	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		HAL029010	B. WING		R 12/15/20 ⁻	
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	, ZIP CODE		
RAYSON	CREEK OF WELCOME		D US HWY 52 TON, NC 27295			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET
D 000	Initial Comments		D 000			
	conducted an annual December 11, 2014 a	sure Section and the partment of Social Services and follow-up survey on nd December 12, 2014 with a telephone on December				
D 014	10A NCAC 13F .0206	Capacity	D 014			
	10A NCAC 13F .0206	10A NCAC 13F .0206 Capacity				
	licensed pursuant to t more residents. (b) The total number exceed the number sl (c) A facility shall be than the number for w space and other requ are available. (d) The bed capacity	nown on the license. icensed for no more beds which the required physical ired facilities in the building and services shall be in 131E, Article 9, regarding				
	TYPE A2 VIOLATION	This Rule is not met as evidenced by: TYPE A2 VIOLATION				
	review, the facility exc of 55 residents (16 be a special care unit an assisted living) and th	n, interview, and record eveded the licensed capacity eds of the 55 designated for d 39 beds designated for e facility was unaware of its residing in the facility.				
	The findings are:					
		s 2014 license revealed the or a total of 55 beds with 16				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		HAL029010	B. WING		R 12/15/	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
GRAYSON	N CREEK OF WELCOME		D US HWY 52 TON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
D 014	Continued From page	91	D 014			
		of the 55 beds designated for special care units beds. The facility would have 39 beds for assisted living residents.				
	 9:00 am with the Administrator-in-Char and Business Office M the following: The BOM stated the residents. The BOM provided a facility. The census list prov the name of a resider 12/9/14 (The census around it on in the 12). The ED stated the fa residents receiving ho hospice agency in the resident on the roster would not be coming The ED stated the rate 	acility did not include 4 ospice care from an outside e daily census and one was in the hospital (but				
	Review of the resident facility at entrance on revealed: - The special care uni the roster with one ma away on 12/9/14 and hospital. - Forty-three residents for the assisted living	it had 14 residents listed on arked as having passed one was listed as in the s were listed on the roster				
	12/11/14 between 9:0 revealed:	0 am and 12:00 noon it had 13 residents, including				

TATEMENT OF DEFICIENCIES		DER/SUPPLIER/CLIA	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:		R	
	HAL	029010	B. WING		12	R 2/15/2014
AME OF PROVIDER OR SUPPL	IER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE		
RAYSON CREEK OF WEL	COME		D US HWY 52 TON, NC 27295			
PREFIX (EACH DE	MARY STATEMENT OF I FICIENCY MUST BE PF DRY OR LSC IDENTIFY	RECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
D 014 Continued From	m page 2		D 014			
the resident re 3 empty beds. - The assisted living in the fac the assisted liv roster.) Based on revie on 12/11/14, th the assisted liv Interviews on 1 pm with the EE - The ED was 1 of the facility. - The ED was 1 facility, and ad - She stated sh listed by hospic census becaus residents and 1 for care. - She had not i receiving hospic outside agency and was not su census in the a over 39 residen - She included Care Unit in the and admitted es section to mak - Facility staff a needs including	turned back from living section, had cility. (Four residen- ring section were in the facility exceeder ring section by 8 m 12/11/14 at 11:30 D revealed: responsible for even- responsible for even- responsible for mar- mitting residents to the did not count the ce as "complete of the facility did not included the hosp ice "complete" can y in the census for ure of a specific dia assisted living seconds. the 3 empty beds e census available extra residents to the e up the difference attended to the ho g assistance with ing, assistance du n administration a	47 residents not listed on the and observations d the capacity for esidents. am and at 2:45 eryday operation arketing the o the facility. the 4 residents are" in the ed care for the receive payment the receive payment ce residents re from an quite some time ate when the tion started being from the Special e for the facility, he assisted living e. spice residents' bathing, iring meal times, t the facility,				

Division of Health Service Regu STATE FORM

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If continuation sheet 3 of 10

