health. The CAA also indicated that the current diabetic enteral formula order for Resident #103 did not meet her estimated calorie needs and the RD recommended to increase the rate of the diabetic enteral formula to 65 cc per hour for 24 hours to meet her estimated calorie needs of 2340 calories per day for nutritional/wound support. A nutrition care plan (CP) dated 5/26/21 documented that Resident #103 required a therapeutic enteral formula regarding her diagnosis of dysphagia and DM and had increased energy needs regarding her elevated	F 693	residents with enteral feeding orders to ensure the enteral formula is set at the prescribed rate as ordered by physician.¿ Any issue identified were addressed and brought into compliance. Director of Nursing J.S. and Unit Manager T.S. will reeducate licensed nurses on tube feeding (enteral feeding) management with a focus on following physicians orders to ensure rate of formula is set as ordered by physician this education will be completed by 8/26/21.¿ Licensed nurses will have a second nurse to verify the rate when administering enteral feeding. All new employees will receive education as part of orientation. Current staff will receive education on their next scheduled shift.¿ The Director of Nursing or designee will perform Quality Improvement Monitoring through observation of 5 residents with enteral feeding orders to ensure the enteral formula is set at the prescribed rate as ordered by physician 2 X weekly for 4 weeks then 1 X weekly for 2 months than 1 X monthly for 3 months.¿ The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the DCS or designee for 6 months and/or until substantial compliance is obtained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 693	Continued From page 18	F 693		

BMI and compromised skin integrity. The CP goal was to maintain adequate nutritional and hydration status with interventions that included stable weights and to follow the diet as prescribed.

Review of physician orders for Resident #103 revealed an order dated 5/26/21 for a diabetic enteral formula at 65 cc per hour for 24 hours and 190 cc free water flush every (q) 4 hours.

An observation of Resident #103 on 07/20/21 at 2:39 PM revealed a bottle of a diabetic enteral formula was connected to a feeding pump. The diabetic enteral formula infused at a rate of 54 cc per hour with 190 cc water flush q 4 hours. Approximately 500 cc of the diabetic enteral formula remained of a 1000 cc bottle. The bottle recorded the diabetic enteral formula was hung on 7/19/21 at 4:00 AM.

Nurse #1 was interviewed on 07/21/21 at 10:58 AM during an observation of Resident #103. A bottle of a diabetic enteral formula was connected to a feeding pump and infused at a rate of 65 cc per hour with 190 cc water flush q 4 hours. Approximately 900 cc of formula remained of a 1000 cc bottle. Nurse #1 stated that when she rounded on Resident #103 that morning, 7/21/21 around 9:00 AM, she noted the bottle of diabetic enteral formula recorded the bottle was hung on 7/21/21 at 5:30 AM. Nurse #1 stated she observed the diabetic enteral formula infused at a rate of 54 cc per hour instead of 65 cc per hour as ordered by the MD so she corrected the rate to 65 cc per hour per the MD order. Nurse #1 stated she would document a progress note and notify the NP. Nurse #1 further stated she was the assigned Nurse for Resident #103 on 7/20/21, on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 693	Continued From page 19	F 693		

the 7 AM - 7 PM shift, but that she could not recall the rate she saw for the diabetic enteral formula that day. Nurse #1 also stated that she received Resident #103 from Nurse #2 when she came on shift on 7/21/21 at 7:00 AM.

A nursing progress note dated 7/21/21 at 2:00 PM documented by Nurse #1, recorded that she noted the diabetic enteral formula for Resident #103 was observed infusing at a rate of 54 cc per hour. Nurse #1 documented she corrected the rate per MD order and notified the nurse practitioner (NP) with no new orders given.

A telephone interview with Nurse #2 occurred on 07/22/21 at 11:30 AM and revealed Nurse #2 was the assigned Nurse for Resident #103 on the 7 PM - 7 AM shift on 7/20/21 and 7/21/21. Nurse #2 stated she was trained to review the MD order prior to hanging an enteral formula to ensure she provided the Resident with the correct enteral formula at the correct rate. Nurse #2 stated she was moving so fast that she may have forgotten to check the MD order for Resident #103 and hung the diabetic enteral formula at the incorrect rate. She further stated, "I didn't check the tube feeding rate."

