Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING			
		HAL029010	B. WING		12/12/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
GRAYSON	CREEK OF WELCOME		US HWY 52 N, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 000	Initial Comments		D 000			
	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 280	10A NCAC 13F .0903(c) Licensed Health Professional Support		D 280			
	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.					
	reviews, the facility fa	as evidenced by: ns, interviews, and record hiled to ensure the quarterly essional Support (LHPS) hipleted within 30 days from				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION (X3) D. A. BUILDING:			
		HAL029010	B. WING	<u></u>	12	2/12/2016
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE		
GRAYSO	N CREEK OF WELCOME		O US HWY 52 ON, 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 1 DEFICIENC	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE
D 280	task and included a p evaluation of the resider recommendations for sampled residents (R #8) with LHPS tasks of restraints. The findings are: A. Review of Resider O7/24/16 revealed: -Diagnoses included of Disoriented constant incontinent of bladder 1. Review of a physic revealed for "soft Velot Review of Resident # Physician's authorizated by the physician on O'-Resident #6 required eating, toileting, ambut grooming and transferating, toileting, ambut grooming and transferating to the facility reversident #6 resided -The resident was sitt common living room, -The resident and the versident and the versident ends of the strategother using Velcro and the resident using Velcro and the velcro using V	eveloped the need for the hysical assessment, dent's progress to care, and changes in care for 5 of 5 esidents #1, #2, #6, #7 and of caring for physical Int #6's current FL2 dated Alzheimer's dementia. Ily, ambulatory with walker, and bowel. Isan's order dated 09/28/16 cro strap." 6's Personal Care tion and Care Plan signed 7/24/16 revealed: I extensive assistance with clation, bathing, dressing, rring. Pelcro strap were not of Resident #6's plan of care. In the special care unit. In the special care unit. In gin a wheelchair in the in front of the television. I wide strap wrapped waist that extended around wheelchair. In were attached to each do prevented movement. In a strength to move, but	D 280			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			
		HAL029010	B. WING		12/12/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GRAYSON	I CREEK OF WELCOME		US HWY 52 DN, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 280	Continued From page	2	D 280			
	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."					
	08/21/16The form documente hospital bed, it was the and comfort reasons, get tangled up in or trails will not be used a	6's record revealed: I by resident's guardian on ed "½ rails were on the ne best interest for safety and the resident would not apped in the ½ rails. The ½ as a restraint but more as a itioning and getting out of				
	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.					
	at 10:30 am with the (RCC) in the special of the strap was used was out of bed. -The strap was used the strap was used to	daily; any time Resident #6 to keep the resident from chair because the resident				
	revealed: -The resident was in wheelchair.					

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GRAYSON CREEK OF WELCOME (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGGED TO THE APPROPRIATE DATE D 280 Continued From page 3 wheelchair, and preventing movementThe strap was closed by attaching both ends using VelcroThe resident was moving her legs around and the chair moved with the residentIt 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 roomThe 6" wide strap was wrapped around the resident's waist and the chair and closed behind the back using Velcro.		F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6781 OLD US HWY 52 LEXINGTON, NC 27295 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 280 Continued From page 3 wheelchair, and preventing movementThe strap was closed by attaching both ends using VelcroThe resident was moving her legs around and the chair moved with the residentIt 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 roomThe 6" wide strap was wrapped around the resident's waist and the chair and closed behind				P WINC				
GRAYSON CREEK OF WELCOME (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 280 Continued From page 3 wheelchair, and preventing movementThe strap was closed by attaching both ends using VelcroThe resident was moving her legs around and the chair moved with the residentIt 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 roomThe 6" wide strap was wrapped around the resident's waist and the chair and closed behind						12/12	2/2016	
