STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 12/07/16, 12/08/16, 12/09/16 with a telephone exit conference on 12/12/16.	D 000		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the quarterly Licensed Health Professional Support (LHPS) evaluations were completed within 30 days from	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 280	Continued From page 1	D 280		

the date a resident developed the need for the task and included a physical assessment, evaluation of the resident's progress to care, and recommendations for changes in care for 5 of 5 sampled residents (Residents #1, #2, #6, #7 and #8) with LHPS tasks of caring for physical restraints.

The findings are:

A. Review of Resident #6's current FL2 dated 07/24/16 revealed:
-Diagnoses included Alzheimer's dementia.
-Disoriented constantly, ambulatory with walker, incontinent of bladder and bowel.

1. Review of a physician's order dated 09/28/16 revealed for "soft Velcro strap."

Review of Resident #6's Personal Care Physician's authorization and Care Plan signed by the physician on 07/24/16 revealed:
-Resident #6 required extensive assistance with eating, toileting, ambulation, bathing, dressing, grooming and transferring.
-The side rails and Velcro strap were not documented as part of Resident #6's plan of care.

Observation on 12/07/16 at 9:36 am during initial tour of the facility revealed:
-Resident #6 resided in the special care unit.
-The resident was sitting in a wheelchair in the common living room, in front of the television.
-The resident had a 6" wide strap wrapped around the resident's waist that extended around the resident and the wheelchair.
-Both ends of the strap were attached to each other using Velcro and prevented movement.
-The resident made no attempts to move, but appeared to be watching television.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

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D 280	Continued From page 2 Review of Resident #6's record revealed an order signed by the physician on 08/17/16 for "half side rails per family member request." Review of Resident #6's record revealed: -A facility form signed by resident's guardian on 08/21/16. -The form documented "½ rails were on the hospital bed, it was the best interest for safety and comfort reasons, and the resident would not get tangled up in or trapped in the ½ rails. The ½ rails will not be used as a restraint but more as a mobility aide in repositioning and getting out of bed." Review of an Licensed Health Professional Support (LHPS) assessment for Resident #6 completed on 07/30/16 revealed there was no documentation the Registered Nurse (RN) completed an LHPS assessment within 30 days of the task restraint usage (Velcro scrap) being identified. Interviews on 12/07/16 at 2:42 pm and 12/08/16 at 10:30 am with the Resident Care Coordinator (RCC) in the special care unit revealed: -The strap was used daily; any time Resident #6 was out of bed. -The strap was used to keep the resident from getting up out of the chair because the resident had Alzheimer's and was confused. Observation on 12/07/16 4:32 pm of Resident #6 revealed: -The resident was in her room sitting in her wheelchair. -There was a 6" wide strap wrapped around the resident's waist and extended around the wheelchair, attaching the resident to the	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 280	Continued From page 3	D 280		

wheelchair, and preventing movement.
-The strap was closed by attaching both ends using Velcro.
-The resident was moving her legs around and the chair moved with the resident.
-It could not be determined if the resident was attempting to get up because she could not raise her bottom from the chair.

Observation on 12/08/16 at 8:23 am of Resident #6 revealed:
-The resident was sitting upright in a wheelchair in the hallway, outside the dining room.
-The 6" wide strap was wrapped around the resident's waist and the chair and closed behind the back using Velcro.

Observation on 12/08/16 at 11:43 am of Resident #6 revealed:
-Resident #6 was up in her wheelchair in the common living room.
-The 6" wide strap was wrapped around the resident's waist and the chair and closed behind the back using Velcro.

Interview on 12/07/16 at 3:38 pm with the Director of Operations revealed:
-Resident #6 had a "lap buddy" to keep the resident from getting up.
-She was aware the lap buddy was a restraint.
-The RN completed an LHPS evaluation on Resident #6 quarterly, but had not addressed restraint care practices.
-The nurse did not complete LHPS evaluations for LHPS for Resident #6's restraint because the LHPS nurse was unaware one needed to be completed.

B. Review of Resident #2's current FL2 dated 06/13/16 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 280	Continued From page 4	D 280		

-Diagnoses included Alzheimer disease, dementia with behaviors disturbance.
-Disorientation status was constant, semi-ambulatory, and incontinent of bowel and bladder.
-The recommended level of care was special care unit.

Review of Resident #2's Physician Assessment and Care Plan signed by the physician on 06/14/16 revealed:
-Resident #2 required extensive assistance with eating, toileting, ambulation, bathing, dressing, grooming, and transfer.
-Side rails and Velcro strap were not addressed in Resident #2's plan of care.

Observation during the initial tour on 12/07/16 at 9:37 am revealed:
-Resident #2 was lying in the bed.
-The resident was positioned with his face to the wall and his back was positioned four to six inches from the half side rail.
-The resident's wheelchair was near the bed, but not against the bed.

Observation on 12/07/16 at 11:45 am of Resident #2 revealed:
-The resident was in a high back wheelchair, in the hallway, outside the dining room.
-Resident #2 had a 6" wide soft strap wrapped around his body, the strap extended to the back of the chair, and closed in the back by attaching both ends with Velcro.
-Resident #2 had slid down in the chair with the Velcro strap under his breast.
-Resident #2 had his eyes closed, and made no movements on his own.

Observation on 12/07/16 at 12:00 pm of Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 280	Continued From page 5 #2 revealed the resident was still slid down in the high back wheelchair with Velcro strap under his breast. Observation on 12/07/16 at 12:05 pm revealed the PCA pulled the resident up in the chair and took him to the dining room. Observation on 12/08/16 at 8:20 am of Resident #2 revealed: -Resident #2 was in a high back chair, in the hallway outside the dining room. -Resident #2 had his eyes closed, and the head of high back chair was leaned back at the head, and the resident's feet were propped up so that this head and feet were level with each other. -There was a 6" wide strap around the resident's upper waist. -The strap extended around the chair and closed in the back of the chair with Velcro. -Two Personal Care Aides (PCAs) pulled Resident #2 up in the chair, and took the resident and the chair to the dining room. Observation on 12/08/16 at 11:48 am revealed: -Resident #2 had his eyes closed and in bed. -There was a ½ side rail on the left side of the bed, and the right side of the bed was against the wall. -Resident #2 was placed on his side with his face toward the wall and his back toward the half side rail. -The resident's wheelchair was placed at the end of the half side rail, along side of the bed. Review of the LHPS evaluation completed on 10/30/16 revealed: -The Registered Nurse (RN) completing the evaluation documented the tasks of fingerstick blood sugar, suppository, ambulation and	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

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D 280	Continued From page 6	D 280		

transferring.
-The RN failed to document the task of restraint usage.