A telephone interview occurred with the RD on 07/22/21 at 9:53 AM. The RD stated that she was in the process of completing a nutrition review for Resident #103, but that she had not been made aware of an error regarding her enteral formula rate. She stated she would follow up on this concern and complete her review. The RD stated she could not explain why Resident #103 received her enteral formula at 54 cc per hour as this was not her recommendation. The RD stated that Resident #103 received a diabetic enteral

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 693	Continued From page 20	F 693		

formula during her hospital stay prior to admission that did not meet her estimated nutritional needs, so the RD recommended to increase the formula rate to 65 cc per hour continuous. The RD stated that Resident #103 received approximately 396 less calories and approximately 201 less cc free water than ordered when the diabetic enteral formula infused at an incorrect rate of 54 cc per hour. The RD stated because the enteral rate was corrected, she did not see a significant impact to Resident #103 at the time but that she recommended weekly weights for continued monitoring to ensure the Resident's nutritional needs were met.

A progress note dated 7/22/21 documented by the RD recorded in part that Resident #103 received nothing by mouth and a current MD order for a diabetic enteral formula at 65 cc per hour for 24 hours with 190 cc water flush q 4 hours to meet the Resident's estimated nutritional needs. The progress note documented that the enteral formula order provided 1560 cc total fluid volume, 2340 calories, 129 grams protein and 1184 cc free water from the enteral formula, plus 1140 cc water from flushes for a total of 2324 cc water per day. The progress note documented a goal for Resident #103 for planned/desired weight loss with a current weight of 367.6 pounds. The progress note indicated this was a possible 28-pound loss since admission that could have resulted from a loss of fluids due to her diagnosis of chronic edema. The RD documented that it was reported via a nurse progress note that the diabetic enteral formula for Resident #103 was observed running at an incorrect rate of 54 cc per hour on 7/21/21 with potential minimal effect over 24 hours due to planned/desired weight loss. The RD documented a recommendation for further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 693	Continued From page 21 monitoring with weekly weights to ensure weights remained stable. The NP was interviewed via telephone on 7/22/21 at 12:00 PM and stated that she was notified that Resident #103 received a diabetic enteral formula at the incorrect rate of 54 cc per hour which resulted in an approximate loss of 396 calories, but that the rate was adjusted. The NP stated that if Resident #103 received the diabetic enteral formula at the incorrect rate of 54 cc per hour for a long period of time, Resident #103 would have the potential for significant weight loss. An interview with the Director of Nursing (DON) occurred on 7/22/21 at 12:15 PM. The DON stated Nurse #1 informed her that she observed Resident #103 with a diabetic enteral formula hung on 7/21/21 at 5:30 AM at 54 cc per hour which was the wrong rate, and that Nurse #1 corrected the rate. The DON stated that nurses were trained to verify the correct enteral formula and the correct rate per the MD order when administering an enteral formula to a resident so that the resident received the nutritional support they needed.	F 693		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for	F 732		8/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 732	Continued From page 22 resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to post accurate staffing information as compared to the Staff Schedule/ Assignment Sheets for 5 days of the 5 days reviewed. Findings included: The Daily Nursing Staffing Form, a posting of the staffing and residents for each shift in the facility, for 7/12/21 revealed the posted staffing for night	F 732	The scheduler B. G. was reeducated by the Administrator M.C. on 8/11/21 regarding the daily posting of licensed staff, unlicensed staff (to include medication aides), and census. The Scheduler immediately corrected Daily Nursing Staffing Forms to reflect Staff Assignment Sheets for 7/12/21-7/16/21.