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		HAL029010	B. WING		12	R 2/15/2014
NAME OF PF	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
GRAYSON	I CREEK OF WELCOME		D US HWY 52			
		LEXING	TON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
D 014	Continued From page	23	D 014			
	- She stated she thou building could be 55.	ght the total census for the				
	beds in the special ca	•				
	- The BOM was responded	s. onsible for maintaining an				
		providing the list to the ED				
	for monitoring admiss					
		BOM did not include the 4				
	hospice residents in t	ne census. omplete the census count				
	daily.					
	-	- The facility had a waiting list for residents				
	-	nd one was admitted when				
	another resident mov					
		the resident roster was not				
	accurate.					
		nergency evacuation, like				
	would be 55.	ent, the census provided				
		were extra beds in the				
		icility had an open house				
		nem; they were planning to				
	increase bed capacity	in the future.				
	Interview on 12/11/14 revealed:	at 12:30 pm with the BOM				
	- She was responsible	e for maintaining the census				
		numbers on all reports.				
	-	t of residents to the ED.				
		when the list of residents in				
	the facility became ina	accurate. ne census daily but were				
		e of all residents in the				
	building.					
	•	she did not include the 4				
		re" residents in the census.				
		the census was not accurate				
	-	identified residents not listed				
	on the roster.					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		HAL029010	B. WING		12	R 2/ 15/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE		
GRAYSON	CREEK OF WELCOME		D US HWY 52 FON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
D 014	Continued From page	e 4	D 014			
	- When asked what the facility would use for identifying residents in the event of an emergency evacuation, she stated 55 would be provided as census.					
	12/11/14 at 12:30 pm facility after the surve residents living in the special care unit (incl	facility, 13 residents in the uding the resident back from n the assisted living section,				
	-	firmed the facility census of 30 pm using the corrected				
	Care Unit Coordinato - She was not aware were being included i assisted living side of - The ED and BOM w admitting residents to - The Unit did not hav	the empty beds in the Unit in the census for the f the building. vere responsible for				
	aide and medication	vs with 2 staff (personal care aide) revealed staff provided including hospice residents, as not in the building.				
	hospice aides reveale -They are in the facili provide personal care -The facility staff are	at 10:00 am with two ed: ty two times a week to of for hospice residents. responsible for care for the en the hospice aides were				

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			R
		HAL029010	B. WING		12	2/15/2014
AME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
RAYSON	I CREEK OF WELCOME		.D US HWY 52 TON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 014	Continued From page	5	D 014			
	revealed hospice was a day. Review of the facility's schedule compared to for the previous 2 we the facility staffed to a	of the hospice providers not in the building 24 hours				
	revealed: - The BOM assisted h - The facility staffed to the building. - The facility routinely residents requirement section for at least the	o meet the total census of staffed to the 41 to 50 ts for the assisted living e last 2 months. a staff in both sections of the				
	The facility provided a 12/11/14 including the - Facility to immediate residents to meet lice additional residents w transferred to the Spe - The Director of the f	Plan of Protection on following: ely and safely discharge 5 nse capacity of 55. Three ill be appropriately				
	CORRECTION DATE VIOLATION SHALL N 2014.	FOR THE TYPE A2 IOT EXCEED JANUARY 14,				
D 176	10A NCAC 13F .0601	Management Of Facilities	D 176			