Interview on 12/08/16 at 8:27 am with the first shift PCA revealed:
-A Velcro strap was put around Resident #2's waist when the resident was up in the high back wheelchair to the keep the resident from sliding.
-The chair was also leaned back to keep the resident from sliding down.
-The strap was also used to keep the resident from sliding down.
-Resident #2 slept a lot, and made no attempt to get up, the strap was used to keep the resident from sliding down and to the side in the chair.

Interview on 12/09/16 at 3:01 pm with the Resident Care Coordinator (RCC) revealed:
-When the resident was in the high back wheelchair, the strap was wrapped around the resident and the chair any time the resident was up.
-Side rails were used when the resident was in the bed to keep the resident from falling out of bed.

Observation on 12/08/16 at 11:48 am revealed:
-Resident #2 was lying in bed with his eyes closed.
-There was a 1/2 bed rail on the left side of the bed and the right side of the bed was up against the wall.
-The resident's wheelchair was at the foot of the bed.
-The resident's face was toward the wall and his back toward the half side rail.

Interview on 12/08/16 at 11:52 am with a first shift PCA revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 280	Continued From page 7	D 280		

-The 1/2 side rails were to keep Resident #2 from rolling out of the bed and staff did not nothing special for residents with side rails.
-Resident #2 was seldom awake, and did not do much, other than sleeping.

Based on record review, and observation it was determined that Resident #2 was not interviewable.

Interview on 12/07/16 at 3:38 pm with the Director of Operations revealed:
-Resident #2 had a "lap buddy" when the resident was in the assisted living part of the facility.
-Resident #2 went to Hospice two weeks and when he returned the resident was admitted to the special care unit.
-The resident had not been assessed to ensure the need for the restraint.
-The ½ side rails on Resident #2's bed were not restraints because they are not stopping the resident from doing anything, but keeping the resident safe when in bed.
-The RN completed an LHPS evaluation on Resident #2 quarterly, but did not address restraint care practices.
-The nurse did not complete LHPS evaluations for Resident #2's restraint because the LHPS nurse was unaware one needed to be completed.

C. Review of Resident #1's current FL2 dated 02/10/16 revealed:
-Diagnoses included Alzheimer's dementia, diabetes, symbolic dysfunction, depression, anemia, and hyperlipidemia.
-Disorientation was constant, semi-ambulatory using a wheelchair, and incontinent with bowel and bladder.

Review of Resident #1's Personal Care Physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 280	Continued From page 8	D 280		

authorization and Care Plan signed by the physician on 07/06/16 revealed:
-Resident #1 required extensive assistance with eating, toileting, ambulation, bathing, dressing, grooming, and transferring.
-No documentation related to the resident's need for the side rails or use of alternatives.

Review of Resident #1's Profile and Care Plan dated 10/30/16 revealed no documentation regarding the need for 1/2 side rails or alternatives used.

Observation on 12/07/16 at 9:37 am of Resident #1 revealed the resident was sitting in a wheelchair in the facility's common living room.

Observation on 12/07/16 at 9:47 am of Resident #1's room revealed two 1/2 side rails were attached to the resident's bed.

Review of the LHPS evaluation completed by the RN on 10/30/16 revealed:
-The resident was evaluated for the tasks of TED hose, fingerstick blood sugar, transferring and ambulation.
-The usage of restraints and alternatives was not addressed as a task.

Interview on 12/08/16 at 3:06 pm with a second shift PCAs revealed Resident #1's 1/2 side rails were put up when the resident was in bed.

Based on record review, observation and attempted interview on 12/07/16, it was determined Resident #1 was not interviewable.

Interview on 12/07/16 at 3:38 pm with the Director of Operations revealed:
-Resident #1 had two ½ side rails, but they were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 280	Continued From page 9	D 280		

not considered restraints.
-The Registered Nurse completed an LHPS evaluation on Resident #1 quarterly, but did not address restraint care practices.
-The nurse had not completed LHPS evaluations for Resident #1 because the Director of Operations did not consider the side rails a restraint and did not tell the nurse to evaluate the side rails.

D. Review of Resident #7's current FL-2 06/08/16 revealed:
-Diagnoses included senile dementia-Alzheimer's type, abnormal gait, mental disorder, muscle weakness, and joint pain.
-Documentation Resident #7 was intermittently confused.

Review of Resident #7's Resident Register revealed an admission date of 07/28/15.

Review of Resident #7's Licensed Health Professional Support (LHPS) Review and Evaluation dated 10/30/16 revealed:
-The resident received medication administration through injections.
-The resident received ambulation using assistive devices that required physical assistance.
-The resident received assistance with transferring.
-Documentation of a physical assessment as related to diagnoses/current condition and progress to care provided of the resident was " semi-ambulatory, uses wheelchair and staff assistance" and a one person assist with transfers.
-The LHPS review was signed by a Registered Nurse.

Review of Resident #7's Care Plan dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 280	Continued From page 10	D 280		

07/10/15 revealed:
-She had an ambulatory with wheelchair status.
-She needed limited assistance by staff with toileting, ambulation and locomotion, bathing, dressing and transferring.
-LHPS tasks listed on the Care Plan: blood pressure and pulse weekly, weight monthly, finger stick blood sugars, care of pressure ulcers, medication administration through injections, oxygen administration and monitoring, and TED hose on in the am and off in the pm.

Review of Resident #7's Profile and Care Plan dated 07/30/16 revealed:
-She required supervision with ambulation.
-She needed limited assistance by staff with toileting, ambulation and locomotion.
-Resident #7 needed extensive assistance with bathing.
-LHPS tasks listed on the Care Plan were for medications administered through injections.
-The Care Plan was signed by a Registered Nurse and a physician.

Observation of Resident #7 on 12/09/16 at 10:34 am revealed:
-Resident #7 was lying in bed with eyes closed.
-The bed was positioned with one side against the wall.
-The opposite of the bed had a half bed rail in the up position.
-A wheelchair was locked into position against the bottom 1/3 of the bed, at the end of the side rail.
-A call bell was hanging behind the head of the bed.