¿ Daily Nursing Staffing Form updated on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 732	Continued From page 23 shift (11:00 PM to 7:00 AM) was blank for Registered Nurses (RNs), blank for Licensed Practical Nurses (LPNs) (which gave the appearance there were no nurses in the facility on the night shift), and 3 Nursing Assistants (NAs) for 22.5 hours. Further review revealed the day shift (7:00 AM to 3:00 PM) 1 RN for 12 hours, 1 LPN for 12 hours, and 4 NAs for 30.0 hours. Lastly, evening shift (3:00 PM to 11:00 PM) was blank for RNs, 2 LPNs for 24 hours, and 4 NAs for 30 hours. The resident census for each shift was documented as 54 residents. The facility daily assignments, a scheduling document which details who actually worked each day and on what shift. for 7/12/21 revealed for Nurses/Medication Aides (MAs) 7:00 AM to 7:00 PM there was 1 MA for 12 hours and 1 RN for 12 hours. For 7:00 PM to 7:00 AM for Nurses/MAs there were 2 LPNs for 24 hours (which provided documentation there were nurses in the facility on the night shift). Further review revealed 4 NAs for 7:00 AM to 3:00 PM for 30 hours, 4 NAs for 3:00 PM to 11:00 PM for 30 hours, and 11:00 PM to 7:00 AM there were 3 NAs for 22.5 hours. There was an LPN who worked as the Unit Manager/Wound Nurse on the assignment sheet with no information regarding her working time and did not appear to be counted on the Daily Nursing Staffing Form. The facility daily assignments documented MAs, however, the MA hours were not documented on the Daily Nursing Staffing Form. The Daily Nursing Staffing Form for 7/13/21 revealed the posted staffing for night shift (11:00 PM to 7:00 AM) was blank for RNs, blank for LPNs (which gave the appearance there were no nurses in the facility on the night shift), and 3 NAs for 22.5 hours. Further review revealed the day	F 732	7/22/21 to include section to record Medication Aides hours by Regional Director of Clinical Services. On 8/14/21 the Scheduler B. G. completed an audit of the Daily Nursing Staffing Forms to Staff Assignments sheets for the last 30 days to ensure accurate staffing information was posted.¿ Any issue identified were addressed and brought into compliance. Director of Nursing J.S. and Unit Manager T.S. reeducated by Administrator M.C. on 8/11/21 regarding the daily posting of nursing staff form, each shift to ensure proper census, licensed and unlicensed hours are correct. The Director of Nursing and Unit Manager will educate licensed nurses by 8/26/21 regarding updating Daily Nursing Form whenever there are changes in the schedule due to callouts or call-ins. Daily Nursing Staffing Form and Staff Assignment Sheet from prior day will be reviewed daily in morning meeting by Administrator, Director of Nursing, and Scheduler to ensure accurate care hours were posted for licensed and unlicensed staff to ensure regulatory compliance.¿ The Administrator or designee will perform Quality Improvement Monitoring of 3 Daily Nursing Staffing Forms to ensure accurate staffing information is being posted 2 X weekly for 4 weeks then 1 X weekly for 2 months than 1 X monthly for 3 months.¿ The results of these audits will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 732	Continued From page 24 shift (7:00 AM to 3:00 PM) was blank for RNs, 1 LPN for 12 hours, and 5 NAs for 37.5 hours. Lastly, evening shift (3:00 PM to 11:00 PM) had 1 RN for 12 hours, 1 LPN for 12 hours, and 4 NAs for 30 hours. The resident census for each shift was documented as 53 residents. The facility daily assignments for 7/13/21 revealed for Nurses/MAs 7:00 AM to 7:00 PM there were 2 MAs for 24 hours and 1 LPN for 12 hours. For 7:00 PM to 7:00 AM for Nurses/MAs there were 2 MAs for 20 hours, 1 LPN for 8 hours, and 1 RN for 12 hours (which provided documentation there were nurses in the facility on the night shift). Further review revealed 5 NAs for 7:00 AM to 3:00 PM for 37.5 hours, 4 NAs for 3:00 PM to 11:00 PM for 30 hours, and 11:00 PM to 7:00 AM there were 4 NAs for 30 hours. There was an LPN who worked as the Unit Manager/Wound Nurse on the assignment sheet with no information regarding her working time and did not appear to be counted on the Daily Nursing Staffing Form. The facility daily assignments documented MAs, however, the MA hours were not documented on the Daily Nursing Staffing Form. The Daily Nursing Staffing Form for 7/14/21 revealed the posted staffing for night shift (11:00 PM to 7:00 AM) was blank for RNs, blank for LPNs (which gave the appearance there were no nurses in the facility on the night shift), and 4 NAs for 30 hours. Further review revealed the day shift (7:00 AM to 3:00 PM) had RN for 12 hours, was blank for LPNs, and 4 NAs for 30.0 hours. Lastly, evening shift (3:00 PM to 11:00 PM) was blank for RNs, had 2 LPN for 20 hours, and 4 NAs for 30 hours. The resident census for each shift was documented as 53 residents. The facility daily assignments for 7/15/21 revealed for	F 732	be reported to the Quality Assurance Performance Improvement Committee by the DCS or designee for 6 months and/or until substantial compliance is obtained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 732	Continued From page 25	F 732		