CX4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE D 280 Continued From page 3 D 280 Wheelchair, and preventing movement.	NAME OF P	ROVIDER OR SUPPLIER		, ,	TE, ZIP CODE			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 280 Continued From page 3 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	GRAYSON	CREEK OF WELCOME						
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	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETE	
Observation on 12/08/16 at 11:43 am of Resident #6 revealed: -Resident #6 was up in her wheelchair in the common living roomThe 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 upShe was aware the lap buddy was a restraintThe RN completed an LHPS evaluation on Resident #6 quarterly, but had not addressed restraint care practicesThe 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	D 280	wheelchair, and preverance of the strap was closed using Velcro. The resident was more the chair moved with a cloud not be deterrated the pottom from the complete of the pottom from the pot	enting movement. d by attaching both ends oving her legs around and the resident. mined if the resident was because she could not raise shair. 6/16 at 8:23 am of Resident ting upright in a wheelchair the the dining room. as wrapped around the the chair and closed behind over the dining room. for at 11:43 am of Resident in her wheelchair in the the chair and closed behind over the dining room. as wrapped around the the chair and closed behind over the dining room. as wrapped around the the chair and closed behind over the dining room. as wrapped around the the chair and closed behind over the dining room. as wrapped around the the chair and closed behind over the dining room. as wrapped around the the chair and closed behind over the dining room. as wrapped around the the chair and closed behind over the dining room. as wrapped around the the chair and closed behind over the dining room. as wrapped around the the chair and closed behind over the dining room. as wrapped around the the chair and closed behind over the dining room. as wrapped around the the chair and closed behind over the dining room. as wrapped around the the chair and closed behind over the dining room. as wrapped around the the chair and closed behind over the dining room. as wrapped around the the chair and closed behind over the dining room. as wrapped around the the chair and closed behind over the dining room. as wrapped around the the chair and closed behind over the dining room. as wrapped around the the chair and closed behind over the dining room. as wrapped around the the chair and closed behind over the dining room. as wrapped around the the chair and closed behind over the dining room. as wrapped around the the chair and closed behind over the dining room. as wrapped around the the chair and closed behind over the dining room. as wrapped around the the chair and closed behind over the dining room. as wrapped around the the chair and closed behind over the dining room.	D 280				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		HAL029010	B. WING		12/12/	2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GRAYSON	I CREEK OF WELCOME		US HWY 52 ON, NC 27295			
	OUR MARK OT		<u> </u>	DD0/#DEDI0 DLAM 05 00DD50	T.0.1	
(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 CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
D 280	Continued From page	e 4	D 280			
	bladder.	ors disturbance.				
	and Care Plan signed 06/14/16 revealed: -Resident #2 required eating, toileting, ambugrooming, and transfe	I extensive assistance with ulation, bathing, dressing, er. strap were not addressed in				
	Observation during the initial tour on 12/07/16 at 9:37 am revealed: -Resident #2 was lying in the bedThe resident was positioned with his face to the wall and his back was positioned four to six inches from the half side railThe resident's wheelchair was near the bed, but not against the bed.					
	#2 revealed: -The resident was in a the hallway, outside the land hallway, outside the land hallway, outside the land hallway, the second hall hall hall hall hall hall hall hal	" wide soft strap wrapped strap extended to the back ed in the back by attaching o. down in the chair with the s breast. eyes closed, and made no yn.				
		7/16 at 12:00 pm of Resident				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY PLETED	
		HAL029010	B. WING		12	2/12/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	·	
CD AVCO	LODEEK OF MELCOME	6781 OLI	D US HWY 52			
GRAYSU	N CREEK OF WELCOME	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 OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 280	Continued From page	e 5	D 280			
		ent was still slid down in the with Velcro strap under his				
		7/16 at 12:05 pm revealed esident up in the chair and groom.				
	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 roomResident #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 otherThere was a 6" wide strap around the resident's upper waistThe strap extended around the chair and closed in the back of the chair with Velcro.					