Interview on 12/09/16 at 10:34 am with a Medication Aide (MA) revealed:
-She helped the resident with transfers, blood pressure monitoring weekly and monthly weights.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 280	Continued From page 11 -Sometimes she redirected the resident due to dementia. Interview on 12/09/16 at 3:15 pm with the Personal Care Aide (PCA) revealed she usually helped Resident #7 with transfers and toileting and a bath if necessary. E. Review of Resident #8's current FL-2 dated 04/26/16 revealed: -Diagnoses included dementia, acute kidney failure, disorientation, depressive disorder, history of falls, abnormal gait, and hypertension. -She was semi-ambulatory and intermittently confused. Review of Resident #8's Care Plan dated 04/26/16 revealed: -She required supervision with ambulation and transfers. -She needed limited assistance with toileting, ambulation, grooming and personal hygiene. -She needed extensive assistance with bathing and dressing. -The care plan was signed by a Registered Nurse and a Physician. Review of Resident #8's current care plan dated 08/01/16 revealed: -She needed limited assistance with bathing, dressing and toileting. -She needed supervision with ambulation and transfers. -She had no Licensed Health Professional Support (LHPS) Personal Care Tasks noted. Review of Resident #8's LHPS Review and Evaluation dated 04/30/16 revealed: -She was confused at times. -She was ambulatory and required no assistance.	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 280	Continued From page 12 -She had no LHPS tasked noted. Review of resident #8's Pre-admission Screening Assessment of Special Care Unit dated 04/26/16 revealed: -She had occasionally disorientation and inability to understand. -She had occasional wandering. -She required limited assistance with ambulation. Observation with Resident #8 on 12/09/16 at 10:34 am revealed: -She was at the bottom of the bed. -She was confused to time and place. -Her wheelchair was along the side of the bed at the end of the side rail. Interview on 12/09/16 at 3:15 pm with a Personal Care Aide (PCA) revealed: -She provided assistance with personal care for Resident #8 which included dressing and bathing. -Resident #8 was a 2 person assist because she had become much weaker now. -"Its hard for the resident to stand on her own and follow commands". Interview on 12/09/16 at 10:34 am with a Medication Aide (MA) revealed: -Resident #8 was almost total care and was not ambulatory due to weakness and not following commands. -She is "stiff" and hard to pivot. Interview on 12/12/16 at 9:00 am with Resident #8's Power of Attorney (POA) revealed: -He was very pleased with the care provided by the staff at the facility. -He was aware of a few falls in the past three months. -He was not aware of Resident #8 becoming	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 280	Continued From page 13 weaker. -He was not aware if Resident #8 was getting physical therapy.	D 280		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 482	Continued From page 14	D 482		

opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observation, interview and record review, the facility failed to assure physical restraints, including side rails were used only after an assessment and care planning process had been completed and used only after alternatives had been tried and a physician's order obtained for 5 of 5 sampled residents (Residents #1, #2, #6, #7 and #8) with restraints.

The findings are:

A. Review of Resident #6's current FL2 dated 07/24/16 revealed:
-Diagnoses included Alzheimer's dementia.
-Disoriented constantly, ambulatory with walker, incontinent of bladder and bowel.

1. Review of Resident #6's record revealed a physician's order dated 09/28/16 for "soft Velcro strap."

Observation on 12/07/16 at 9:36 am during initial

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

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D 482	Continued From page 15	D 482		

tour of the facility revealed:
-Resident #6 resided in the special care unit.
-The resident was sitting in a wheelchair in the common living room, in front of the television.
-The resident had a 6" wide strap wrapped around the resident's waist that extended around the resident and the wheelchair.
-Both ends of the strap were attached to each other using Velcro and prevented movement.
-The resident made no attempts to move, but appeared to be watching television.

Review of Resident #6's Personal Care Physician's authorization and Care Plan signed by the physician on 07/24/16 revealed:
-Resident #6 required extensive assistance with eating, toileting, ambulation, bathing, dressing, grooming and transferring.
-The Velcro strap was not documented as part of Resident #6's plan of care.

Review of the nurse notes in Resident #6's record revealed notes were specific to date, but no times were documented as follows:
-On 08/01/16 Resident #6 kept trying to get up from wheelchair.
-On 08/03/16 Resident #6 keeps trying to get up from wheelchair, "afraid, she will fall over leg rest".
-On 08/06/16 Resident #6 would not stand for staff, when left in her wheelchair the resident tried to get up and stand.
-On 08/07/16 Resident #6 fell tonight in the TV room.
-On 08/11/16 Resident #6 got out of wheelchair and put self on couch.
-On 08/12/16 Resident #6 wanting to get up and walk without a walker, reaches out and grabs a lot of things around her.
-On 08/13/16 Resident #6 is getting out of her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 482	Continued From page 16	D 482		

wheelchair and pushing it.
-On 08/19/16 Resident #6 kept trying to get out of her wheelchair.
-On 08/21/16 Resident #6 kept trying to get out of wheelchair.
-On 08/23/16 Resident #6 keeps wanting to get up from wheelchair.
-On 08/27/16 Resident #6 kept getting up and wanting to walk with her walker.
-On 11/01/16 "had to use Velcro strap".
-On 11/02/16 "had to use Velcro straps".

There were no notes that documented the resident's activity in September and October 2016.

Observation on 12/07/16 at 4:32 pm of Resident #6 revealed:
-The resident was in her room sitting in her wheelchair.
-There was a 6" wide strap wrapped around the resident's waist and extended around the wheelchair, attaching the resident to the wheelchair, and preventing movement.
-The strap was closed by attaching both ends using Velcro.
-The resident was moving her legs around and the chair moved with the resident.
-It could not be determined if the resident was attempting to get up because she could not raise her bottom from the chair.

Observation on 12/08/16 at 8:23 am of Resident #6 revealed:
-The resident was sitting upright in a wheelchair in the hallway, outside the dining room.
-The 6" wide strap was wrapped around the resident's waist and the chair and closed behind the back using Velcro.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 482	Continued From page 17	D 482		

Observation on 12/08/16 at 11:43 am of Resident #6 revealed:
-Resident #6 was up in her wheelchair in the common living room.
-The 6" wide strap was wrapped around the resident's waist and the chair and closed behind the back using Velcro.