Nurses/MAs 7:00 AM to 7:00 PM there were 2 MAs for 24 hours and 1 RN for 12 hours. For 7:00 PM to 7:00 AM for Nurses/MAs there was 2 LPNs for 20 hours and 1 MA for 4 hours (which provided documentation there were nurses in the facility on the night shift). Further review revealed 4 NAs for 7:00 AM to 3:00 PM for 30.0 hours, 4 NAs for 3:00 PM to 11:00 PM for 30 hours, and 11:00 PM to 7:00 AM there were 4 NAs for 30 hours. There was an LPN who worked as the Unit Manager/Wound Nurse on the assignment sheet with no information regarding her working time and did not appear to be counted on the Daily Nursing Staffing Form. The facility daily assignments documented MAs, however, the MA hours were not documented on the Daily Nursing Staffing Form.

The Daily Nursing Staffing Form for 7/15/21 revealed the posted staffing for night shift (11:00 PM to 7:00 AM) was blank for RNs, blank for LPNs (which gave the appearance there were no nurses in the facility on the night shift), and 3 NAs for 22.5 hours. Further review revealed the day shift (7:00 AM to 3:00 PM) was blank for RNs, had 1 LPN for 12 hours, and 4 NAs for 30.0 hours. Lastly, evening shift (3:00 PM to 11:00 PM) had 1 RN for 12 hours, had 1 LPN for 12 hours, and 4 NAs for 30 hours. The resident census for each shift was documented as 52 residents. The facility daily assignments for 7/15/21 revealed for Nurses/MAs 7:00 AM to 7:00 PM there were 2 MAs for 22 hours and 1 LPN for 12 hours. For 7:00 PM to 7:00 AM for Nurses/MAs there was 1 RN for 12 hours and 1 LPN for 12 hours (which provided documentation there were nurses in the facility on the night shift). Further review revealed 4 NAs for 7:00 AM to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 732	Continued From page 26	F 732		

3:00 PM for 30.0 hours, 4 NAs for 3:00 PM to 11:00 PM for 30 hours, and 11:00 PM to 7:00 AM there were 3 NAs for 22.5 hours. There was an LPN who worked as the Unit Manager/Wound Nurse on the assignment sheet with no information regarding her working time and did not appear to be counted on the Daily Nursing Staffing Form. The facility daily assignments documented MAs, however, the MA hours were not documented on the Daily Nursing Staffing Form.

The Daily Nursing Staffing Form for 7/16/21 revealed the posted staffing for night shift (11:00 PM to 7:00 AM) was blank for RNs, blank for LPNs (which gave the appearance there were no nurses in the facility on the night shift), and 3 NAs for 22.5 hours. Further review revealed the day shift (7:00 AM to 3:00 PM) was blank for RNs, had 1 LPN for 12 hours, and 4 NAs for 30.0 hours. Lastly, evening shift (3:00 PM to 11:00 PM) had 1 RN for 12 hours, had 1 LPN for 12 hours, and 4 NAs for 30 hours. The resident census for each shift was documented as 50 residents. The facility daily assignments for 7/16/21 revealed for Nurses/MAs 7:00 AM to 7:00 PM there was 1 MA for 12 hours and 1 LPN for 12 hours. For 7:00 PM to 7:00 AM for Nurses/MAs there was 1 RN for 12 hours and 1 LPN for 12 hours (which provided documentation there were nurses in the facility on the night shift). Further review revealed 4 NAs for 7:00 AM to 3:00 PM for 30.0 hours, 4 NAs for 3:00 PM to 11:00 PM for 30 hours, and 11:00 PM to 7:00 AM there were 3 NAs for 22.5 hours. There was an LPN who worked as the Unit Manager/Wound Nurse on the assignment sheet with no information regarding her working time and did not appear to be counted on the Daily Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 732	Continued From page 27	F 732		

Staffing Form. The facility daily assignments documented MAs, however, the MA hours were not documented on the Daily Nursing Staffing Form.