	-Two Personal Care A Resident #2 up in the and the chair to the d	chair, and took the resident				
	-Resident #2 had his -There was a ½ side bed, and the right sid wall. -Resident #2 was pla	8/16 at 11:48 am revealed: eyes closed and in bed. rail on the left side of the e of the bed was against the ced on his side with his face				
	rail.	lis back toward the half side lchair was placed at the end long side of the bed.				
	10/30/16 revealed: -The Registered Nurs	evaluation completed on se (RN) completing the ed the tasks of fingerstick tory, ambulation and				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION		
AIND FLAIN (O CONNECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED	
		HAL029010	B. WING		12/12/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
GRAYSON	I CREEK OF WELCOME		O US HWY 52			
040.15	STIMMADA ST	ATEMENT OF DEFICIENCIES	ON, NC 27295	PROVIDER'S PLAN OF CORRECTIO	N OVE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 280	Continued From page 6		D 280			
	transferringThe 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 downThe strap was also used to keep the resident					
	from sliding downResident #2 slept a lot, and made no attempt to					
		used to keep the resident				
	from sliding down and	d 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 esident from falling out of				
	-Resident #2 was lyin closed.	3/16 at 11:48 am revealed: g in bed with his eyes				
	bed and the right side the wall.	rail on the left side of the of the bed was up against				
	bed.	chair was at the foot of the				
	-The resident's face v back toward the half s	vas toward the wall and his side rail.				
	Interview on 12/08/16	at 11:52 am with a first shift				

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PCA revealed:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL029010	B. WING		12/12/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GRAYSO	CREEK OF WELCOME	6781 OLD I LEXINGTO	JS HWY 52 N, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 280	rolling out of the bed a special for residents was selemuch, other than sleet much, other than sleet much much much much much much much much	re to keep Resident #2 from and staff did not nothing with side rails. dom awake, and did not do eping. ew, and observation it was dent #2 was not at 3:38 pm with the Director d: ap buddy" when the resident ving part of the facility. Hospice two weeks and resident was admitted to been assessed to ensure aint. Resident #2's bed were not ey are not stopping the nything, but keeping the bed. In LHPS evaluation on but did not address as. Implete LHPS evaluations raint because the LHPS ne needed to be completed. Alzheimer's dementia, sfunction, depression,	D 280			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X3) DA A. BUILDING:			
		HAL029010	B. WING		12	2/12/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
GRAYSO	N CREEK OF WELCOME		D US HWY 52			
	T		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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 280	Continued From page	8	D 280			
D 2000	authorization and Ca physician on 07/06/16 -Resident #1 required eating, toileting, ambu grooming, and transfe -No documentation re for the side rails or us Review of Resident # dated 10/30/16 revea regarding the need for alternatives used. Observation on 12/07 #1 revealed the reside wheelchair in the facile	re Plan signed by the 6 revealed: I extensive assistance with plation, bathing, dressing, erring. Plated to the resident's need are of alternatives. 1's Profile and Care Plan led no documentation or 1/2 side rails or 1/16 at 9:37 am of Resident ent was sitting in a lity's common living room.	D 200			
	RN on 10/30/16 revealed Find the resident was evaluated ambulation. The usage of restrain addressed as a task. Interview on 12/08/16 shift PCAs revealed Find were put up when the Based on record revieattempted interview of determined Resident.	aluated for the tasks of TED d sugar, transferring and hts and alternatives was not at 3:06 pm with a second Resident #1's 1/2 side rails resident was in bed. ew, observation and in 12/07/16, it was #1 was not interviewable.				