Review of the facility's 30 minute check for restraints from December 1 through 8th, 2016 on the 1st and 2nd shift revealed:
-The reason for the document was Resident #6 had a Velcro restraint.
-Staff on the first and second shifts document every 15 minutes of the velcro strap in place, from December 1st through 8th, 2016.

Interviews on 12/07/16 at 2:42 pm and 12/08/16 at 10:30 am with the Resident Care Coordinator (RCC) in the special care unit revealed:
-Resident #6 often tried to get out of her wheelchair.
-The strap was used to keep the resident from getting up out of the chair.
-Resident #6 had Alzheimer's and was confused.
-The resident does not remember she cannot walk and often fell to the floor because she could not stand on her legs.
-The resident now required two people for ambulation and transfer and was unable to stand or move her legs.
-In September 2016, Resident #6 was ordered a strap to prevent her from getting up out of the wheelchair.
-She was not sure how the resident was able to maneuver it, but Resident #6 had gotten out of the strap twice since September 2016.
-It was the facility's policy to residents with restraints on 30 minutes checks.
-Resident #6 was put on 30 minutes checks, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 482	Continued From page 18	D 482		

sometimes was released by putting her in the bed.

Interview on 12/07/16 at 4:35 pm with the second shift Medication Aide (MA) revealed:
-Resident #6 often tried to get up and previously fell at another facility and broke her hip due to a fall.
-Resident #6 still often tried to get up, but the strap prevented the resident from getting up.
-In September 2016, when Resident #6 got the strap the Director of operations informed staff to monitor the resident every 30 minutes when in the wheelchair.

Interview on 12/07/16 at 3:38 pm with the Director of Operations revealed:
-Resident #6 had a "lap buddy" to keep the resident from getting up, and falling.
-She was aware the lap buddy was a restraint.
-Staff had been trained to use restraints.
-She verbally informed staff in the special care unit that Resident #6 needed to be checked on at least every 30 minutes, and released every two hours.
-Staff should be documenting this on the form that she developed.
-She was unaware the physician had to write orders specific to the need, hold and release times of the restraint.
-The nurse did not complete LHPS evaluations for LHPS for Resident #6's restraint because she had not informed the nurse, being she was unaware restraints was on the LHPS evaluation.
-She was unaware that restraint orders had to be updated every three months, until it was bought her attention by the surveyor.

Interview on 12/12/16 at 2:25 pm with Resident #6's guardian revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 482	Continued From page 19 -The "lap belt" (Velcro strap) was used to keep Resident #6 in the wheelchair. -The resident tried to get up without assistance, and previously had broken her hip at another facility. -When Resident #6 had "dark days," when she was confused, she got up and wandered and was unaware what she was doing. -Resident #6 had "electrical storms," which was when she did not recognize anyone and wandered, not following commands, had no idea who or where she was at, she can't understand anything on those days. -Recently, Resident #6 had a lot of "electrical storm" days. -On the "storming" days Resident #6 will end up at the bottom of the bed and try to get out of bed. -Her biggest fear was that Resident #6 will break another hip from falling out of bed. -No one at the facility had offered or discussed other alternatives to using the strap to keep Resident #6 from getting up out of the wheelchair. -She did feel Resident #6 could get caught between the mattress and side rail, and that was why she and the facility staff used pillows to prevent the resident from getting trapped. -Also, there was the possibility that Resident #6 could smother if she rolled over into the pillow, especially on days previously mentioned when the resident was very confused. Refer to interview on 12/07/16 at 3:38 pm and 12/09/16 at 4:00 pm with the Director of Operations. Refer to interview on 12/09/16 at 10:34 am with the RCC. Refer to interview on 12/09/16 at 3:15 pm with the second shift PCA.	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

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D 482	Continued From page 20 Refer to facility's restraint policy. 2. Review of Resident #6's record revealed an order signed by the physician on 08/17/16 for "half side rails per family member request." Review of Resident #6's record revealed: -A facility form signed by resident's guardian on 08/21/16. -The form documented "½ rails were on the hospital bed, it was the best interest for safety and comfort reasons, and the resident would not get tangled up in or trapped in the ½ rails. The ½ rails will not be used as a restraint but more as a mobility aide in repositioning and getting out of bed." Interview on 12/09/16 at 10:34 am with the Resident Care Coordinator (RCC) revealed: -Resident #6 was a 2 person assist with ambulation and transferring. -The resident had 1 side rail because the other side of her bed was against the wall to keep the resident from getting out of bed. -When the resident was in bed the side rail was up and the wheelchair was positioned at the bottom side of the bed, at the end of the side rail to keep the resident from getting out of bed. -She could not identify any other alternatives used with this resident prior to using the restraints. Observation on 12/09/16 at 3:10 pm of Resident #6 revealed: -Resident #6 was in bed. -The bed rails were up on the left side, the bed was against the wall on the right side. -Resident #6 was scooted down to the bottom of the bed with the blankets wrapped around the	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

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D 482	Continued From page 21	D 482		

lower half of her body, and leg wrapped in the blanket hanging off the lower left side of the bed below the side rail, and the resident was trying to get up.

Interview on 12/09/16 at 3:15 pm with the second shift Personal Care Aide (PCA) revealed:
-A wheelchair and side rails were used to keep Resident #6 from getting out of bed.
-The resident was "very stubborn" when trying to stand, and often wanted to stand.
-Resident #6 was almost total care and required 2 people to assist with ambulation and transferring.

Attempted interview via telephone on 12/07/16 with Resident #6's physician revealed no return phone call prior to exiting the survey.

Based on record review, observation and attempted interview on 12/07/16, it was determined that Resident #6 was not interviewable.

Refer to interview on 12/07/16 at 3:38 pm and 12/09/16 at 4:00 pm with the Director of Operations.
Refer to interview on 12/09/16 at 10:34 am with the RCC.

Refer to interview on 12/09/16 at 3:15 pm with the second shift PCA.

Refer to facility's restraint policy.

B. Review of Resident #2's current FL2 dated 06/13/16 revealed:
-Diagnoses included Alzheimer disease, dementia with behaviors disturbance.
-Disorientation status was constant, semi-ambulatory, and incontinent of bowel and

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	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 482	Continued From page 22	D 482		

bladder.
-The recommended level of care was special care unit.

1. Review of the a facility's form titled "Resident change of status form" revealed Resident #2 was transferred to the special care unit (SCU) on 06/14/16 due a decline in status.