An interview was conducted in conjunction with a record review on 7/20/21 at 3:49 PM with the scheduler. He said he updated the Daily Nursing Staffing Form when he arrived in the morning. He stated the sheet did not count MAs and he said there was no place to record MAs on the staffing form. He said the hours for the nurses for third shift were counted under the evening hours and that was why the form was blank for nurses on the night shift. He explained the day shift hours where the nurses were counted for 12-hour shifts, actually only 8 of the hours were on day shift, and the other 4 hours were on evening shift because the nurses and MAs worked 12-hour shifts.

During an interview conducted with the Director of Nursing (DON) and the scheduler on 7/20/21 at the conclusion of the interview with the scheduler, she explained the resident census was reconciled after the midnight census by the nurse manager on the weekend and whoever was the charge nurse at night. The scheduler stated the resident census was not updated as residents were admitted and discharged, but by the business office manager in the morning. She said there was not a column for MAs on the Daily Nursing Staffing form and that was why the NAs, who were unlicensed staff, were not being recorded. She further explained the nurses worked 12 hours shifts and their hours were counted on the day shift and the evening shift. She said the total hours for the day were accurate with nurses. She also stated she did have nurses in the facility for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 732	Continued From page 28 the night shift. A follow up interview was conducted with the DON on 7/21/21 at 1:06 PM and she stated she was still waiting on the Vice President of Clinical Operations to approve a change to the staffing sheets to accommodate recording the hours for the MAs. An interview was conducted on 7/22/21 at 4:09 PM with the DON in the presence of the Administrator. He stated the MAs should have been counted on the Daily Nursing Staffing Form and should have been included with the NAs.	F 732		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		8/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 880	Continued From page 29 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 880	Continued From page 30 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, review of the Centers for Disease Control and Prevention (CDC) recommended guidance and review of the facility's Personal Protective Equipment (PPE), the facility failed to ensure a staff member, Nursing Assistant (NA) #2, wore a mask concealing her mouth and nose as she was within 6 feet of 6 of 6 residents, Residents #2, #43, #21, #5, #38, and #18, on the dementia unit during the observation. This failure occurred during a global pandemic. Findings included: CDC guidance titled "How to Wear Masks", dated 6/11/2021 was reviewed. It read in part: Put the mask over your nose and mouth and secure it under your chin. Review of a facility policy titled, "Personal Protective Equipment," with a revision date of October 2018 read in part, Training of the proper donning, use and disposal of Personal Protective Equipment (PPE) is provided upon orientation and at regular intervals. A continuous observation was conducted on the dementia unit on 7/21/21 from 8:48 AM through 9:08 AM. Nursing Assistant (NA) #2 was observed to be wearing a facemask below her nose. The NA was observed to go and assist Resident #2, Resident #43, Resident #21, Resident #5, then walked past Resident #38,	F 880	NA#2, B.D. was reeducated on the proper way to wear a mask by the Director of Nursing J.S. on 7/21/21. Additionally the Director of Nursing provided NA#2 with a surgical mask due to NA#2□s medical condition which made it difficult to breath in the N95 mask. On 7/21/21 through 8/26/21 the Director of Nursing J.S. and/or designee performed a Quality Improvement Monitoring for all staff to include: All Nursing Staff (Licensed Nurses, Certified Nursing Assistant, Medication Aides, and Patient Care Assistant), Receptionist, Administrator, Department Managers, Housekeeping, Dietary, Therapy, and Administrative staff on the proper way to wear PPE with special focus on ensuring mask conceals mouth and nose by completing competencies on DONNING/DOFFING Personal Protective Equipment. The Root Cause Analysis was completed by the Regional Director of Clinical Services E.W, Executive Director M.C, and the Director of Nursing J.S. on 8/13/21. The Director of Nursing and/or designee will re-educate staff to include: All Nursing Staff (Licensed Nurses, Certified Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 880	Continued From page 31 before entering into room 401 where there was no resident. The NA exited room 401 with the mask still improperly positioned which did not conceal her nose and walked past Medication Aide (MA) #1. The NA then proceeded to get eyeglasses for Resident #18 and place them on her face