		u. ½ side rails, but they were				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			D WING			
		HAL029010	B. WING		12/12	2/2016
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
GRAYSON	I CREEK OF WELCOME		US HWY 52 N, NC 27295			
(V4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETE DATE
D 280	evaluation on Resider address restraint care address resident #1 becaut Operations did not to restraint and did not to side rails. D. Review of Resident revealed: -Diagnoses included stype, abnormal gait, noweakness, and joint periodic procumentation Resident #1 revealed an admission resident received through injections. -The resident received through injectionsThe resident received through injections.	ints. e completed an LHPS nt #1 quarterly, but did not e practices. completed LHPS evaluations use the Director of nsider the side rails a ell the nurse to evaluate the at #7's current FL-2 06/08/16 senile dementia-Alzheimer's mental disorder, muscle eain. dent #7 was intermittently 7's Resident Register in date of 07/28/15. 7's Licensed Health (LHPS) Review and 80/16 revealed: d medication administration d ambulation using assistive physical assistance. d assistance with chysical assessment as current condition and ided of the resident was " es wheelchair and staff	D 280			
	Review of Resident #	7's Care Plan dated				

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DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
			1	_		
			B. WING			
		HAL029010	D. WING		<u> 12/1</u>	2/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		6781 OLD	US HWY 52			
GRAYSON	I CREEK OF WELCOME		N, NC 27295			
			TN, NC 27295			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
IAG	TEODE TOTAL OILE	100 IDENTIFICATION OF COMPANIENTS	IAG	DEFICIENCY)		
			+			
D 280	Continued From page	e 10	D 280			
	07/10/15 revealed:					
		ory with wheelchair status.				
		assistance by staff with				
	_	and locomotion, bathing,				
	dressing and transfer	-				
	-LHPS tasks listed on					
		eekly, weight monthly, finger				
	stick blood sugars, care of pressure ulcers,					
	medication administra	ation through injections,				
	oxygen administration	n and monitoring, and TED				
	hose on in the am and	-				
		•				
	Review of Resident #	7's Profile and Care Plan				
	dated 07/30/16 revea					
	-She required supervi					
		assistance by staff with				
	toileting, ambulation a					
	_	extensive assistance with				
	bathing.	extensive assistance with				
	•	the Care Plan were for				
		ered through injections.				
		0 ,				
		signed by a Registered				
	Nurse and a physicial	n.				
	01 (1 (5))					
		ent #7 on 12/09/16 at 10:34				
	am revealed:					
	-	g in bed with eyes closed.				
	 The bed was position 	ned with one side against				
	the wall.					
		ped had a half bed rail in the				
	up position.					
	-A wheelchair was loo	cked into position against the				
	bottom 1/3 of the bed	, at the end of the side rail.				
		ng behind the head of the				
	bed.	-				
	Interview on 12/09/16	at 10:34 am with a				
	Medication Aide (MA)					
		ent with transfers blood				

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pressure monitoring weekly and monthly weights.

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Division of	Division of Health Service Regulation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		PLETED
		HAL029010	B. WING		12	2/12/2016
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
GRAYSON	I CREEK OF WELCOME		US HWY 52			
		LEXINGT	ON, NC 27295	Ţ		
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE A	APPROPRIATE	DATE
			-	,		_
D 280	Continued From page	e 11	D 280			
	-Sometimes she redir dementia.	rected the resident due to				
	Interview on 12/09/16	S at 3:15 nm with the				
	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 necessa	ry.				
	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					
	-She was semi-ambu confused.	latory and intermittently				
	Review of Resident # 04/26/16 revealed:	8's Care Plan dated				
		ision with ambulation and				
		assistance with toileting,				
		g and personal hygiene.				
	-She needed extensive	ve assistance with bathing				
	and dressing.	inned hore Devictored None				
	and a Physician.	igned by a Registered Nurse				
	and a r mysician.					
		8's current care plan dated				
	08/01/16 revealed: -She needed limited a	assistance with bathing,				
	dressing and toileting					
		sion with ambulation and				
	transfers.					
	-She had no Licensed					
	Support (LHPS) Pers	onal Care Tasks noted.				