Review of the facility's admission and screening assessment form for Resident #2's dated 06/14/16 revealed:
-Resident #2 had moderate impairment of communication ability.
-The resident was disoriented to time, place and person.
-Resident #2 required regular assistance with mobility.
-Resident #2 was a fall risk and had a restraint "Geri Chair."
-Resident #2 was incontinent requiring full assistance, needed supervision and assistance with bathing, grooming, dressing, eating, and occasionally wandered.

Review of an order signed by the physician on 04/27/16 (prior to admission to the SCU) revealed the "resident to use Velcro restraint to prevent falls."

There was no updated order for the Velcro restraint after Resident #2 was transferred to the SCU.

Review of Resident #2's Personal Care Physician's authorization and Care Plan signed by the physician on 06/14/16 revealed:
-Resident #6 required extensive assistance with eating, toileting, ambulation, bathing, dressing, grooming, and transfer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 482	Continued From page 23 -The Velcro restraint was not documented as part of Resident #2's plan of care. Observation on 12/07/16 at 11:45 am of Resident #2 revealed: -The resident was in a high back wheelchair, in the hallway, outside the dining room. -Resident #2 had a 6" wide soft strap wrapped around his body, the strap extended to the back of the chair, and closed in the back by attaching both ends with Velcro. -Resident #2 had slid down in the chair with the Velcro strap under his breast. -Resident #2 had his eyes closed, and made no movements on his own. -At 12:00 pm Resident #6 was still slid down in the high back wheelchair with Velcro strap under his breast. -At 12:05 pm the PCA pulled the resident up in the chair and took him to the dining room. Observation on 12/07/16 at 4:32 pm of Resident #2 revealed: -Resident #2 was in a high back wheelchair, in the hallway outside the dining room. -Resident had a 6" wide soft strap wrapped around his waist that also extended to the back of the chair, with both ends of the strap attached together with Velcro. -Resident #2 had his eyes closed, and staff moved the resident into the dining room. Observation on 12/08/16 at 8:20 am of Resident #2 revealed: -Resident #2 was in a high back chair, in the hallway outside the dining room. -Resident #2 was sleep, and the head of high back chair was leaned back, and the resident's feet were propped up so that this head and feet were leveled with each other.	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 482	Continued From page 24 -There was a 6" wide strap around the resident's upper waist near the stomach. -The strap extended around the chair and closed in the back of the chair with Velcro. -Two Personal Care Aides (PCAs) pulled Resident #2 in the chair, and took the resident and the chair to the dining room. Review of the facility's 30 minute check for restraints from December 1 through 8th, 2016 on the 1st and 2nd shift revealed: -The reason for the document was Resident #6 had a Velcro restraint. -Staff on the first and second shifts document every 15 minutes from December 1st through 8th, 2016. Interview on 12/08/16 at 8:27 am with the first shift PCA revealed: -A strap was put around Resident #2's waist when the resident up in the high back wheelchair. -The chair was leaned back to keep the resident from sliding down. -The strap was also used to keep the resident from sliding down. -Resident #2 had the high back wheelchair and strap when the resident came to the special care unit. -The Director of Operations had instructed staff to document the resident was checked every 30 minutes. -Resident #2 was usually put in bed after breakfast and gotten up one hour to 30 minutes before lunch. -Resident #2 sleeps a lot, and made no attempt to get up, the strap was used to keep the resident from sliding down and to the side in the chair. Interviews on 12/09/16 at 10:00 am and 10:34 am with the RCC revealed:	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 482	Continued From page 25 -Resident #2 was total care, because the resident was so "out of it" you could not get him to understand when communicating with him. -Resident #2 used the "lap belt" (Velcro strap) to keep him from sliding out of the chair because the resident had loss of pelvic and lower body muscle strength. -Resident #2 had the Velcro scrap prior to admission to the SCU. -She was unaware if the physician assessed the resident's use of the Velcro strap since he moved to the SCU. Second interview on 12/09/16 at 3:01 pm with the RCC revealed: -Resident #2 slid down and to the side in his high back wheelchair and the straps were used to keep the resident from sliding. -Resident #2 was totally dependent on facility staff for all his health care needs. -The resident mostly slept and made no attempts to get out of bed. -The Director of Operations told PCAs to document every 30 minutes they had observed the resident, except when the resident was in bed. Interview on 12/09/16 at 2:45 pm with Resident #2's family member revealed: -The resident used to have issues with getting up and there was a fear of the resident falling, so the strap was ordered. -Lately, Resident #2's muscles in his legs and feet were weak from non-use, and the resident was unable to bear weight on his legs and feet. -He visited the resident every other day, and Resident #2 was always sleep when he visited. -Staff had told him that sometimes Resident #2 woke up and moved around, but he had not observed that.	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 482	Continued From page 26 -Resident #2 was always put in the high back wheelchair when he was up, and facility staff leaned the head of the chair back and propped up the resident's feet, so he could not get up, if he tried. Refer to interview on 12/07/16 at 3:38 pm and 12/09/16 at 4:00 pm with the Director of Operations. Refer to interview on 12/09/16 at 10:34 am with the RCC. Refer to interview on 12/09/16 at 3:15 pm with the second shift PCA. Refer to facility's restraint policy. 2. Observation during the initial tour on 12/07/16 at 9:37 am revealed: -Resident #2 was lying in the bed. -The resident was positioned with his face to the wall and his back was positioned four to six inches from the half side rail. -The resident's wheelchair was near the bed, but not against the bed. Observation on 12/08/16 at 11:48 am revealed: -Resident #2 was sleep in bed. -The resident's face was toward the wall and his back toward the half side rail. Interview on 12/08/16 at 11:52 am with a first shift PCA revealed: -Resident #2 slept a lot, they usually had to wake the resident to eat. -The Director of Operations instructed staff to initial they had checked on Resident #2 every 30 minutes when the resident was up in his high back chair.	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