and moved the resident's wheelchair. The resident then went into room 405 where there was no resident and was observed to make the bed, with mask remaining below her nose. The NA went to get linens and passed in front of Housekeeper #1 on the unit and returned to room 405. The NA then left the room, was observed to put her hand on the mask to reposition the mask, and the mask remained below her nose. The NA then passed in front of NA #3. Nurse #1 was observed to have been in the dementia unit during a portion of the observation period passing out drinks from a beverage cart. An interview was conducted with NA #2 on 7/21/21 at 9:08 AM. At the start of the interview, the NA was observed pulling her mask down to speak during the interview. The NA stated she had bronchitis and she said she had to keep the mask down below her nose to breath. She also stated the mask kept slipping down on her face. She explained she was instructed to wear the mask covering her mouth and nose. She further state this was the first day she had been wearing a KN95 mask because she had just received the mask yesterday but had not talked to anyone about the mask slipping down or that she had bronchitis. An interview was conducted with NA #3 on 7/21/21 at 9:13 AM. She stated she did not notice NA #2's mask was below her nose. She said all staff were instructed to wear the masks	F 880	Assistant, Medication Aides, and Patient Care Assistant), Receptionist, Administrator, Department Managers, Housekeeping, Dietary, Therapy, and Administrative staff on the proper way to wear PPE with special focus on ensuring mask conceals mouth and nose. The Director of Nursing and/or designee will review the Facemask Do□s and Don□ts with staff which was provided by the CDC. The Facemask Do□s and Don□ts information sheet will be posted throughout facility as a reminder to staff. Additionally if any employee has any health issues that make it difficult to wear mask, they are to immediately report to their supervisor before working in patient care areas. This education will be completed by 8/26/21. This education will also be provided to all new employees as part of new hire orientation, contract staff and agency staff, this education will be provided prior to starting work. All current staff will be educated prior to their next scheduled shift. The Director of Nursing or designee will perform Quality Improvement Monitoring through observation of 5 random employees to ensure employees are wearing PPE (Personal Protective Equipment) correctly with special focus on mask concealing mouth and nose 2 X weekly for 4 weeks then 1 X weekly for 2 months than 1 X monthly for 3 months. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee by the DCS or designee for 6 months and/or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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) COMPLETION DATE
F 880	Continued From page 32 properly, to cover their nose and their mouth. She said she was not aware of other staff not wearing their masks properly and they have been wearing masks throughout the pandemic. During an interview conducted on 7/21/21 at 9:29 AM with Nurse #1 she stated she was responsible for overseeing the Medication Aides and the NAs on the dementia unit. She said she remembered NA #2 assisting residents when she was back on the dementia unit but did not see her mask was below her nose. She said the staff at the facility had been taught to wear their mask, so it covers their nose and mouth. She said if she would have seen the mask on NA #2 was below her nose, she would have asked her to move it up and cover her nose. An interview was conducted on 7/21/21 at 1:09 PM and the Director of Nursing (DON) stated NA #2 had told her that her mask slides down and she was holding it at her nose because she had bronchitis. The DON stated she had told the NA to bring in a note about her bronchitis and she had provided a surgical mask to the NA as an alternate to the N95 mask. The DON explained the NA should have come to her if she was having problems with the mask. During an interview conducted on 7/21/21 at 4:09 PM the Administrator stated it was his expectation for the facility staff to wear masks properly. He further stated he had not seen NA #2 wearing her mask under her nose, but he had become aware the NA had bronchitis, and she was supplied with a surgical mask to replace the N95 mask.	F 880	until substantial compliance is obtained. On 8/18/21 the Executive Director M.C. and Director of Nursing J.S. introduced the direct plan of correction for Infection Prevention and Control (PPE-Personal Protective Equipment) to the Quality Assurance Performance Improvement Committee. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee Members consist of but not limited to Executive Director, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct Care giver. Quality Improvement Quality Monitoring schedule modified based on findings Completion date is 8/26/21.	