	Review of Resident #	8's LHPS Review and				
	Evaluation dated 04/3					
	-She was confused a					

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-She was ambulatory and required no assistance.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		HAL029010	B. WING		12	2/12/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
GRAVSON	N CREEK OF WELCOME	6781 OLI	D US HWY 52			
GRATSON	CREEK OF WELCOME	LEXINGT	ON, 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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 280	Continued From page	: 12	D 280			
	-She had no LHPS ta	sked noted.				
	Assessment of Special revealed: -She had occasionally to understandShe had occasional value.	o's Pre-admission Screening al Care Unit dated 04/26/16 or disorientation and inability wandering. assistance with ambulation.				
	10:34 am revealed: -She was at the botto -She was confused to	time and place. along the side of the bed at				
	Care Aide (PCA) reverse -She provided assistated Resident #8 which incomes -Resident #8 was a 2 had become much we	ince with personal care for cluded dressing and bathing. person assist because she				
		revealed: lost total care and was not lakness and not following				
	#8's Power of Attorne -He was very pleased the staff at the facility -He was aware of a fe months.	with the care provided by				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		HAL029010	B. WING		12/12/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
0041/001	LODGEK OF WELCOME	6781 OLD	US HWY 52		
GRAYSON	I CREEK OF WELCOME	LEXINGT	ON, NC 27295		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DN (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 280	Continued From page	e 13	D 280		
	weakerHe was not aware if physical therapy.	Resident #8 was getting			
D 482	10A NCAC 13F .1501 Restraints And Alterna	•	D 482		
	10A NCAC 13F .1501 And Alternatives	Use Of Physical Restraints			
	(a) An adult care home shall assure that a				
	physical restraint, any physical or mechanical				
	device attached to or	adjacent to the resident's			
		t cannot remove easily and			
	-	m of movement or normal			
	access to one's body	, shall be:			
	_	circumstances in which the			
	resident has medical	symptoms that warrant the			
	use of restraints and	not for discipline or			
	convenience purpose	es;			
		ritten order from a physician			
	except in emergencie	s, according to Paragraph			
	(e) of this Rule;				
	(3) the least restrictive	e restraint that would			
	provide safety;				
	, , , , , , , , , , , , , , , , , , ,	ernatives that would provide			
		and prevent a potential			
		t's functioning have been			
		d in the resident's record.			
	, , , , , , , , , , , , , , , , , , ,	assessment and care			
		been completed, except in			
	-	ing to Paragraph (d) of this			
	Rule;	according to the			
	(6) applied correctly a	ctions and the physician's			
	order; and	cuons and the physician's			
		n with alternatives in an			
	effort to reduce restra				
		estraints when used to keep			
		tarily getting out of bed as			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	HAL029010		B. WING		12/12/2016
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	12/12/2010
GRAYSON	I CREEK OF WELCOME		JS HWY 52 N, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 482	while in bed. Example are: providing restorations abilities to stand safet device that monitors a bed, placing the bed if frequent staff monitor in toileting and ambul providing activities, or environment with min and providing support cushions. This Rule is not met	g mobility of the resident es of restraint alternatives ative care to enhance ly and walk, providing a attempts to rise from chair or ower to the floor, providing ing with periodic assistance ation and offering fluids, ontrolling pain, providing an imal noise and confusion, tive devices such as wedge	D 482		
	review, the facility fail restraints, including s an assessment and c been completed and a had been tried and a for 5 of 5 sampled res#6, #7 and #8) with res. The findings are: A. Review of Residen 07/24/16 revealed: -Diagnoses included a -Disoriented constant incontinent of bladder 1. Review of Residen physician's order date strap."	ide rails were used only after are planning process had used only after alternatives physician's order obtained sidents (Residents #1, #2, estraints. It #6's current FL2 dated Alzheimer's dementia. Ily, ambulatory with walker,			

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HAL029010 B. WING	12/12/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6781 OLD US HWY 52	