STATEMENT	of Health Service Regu FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			R
		HAL029010	B. WING		12	2/15/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
GRAYSON	I CREEK OF WELCOME		.D US HWY 52 TON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
D 176	Continued From page	e 6	D 176			
	10A NCAC 13F .0601	Management Of Facilites				
	responsible for the to home and shall also b Division of Facility Se department of social maintaining the rules co-administrator, whe equal responsibility w operation of the home maintaining the rules	ervices and the county services for meeting and of this Subchapter. The en there is one, shall share vith the administrator for the e and for meeting and of this Subchapter. The so refers to co-administrator				
	This Rule is not met TYPE A2 VIOLATION	-				
	review, the Administra Director (ED) was no	n, interview and record ator-in Charge/Executive t aware of the census of the ssure the licensed capacity ot exceeded.				
	The findings are:					
	Capacity). Based on observation review, the facility exit of 55 residents (16 be a special care unit an assisted living) and the the number of resident	10A NCAC 13F .0206 n, interview, and record ceeded the licensed capacity eds of the 55 designated for id 39 beds designated for ne facility was unaware of ints residing in the facility. 4 at 11:30 am and at 2:45				
rision of Hea		rator-in-Charge/Executive				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		IDENTIFICATION NOMBER.	A. BUILDING:			
		HAL029010	B. WING		12	R 2/ 15/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
RAYSON	I CREEK OF WELCOME		D US HWY 52			
		LEXING	TON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 176	Continued From page	e 7	D 176			
	- The ED was respon	sible for everyday operation				
	of the facility.					
		sible for marketing the				
	facility, and admitting	residents to the facility.				
	- She stated she did r	not count the 4 residents				
	listed by hospice as "	complete care" in the				
	census because hospice provided care for the					
	residents and the faci	esidents and the facility did not receive payment				
	for care.					
		d the hospice residents				
	. .	receiving hospice "complete" care from an				
		outside agency in the census for quite some time				
	out was not sure of a specific date when the					
		census in the assisted living section started being				
	over 39 residents.					
		empty beds from the Special				
		us available for the facility,				
		sidents to the assisted living				
	section to make up th					
	Ū	al census for the building				
		was unaware she should not				
		e special care unit as part of				
	the assisted living see	e Manager (BOM) was				
		aining an accurate census				
		to the ED for monitoring				
	admissions.	to the EB for monitoring				
		BOM did not include the 4				
	hospice residents in t					
	-	complete the census count				
	daily.	-				
		aiting list for residents				
	2	nd one was admitted when				
	another resident mov	ed or passed away.				
	- She was not aware	the resident roster list was				
	not accurate.					
	- In the event of an er	mergency evacuation, like				
	with the fire departme	ent, the census provided				
	would be 55.					
	- The ED stated there	were extra beds in the	1			

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		R 12/15/2014	
		HAL029010	B. WING			
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
GRAYSON	I CREEK OF WELCOME		D US HWY 52 FON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	IOULD BE	(X5) COMPLET DATE
D 176	Continued From page	8	D 176			
	facility because the facility had an open house and never removed them; they were planning to increase bed capacity in the future.					
	12/11/14 including the - Facility to immediate residents to meet lice additional residents w transferred to the Spe - The Director of the f	ely and safely discharge 5 nse capacity of 55. Three /ill be appropriately				
	CORRECTION DATE VIOLATION SHALL N 2014.	EFOR THE TYPE A2 IOT EXCEED JANUARY 14,				
D912	G.S. 131D-21(2) Dec	laration of Residents' Rights	D912			
	Every resident shall h 2. To receive care an adequate, appropriate	ration of Residents' Rights have the following rights: ad services which are e, and in compliance with state laws and rules and				
	interviews, the facility received care and set appropriate, and in co	ns, record reviews, and failed to assure residents rvices which were adequate, ompliance with relevant s and rules and regulations				
	The findings are:					

ODI611

If continuation sheet 9 of 10

	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		HAL029010	B. WING		12	R 2/ 15/2014
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
RAYSO	N CREEK OF WELCOME		D US HWY 52 TON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D912	Continued From page	9	D912			
	review, the facility exe of 55 residents (16 be a special care unit an assisted living) and th the number of residen [Refer to Tag D0014, Capacity (Type A2 Vi B. Based on observa review, the Administra Director (ED) was no facility and failed to a of 55 residents was no	ation, interview and record ator-in-Charge/Executive t aware of the census of the ssure the licensed capacity ot exceeded. [Refer to Tag 3F .0601(a) Management of				