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D 482	Continued From page 27 -The side rails were to keep Resident #2 from rolling out of the bed and staff did nothing special for residents with side rails. -Resident #2 was seldom awake, and did not do much, other than sleeping. Interview on 12/09/16 at 10:00 am with the RCC revealed; -Resident #2 had a gel cushion in the chair to help with pressure points. -Resident #2 had 1 side rail on the left side and the right side against the wall to keep him from falling out of bed. Interview on 12/09/16 at 2:45 pm with Resident #2's family member revealed: -He had never seen the resident try to get out of bed. -He would be concerned if there were no side rails because he could see Resident #2 rolling out of bed onto the floor. Attempted interview via telephone on 12/07/16 with Resident #2's physician revealed no return phone call prior to exiting the survey. Based on record review, and observation it was determined that Resident #2 was not interviewable. Refer to interview on 12/07/16 at 3:38 pm and 12/09/16 at 4:00 pm with the Director of Operations. Refer to interview on 12/09/16 at 10:34 am with the RCC. Refer to interview on 12/09/16 at 3:15 pm with the second shift PCA.	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

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D 482	Continued From page 28 Refer to facility's restraint policy. C. Review of Resident #1's current FL2 dated 02/10/16 revealed: -Diagnoses included Alzheimer's dementia, diabetes, symbolic dysfunction, depression, anemia, and hyperlipidemia. -Disorientation was constant, semi-ambulatory using a wheelchair, and incontinent with bowel and bladder. Review of Resident #1's record revealed a physician's order for "side rails," signed by the physician on 12/16/15. Review of Resident #1's record revealed: -A facility form signed by resident's guardian on 12/18/15. -The form documented "½ rails were on the hospital bed, it was the best interest for safety and comfort reasons, and the resident would not get tangled up in or trapped in the ½ rails. The ½ rails will not be used as a restraint but more as a mobility aide in repositioning and getting out of bed." Review of Resident #1's Personal Care Physician authorization and Care Plan signed by the physician on 07/06/16 revealed: -Resident #1 required extensive assistance with eating, toileting, ambulation, bathing, dressing, grooming, and transferring. -No documentation related to the resident's need for the side rails or use of alternatives. Observation on 12/07/16 at 9:37 am of Resident #1 revealed the resident was sitting in a wheelchair, in the facility's common living room. Observation on 12/07/16 at 9:47 am of Resident	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

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D 482	Continued From page 29	D 482		

#1's room revealed two 1/2 side rails were attached to the resident's bed.

Interview on 12/08/16 at 3:06 pm and 3:15 pm with a second shift PCAs revealed:
-Resident #1 was non-ambulatory and needed extensive assistance with bathing and dressing.
-Resident #1's side rails were put up to keep the resident from rolling out of bed.
-There was a safety concerns because the resident could not transferring herself.
-The resident moves around in the bed.

Interview on 12/09/16 at 10:34 am with the RCC revealed:
-Resident #1 was a 2 person assist, because the resident did not walk, just stand and pivot.
-Resident #1 had to be redirect a lot because she got ridged at times, and was confused about commands.
-The staff puts the wheelchair against her bed and side rail to keep the resident from getting out of bed and falling.
-Resident #1 could get tangled up in the sheets and blanket.
-She was not sure if the resident was caught between the mattress and side rail she could get herself out.
-She was unable to recall the resident experiencing falls since admission to the facility in 2014.

Interview on 12/08/16 at 3:03 pm with Resident #1's guardian revealed:
-The resident had declined since her admission to the facility in 2014.
-Initially, the ½ bed rails were used to help the resident reposition herself in bed.
-If the resident was no longer was able to use the side rails for repositioning then she was okay with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 482	Continued From page 30	D 482		

the facility removing them.
-Resident #1 had no incidents of falls at the facility.
-She feels that the resident does not have the upper body strength like she used to.

Interview on 12/07/16 at 4:35 pm with the second shift PCA revealed:
-Resident #1 had 2 side rails, which were used to keep the resident from falling out of the bed.
-The resident did not try to get up but rolled in her sleep.
-If the resident was caught between the side rail and mattress, she could not get herself out.

Interview on 12/08/16 at 11:48 am with the first shift PCA revealed:
-Resident #1 had two side rails that were used to prevent the resident from falling out of bed.
-The resident did not move much when in the bed due a fear of falling.
-Resident #1 did not like staff turning her on her side because the resident feared falling out of bed.
-Prior to coming to the facility, Resident #2 had a fall that resulted in a broken hip; now the resident had a fear falling out of bed.
-The resident did not verbally tell her she was afraid of falling out of bed, but the resident yelled "no, no" when staff tried to reposition the resident on her side.
-The resident's family member told her the resident had a previous fall that resulted in a broken hip.
-Resident #1 had not falls since her admission to the facility.

Based on record review, observation and attempt interview on 12/07/16, it was determined Resident #1 was not interviewable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 482	Continued From page 31 Attempted interview via telephone on 12/07/16 with Resident #1's physician revealed no return phone call prior to exiting the survey. Refer to interview on 12/07/16 at 3:38 pm and 12/09/16 at 4:00 pm with the Director of Operations. Refer to interview on 12/09/16 at 10:34 am with the RCC. Refer to interview on 12/09/16 at 3:15 pm with the second shift PCA. Refer to facility's restraint policy. D. Review of Resident #7's current FL-2 06/08/16 revealed: -Diagnoses included senile dementia-Alzheimer's type, abnormal gait, mental disorder, muscle weakness, and joint pain. -She was intermittently confused. Review of Resident #7's current care plan dated 07/30/16 revealed: -She required supervision with ambulation and transfers. -She had a Licensed health Professional Support (LHPS) Personal Care Task of medications administered through injections. -She is a wanderer and requires redirection by staff. Review on 12/09/16 of Resident #7's record revealed: -There was no documentation on the every 30 minute checks noted per the facility's policy. -There was 4 falls documented this year to date with injuries requiring an emergency room visit	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 482	Continued From page 32	D 482		

including: a closed head injury with a forehead contusion, a hip and pelvis injury resulting in pain with ambulation and standing, minor hip and pelvis contusion and facial lacerations requiring sutures and glue.
-A signed physicians order dated 07/13/16 for half bed rails due to fall risk.
-A restraint form signed by POA for the use of side rails for mobility aid in repositioning and getting out of bed but not to be used as a restraint.

Observation of Resident #7 on 12/09/16 at 10:34 am revealed:
-She was lying in bed with eyes closed.
-The bed was positioned with one side against the wall.
-The opposite of the bed had a half bed rail in the up position.
-A wheelchair was locked into position against the bottom 1/3 of the bed, at the end of the side rail.
-A call bell was hanging behind the head of the bed.