GRAYSON CREEK OF WELCOME LEXINGTON, NC 27295	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATION) TAG CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	D BE COMPLETE
tour of the facility revealed: -Resident #6 resided in the special care unitThe resident was sitting in a wheelchair in the common living room, in front of the televisionThe resident had a 6" wide strap wrapped around the resident's waist that extended around the resident and the wheelchairBoth ends of the strap were attached to each other using Velcro and prevented movementThe 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 08/03/16 Resident #6 kept trying to get up from wheelchairOn 08/03/16 Resident #6 keeps trying to get up from wheelchairOn 08/03/16 Resident #6 would not stand for staff, when left in her wheelchair there is the resident tried to get up and standOn 08/11/16 Resident #6 got out of wheelchair and put self on couchOn 08/11/16 Resident #6 wanting to get up and walk without a walker, reaches out and grabs a lot of things around herOn 08/13/16 Resident #6 is getting out of her	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL029010	B. WING		12/12/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
GRAYSON	I CREEK OF WELCOME	6781 OLD	US HWY 52		
		LEXINGT	ON, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 482	Continued From page	e 16	D 482		
D 402	wheelchair and pushir-On 08/19/16 Resider her wheelchairOn 08/21/16 Resider wheelchairOn 08/23/16 Resider up from wheelchairOn 08/27/16 Resider wanting to walk with r-On 11/01/16 "had to -On 11/02/16 "had to -On 11/03/16 "had to -O	In the sept trying to get out of and the september and October The strap wrapped around the september daround the september to the september and October The strap wrapped around the september to the september and October The strap wrapped around the september and October The strap wrapped around the september to the september and October The strap wrapped around the september to the september and October The strap wrapped around the september to the september and october The strap wrapped around the september around the september around the september around and the resident to the september around and the resident. The strap wrapped around and the september around the s	D 402		
		as wrapped around the he chair and closed behind			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL029010	B. WING		12	2/12/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STAT	E, ZIP CODE		
GRAYSON	N CREEK OF WELCOME	6781 OLD	US HWY 52			
GIVATOO	TORLER OF WELCOME	LEXINGT	ON, 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 TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 482	Continued From page	: 17	D 482			
	#6 revealed: -Resident #6 was up i common living roomThe 6" wide strap wa	/16 at 11:43 am of Resident in her wheelchair in the as wrapped around the ne chair and closed behind .				
	the 1st and 2nd shift r -The reason for the do had a Velcro restraint -Staff on the first and	nber 1 through 8th, 2016 on revealed: ocument was Resident #6 second shifts document ne velcro strap in place,				
	at 10:30 am with the R (RCC) in the special of Resident #6 often trie wheelchair. -The strap was used to getting up out of the of Resident #6 had Alzti-The resident does not walk and often fell to not stand on her legs. -The resident now recombulation and transfor move her legsIn September 2016, 19	ed to get out of her to keep the resident from thair. neimer's and was confused. of remember she cannot the floor because she could				
	-She was not sure ho maneuver it, but Resi the strap twice since s -It was the facility's po restraints on 30 minut	olicy to residents with				

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DIVISION	n nealth Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING:		COMPL	LETED
		HAL029010	B. WING		12/	12/2016
NAME OF D	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE ZIR CODE		
NAME OF FI	NOVIDER OR SUFFLIER			TE, ZIF GODE		
GRAYSON	CREEK OF WELCOME		US HWY 52			
		LEXINGTO	ON, NC 27295			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AF DEFICIENCY)	PROPRIATE	DATE
			1	DEFICIENCY)		
D 482	Continued From page	e 18	D 482			
	. •					
	sometimes was relea	sed 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 trie	ed to get up and previously				
		and broke her hip due to a				
	fall.	•				
	-	n tried to get up, but the				
		esident from getting up.				
		when Resident #6 got the				
		<u> </u>				
		operations informed staff to				
		every 30 minutes when in				
	the wheelchair.					
		3 at 3:38 pm with the Director				
	of Operations reveale					
		ap buddy" to keep the				
	resident from getting	up, and falling.				