Interviews on 12/09/16 at 10:00 am with Resident Care Coordinator (RCC) revealed:
-The side rail is in the up position and the wheelchair was placed against the bed when the resident was in bed to prevent the resident from falling out of the bed.
-The resident could not let the side rails down and it was up to the staff to let the side rails down so the resident could get out of bed.
-She has seen the resident attempt to get out of bed around and over the bed rails or the wheelchair.
-The resident is not physically able to get out of bed independently, so the wheelchair is parked and locked at the end of the bed so they can keep her from getting out of the bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 482	Continued From page 33 -The resident is a fall risk and was not physically capable of walking where she wanted to, but staff did not allow her to ambulate independently because she is a high risk for falls and could not hold her weight alone. -The resident moves around in the bed. -She does not consider side rails or positioning of the wheel chair at the end of the side rails, along the side of the bed to prevent the resident from exiting and/or falling out of bed a restraint. -She considers restraints as "lap belts (velcro belts) and tie downs". -She feels that placing the resident in the bed with the siderail up and the wheelchair placed at the end of the siderail forces the resident to call for help but can see that with the resident having dementia could be at risk for injury. Interviews on 12/09/16 at 3:15 pm with a Personal Care Assistant (PCA) revealed: -The side rail was in the up position and the wheelchair was placed against the bed when the resident was in bed to prevent the resident from falling out of the bed. -The resident could not let the side rails down and it was up to the staff to let the side rails down so the resident could get out of bed. -She had never seen the resident attempt to get out of bed around or over the bed rails or the wheelchair. -The resident is not physically able to get out of bed independently, so the wheelchair is parked and locked at the end of the bed so they can keep her from getting out of the bed. -The resident is a fall risk and was not physically capable of walking where she wanted to, but staff did not allow her to ambulate independently because she was a high risk for falls and could not hold her weight alone. -The resident does move around in the bed and	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 482	Continued From page 34	D 482		

has been known to "scoot" to the bottom of the bed to get out.
-She does not consider side rails or positioning of the wheel chair at the end of the side rails, along the side of the bed to prevent the resident from exiting and/or falling out of bed a restraint.
-The bed against the wall, with the other side rail up and the wheelchair at the bottom of the rail keeps the resident in the bed and then they must use the call bell for us to help them out. "This is how we are trained".

Interview on 12/12/16 with Resident #7's Power of Attorney (POA) at 9:15 am revealed:
-The side rails are to keep the resident in the bed because she has fallen many times but only once at the facility.
-The resident does not have enough strength to use side rails to pull up in the bed or to get herself out if becomes trapped between the mattress and side rail.
-She is more concerned about falling out of bed and getting a broken hip.
-The resident uses the side rails to keep from falling out of bed and stated that she could get trapped in the sheets and blankets trying to get out if staff does not let the side rail down.

Refer to interview on 12/07/16 at 3:38 pm and 12/09/16 at 4:00 pm with the Director of Operations.

Refer to interview on 12/09/16 at 10:34 am with the RCC.

Refer to interview on 12/09/16 at 3:15 pm with the second shift PCA.

Refer to facility's restraint policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 482	Continued From page 35	D 482		

E. Review of Resident #8's current FL-2 dated 04/26/16 revealed:
-Diagnoses included dementia, disorientation, depressive disorder, history of falls, and abnormal gait.
-The resident was semi-ambulatory and intermittently confused.

Review of Resident #8's current care plan dated 08/01/16 revealed:
-She required supervision with ambulation and transfers.
-She had no Licensed health Professional Support (LHPS) Personal Care Tasks noted.

Review of Resident #8's LHPS Evaluation dated 04/30/16 revealed:
-She was confused at times.
-She was ambulatory and required no assistance.
-She had no LHPS tasked noted.

Review of resident #8's Pre-admission Screening Assessment of Special Care Unit dated 04/26/16 revealed:
-She had occasionally disorientation and inability to understand.
-She had occasional wandering.
-She required limited assistance with ambulation.

Interview and observation with Resident #8 on 12/09/16 at 10:34 am revealed:
-She was lying in bed.
-The bed was positioned with one side against the wall.
-The opposite of the bed had a bed rail in the up position.
-A wheelchair was locked into position against the bottom 1/3 of the bed, at the end of the side rail.
-Resident #8 stated that she cannot put down the side rail and the staff has to let her out.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 482	Continued From page 36 -Sometimes she "scoots to the bottom of the bed and gets out that way". -She has to scoot to the bottom of the bed often. Review of Resident #8's record on 12/09/16 revealed a signed physicians order dated 08/03/16 for side rails. Review of Resident #8's record on 12/09/16 revealed a facility form signed by POA for the use of side rails for mobility aid in repositioning and getting out of bed but not to be used as a restraint. Review of Resident #8's record on 12/09/16 revealed: -A resident care note dated 11/11/16 thru 11/30/16 with documentation of: resident #8 not being able to walk and needing 2 person assistance, not wanting to stand even with a 2 person assistance, resident found in floor in bedroom, resident continuing to get up and walk without assistance and falling a lot because her legs wont hold her up anymore, a fall in the bathroom, getting up and stumbling, not able to put words together and more confusion. Review of Resident #8's record revealed no additional assessment or care plan documented since 08/01/16. Interviews on 12/09/16 at 10:00 am with Resident Care Coordinator (RCC) revealed: -The side rail was in the up position and the wheelchair was placed against the bed when the resident was in bed to prevent the resident from falling out of the bed. -The resident could not let the side rails down and it was up to the staff to let the side rails down so the resident could get out of bed.	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 482	Continued From page 37	D 482		

-She has seen the resident attempt to get out of bed around and over the bed rails or the wheelchair.
-The resident was not physically able to get out of bed independently, so the wheelchair is parked and locked at the end of the bed so they can keep her from getting out of the bed.
-The resident was a fall risk and was not physically capable of walking where she wanted to, but staff did not allow her to ambulate independently because she was a high risk for falls and could not hold her weight alone.
-The resident is capable of becoming trapped between the mattress and side rail and could get tangled up in the covers trying to get out of bed and then could fall.
-She does not consider side rails or positioning of the wheel chair at the end of the side rails, along the side of the bed to prevent the resident from exiting and/or falling out of bed constituted a restraint.
-She considers restraints as "lap belts (velcro belts) and tie downs".
-She feels that placing the resident in the bed with the siderail up and the wheelchair placed at the end of the siderail forces the resident to call for help but can see that with the resident having dementia could be at risk for injury.

Interviews on 12/09/16 at 3:15 pm with a Personal Care Assistant (PCA) revealed:
-The side rail was in the up position and the wheelchair was placed against the bed when the resident was in bed to prevent the resident from falling out of the bed.
-The resident could not let the side rails down and it was up to the staff to let the side rails down so the resident could get out of bed.
-She had never seen the resident attempt to get out of bed around or over the bed rails or the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 482	Continued From page 38	D 482		

wheelchair.
-The resident was not physically able to get out of bed independently, so the wheelchair is parked and locked at the end of the bed so they can keep her from getting out of the bed.
-The resident is a fall risk and is not physically capable of walking where she wanted to, but staff did not allow her to ambulate independently because she is a high risk for falls and could not hold her weight alone.
-The resident does move around in the bed.
-She does not consider side rails or positioning of the wheel chair at the end of the side rails, along the side of the bed to prevent the resident from exiting and/or falling out of bed a restraint.
-The bed against the wall, with the other side rail up and the wheelchair at the bottom of the rail keeps the resident in the bed and then they must use the call bell for us to help them out. "This is how we are trained".

Telephone interview on 12/12/16 with Resident #8's Power of Attorney (POA) at 9:00 am revealed:
-Most of the resident's falls were while getting out of bed, and changing clothes and he was fine with rails to prevent the resident from getting out of bed and falling at night.
-The resident is sometimes confused and "forgets" to call for assistance and will try to do on her own.
-The resident "scoots" to the bottom of the bed to get out and will climb over the wheelchair at the end of the bed.
-The resident used the side rails to keep from falling out of bed and stated that she could get trapped in the sheets and blankets trying to get out if staff does not let the side rail down.

Refer to interview on 12/07/16 at 3:38 pm and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 482	Continued From page 39 12/09/16 at 4:00 pm with the Director of Operations. Refer to interview on 12/09/16 at 10:34 am with the RCC. Refer to interview on 12/09/16 at 3:15 pm with the second shift PCA. Refer to facility's restraint policy. Interview on 12/07/16 at 3:38 pm and 12/09/16 at 4:00 pm with the Director of Operations revealed: -She did not consider ½ side rails restraints, or full side rails as restraint. -She had been previously told that ½ bed rails were not restraints, but was unable to recall who told her. -She was aware staff were placing the wheelchair against the side of the bed, at the end of the side rail to block the residents from exiting the bed and falling. -She was aware facility staff did not follow restraint protocol because ½ rails were not considered restraints. -She did not consider a wheelchair beside a resident's bed, at the end of a side rail to the bottom of the bed to be a restraint. -She did consider it an issue if the residents became tangled in the sheets and blankets and tried to get out of the bed over the wheelchair or the side rails. -Staff had been trained to use restraints because 2 residents had lap buddies, which were restraints or a hazard. -Per the facilities policy there was to be 30 minute checks on all residents that had restraints. -She only had two residents with restraints (Velcro strap). -I have an order for the restraint and side rails,	D 482		

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	HAL029010	A. BUILDING: _____ B. WING _____	12/12/2016

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D 482	Continued From page 40	D 482		

nothing else is needed.
-There was no documentation for the use of alternatives to restraints because she had not tried alternatives, she was unaware of the type of alternatives to use.

Interview on 12/09/16 at 10:34 am with the RCC revealed:
-All residents have to be let out of the bed by staff because of the side rails.
-The facility used side rails to keep residents from getting out of bed and falling.
-When the residents were in bed staff always put the side rails up.
-The wheelchair was parked at the end of the bed, at the end of the bed rail to keep the resident from getting out of the bed.
-Residents could get tangled in the sheets and covers, and could fall over the wheelchair or side rail.

Interview on 12/09/16 at 3:15 pm with the second shift PCA revealed:
-Wheelchairs were kept beside most residents' bed, placed at the end of the side rail to keep the resident from getting out of bed.
-Residents could get caught up in the sheets and covers and could get hurt.
-Residents could also fall over the wheelchair or side rails, but wheelchairs and side rails were not restraints.

Review of the facility's restraint policy revealed:
-Restraints cannot be used for discipline or staff convenience, and can only be applied for medical symptoms such as confusion with the risk of falls or abusive and injurious behaviors to self or others.
-Alternatives must be tried before the use of physical restraints and documented such as:

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D 482	Continued From page 41 physical therapy to restore mobility, devices that assist, frequent monitoring by staff, pain control, family involvement, communication. -Physician restraint order must be obtained prior to application of restraints, and must include the following: resident's name, medical reason for restraints, type of restraint to be used, time period restraint is to be used, time intervals the restraint must be checked, loosened, and removed, signature of physician. -A consent for physician restraint use that consist of benefits and risk shall be signed by the resident and/or resident representative. -A restraint assessment and care plan shall be developed. -Staff shall document on the restraint use oversight record. The facility failed to consistently obtain a complete physician's order, provide assessment and care planning, and document attempted alternatives to restraints, strapping 2 residents to their wheelchair (Residents #2 and #6), and using side rails and the resident's wheelchair to keep the resident from falling and getting out of bed for 5 of 5 sampled residents (Residents #1, #2, #6, #7 and #8). The facility's failure to monitor the residents put residents at substantial risk of falling over the wheelchairs or smothering getting caught between the mattresses and bed rails which was detrimental to the health and safety of the residents and constitutes a Type B Violation. On 12/09/16, the facility submitted a Plan of Protection as follows: -The facility will make a list of all who have restraints. -Monday the RCC and Supervision will pull all charts and orders for the physician to see on Wednesday and write detailed orders according	D 482		

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D 482	Continued From page 42 to regulations. -The RCC will access all residents need for restraints. -The Director will instruct all staff on the use and documentation of restraints. -The Director will ensure the nurse assesses all residents for the restraints and makes adequate documentation. CORRECTION DATE FOR THE B VIOLATION SHALL NOT EXCEED JANUARY 26, 2017.	D 482		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding use of restraints. The findings are: Based on observation, interview and record review, the facility failed to assure physical restraints, including side rails were used only after an assessment and care planning process had been completed and used only after alternatives had been tried and a physician's order obtained	D912		

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D912	Continued From page 43 for 5 of 5 sampled residents (Residents #1, #2, #6, #7 and #8) with restraints. [Refer to Tag 482, 10A NCAC 13F .1501 (a) (Type B Violation).]	D912		