	-She was aware the la	ap buddy was a restraint.				
	-Staff had been traine	ed to use restraints.				
	-She verbally informe	d staff in the special care				
	•	needed to be checked on at				
		es, and released every two				
	hours.	o, and released every two				
		menting this on the form				
		menting this on the form				
	that she developed.					
		e physician had to write				
		need, hold and release				
	times of the restraint.					
		mplete LHPS evaluations				
	for LHPS for Residen	t #6's restraint because she				
	had not informed the	nurse, being she was				
		as on the LHPS evaluation.				
		at restraint orders had to be				
		months, until it was bought				
	-					
	her attention by the s	urveyor.				
	Interview on 12/12/16	at 2:25 pm with Resident				

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#6's guardian revealed:

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Division c	Division of Health Service Regulation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		ETED
			_			
			5			
HAL029010			B. WING		12/1	2/2016
NAME OF D	DOVIDED OD CUDDUED	CTDEET AD	DDEEC CITY OTA	TE 710 CODE		
NAME OF PE	ROVIDER OR SUPPLIER		DRESS, CITY, STA	II E, ZIP CODE		
GRAYSON	CREEK OF WELCOME	6781 OLD	US HWY 52			
0.0		LEXINGTO	ON, NC 27295			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG			TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
D 482	Continued From nego	- 10	D 482			
D 402	Continued From page	= 19	D 402			
	-The "lap belt" (Velcro	o strap) was used to keep				
	Resident #6 in the wh					
		get up without assistance,				
		roken her hip at another				
	•	Token her hip at another				
	facility.					
		ad "dark days," when she				
	-	ot up and wandered and was				
	unaware what she wa					
		ectrical storms," which was				
	when she did not reco	ognize anyone and				
	wandered, not followi	ng commands, had no idea				
	who or where she wa	is at, she can't understand				
	anything on those day	VS.				
		#6 had a lot of "electrical				
	storm" days.					
		ays Resident #6 will end up				
	_	ned and try to get out of bed.				
		s that Resident #6 will break				
	another hip from fallin	_				
	· ·	had offered or discussed				
		using the strap to keep				
	•	ting up out of the wheelchair.				
	-She did feel Residen	nt #6 could get caught				
	between the mattress	s and side rail, and that was				
	why she and the facili	ity staff used pillows to				
	prevent the resident f	rom getting trapped.				
		possibility that Resident #6				
		rolled over into the pillow,				
		eviously mentioned when				
	the resident was very					
	the resident was very	Cornusea.				
	D ()	10/07/10 10 00				
		12/07/16 at 3:38 pm and				
	12/09/16 at 4:00 pm v	with the Director of				
	Operations.					
	Refer to interview on	12/09/16 at 10:34 am with				
	the RCC.					

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second shift PCA.

Refer to interview on 12/09/16 at 3:15 pm with the

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
			A. BOILDING.	A. BUILDING:		
		HAL029010	B. WING	 	12	2/12/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE		
GRAYSON	N CREEK OF WELCOME	6781 OLD	US HWY 52			
		LEXINGT	ON, 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 TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 482	Continued From page	e 20	D 482			
	Refer to facility's restr	raint policy.				
		t #6's record revealed an hysician on 08/17/16 for nily member request."				
	08/21/16The form documente hospital bed, it was that and comfort reasons, get tangled up in or trails will not be used a	6's record revealed: I by resident's guardian on ed "½ rails were on the ne best interest for safety and the resident would not apped in the ½ rails. The ½ as a restraint but more as a itioning and getting out of				
	-Resident #6 was a 2 ambulation and transful -The resident had 1 s side of her bed was a resident from getting -When the resident wup and the wheelchai bottom side of the bed to keep the resident fi	inator (RCC) revealed: person assist with ferring. ide rail because the other gainst the wall to keep the out of bed. as in bed the side rail was r was positioned at the d, at the end of the side rail rom getting out of bed. y any other alternatives				
	#6 revealed: -Resident #6 was in b -The bed rails were u was against the wall o -Resident #6 was sco	p on the left side, the bed				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		HAL029010	B. WING		12	2/12/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	·	
GPAVSON	I CREEK OF WELCOME	6781 OL	D US HWY 52			
GRAISON	CREEK OF WELCOME	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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 482	Continued From page	21	D 482			
	blanket hanging off th	r, and leg wrapped in the lower left side of the bed and the resident was trying to				
	shift Personal Care A -A wheelchair and sid Resident #6 from get -The resident was "ve stand, and often wan -Resident #6 was alm	e rails were used to keep ting out of bed. ery stubborn" when trying to				
		ria telephone on 12/07/16 ysician revealed no return ting the survey.				
	Based on record review of attempted interview of determined that Residenterviewable.	n 12/07/16, it was				
	12/09/16 at 4:00 pm v Operations.	12/07/16 at 3:38 pm and with the Director of 12/09/16 at 10:34 am with				
	Refer to interview on second shift PCA.	12/09/16 at 3:15 pm with the				
	Refer to facility's restr	raint policy.				
	06/13/16 revealed: -Diagnoses included a dementia with behavi -Disorientation status	ors disturbance.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
		HAL029010	B. WING		12	2/12/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
GRAYSO	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 SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 482	care unit. 1. Review of the a fact change of status form transferred to the specific of the s	cility's form titled "Resident "revealed Resident #2 was cial care unit (SCU) on the in status. Is admission and screening Resident #2's dated derate impairment of the coriented to time, place and all regular assistance with all risk and had a restraint continent requiring full upervision and assistance g, dressing, eating, and the coriented to the SCU) revealed felcro restraint to prevent the content of the Velcro and the coriented to the Velcro and Care Plan signed 6/14/16 revealed: If extensive assistance with continent case of the Velcro and Care the Velc	D 482			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING			
		HAL029010	B. WING		12/12/2016	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
GRAYSON	I CREEK OF WELCOME		US HWY 52 N, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 482	Continued From page	23	D 482			
	-The Velcro restraint of Resident #2's plan	was not documented as part of care.				
	#2 revealed:	7/16 at 11:45 am of Resident				
	 The resident was in a the hallway, outside the 	a high back wheelchair, in he dining room.				
	-Resident #2 had a 6'	' wide soft strap wrapped				
		strap extended to the back ed in the back by attaching				
	both ends with Velcro -Resident #2 had slid	down in the chair with the				
	Velcro strap under his	s breast.				
	 Resident #2 had his movements on his ow 	eyes closed, and made no /n.				
		nt #6 was still slid down in hair with Velcro strap under				
	his breast.					
	-At 12:05 pm the PCA the chair and took him	A pulled the resident up in n to the dining room.				
	Observation on 12/07 #2 revealed:	7/16 at 4:32 pm of Resident				
	-Resident #2 was in a	high back wheelchair, in				
	the hallway outside the Resident had a 6" wi	ie dining room. de soft strap wrapped				
		also extended to the back of nds of the strap attached				
	together with Velcro.	·				
	-Resident #2 had his moved the resident in	eyes closed, and staff to the dining room.				
	Observation on 12/08 #2 revealed:	1/16 at 8:20 am of Resident				
		high back chair, in the				
	hallway outside the di	ining room. ep, and the head of high				
		d back, and the resident's				
	feet were propped up	so that this head and feet				

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were leveled with each other.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HAL029010	B. WING		12	2/12/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STATE	E, ZIP CODE	-	
GRAYSON	N CREEK OF WELCOME	6781 OLD	US HWY 52			
GIVATOOI	VORLER OF WELCOME	LEXINGT	ON, 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 482		strap around the resident's	D 482			
	in the back of the cha -Two Personal Care A	around the chair and closed ir with Velcro. Aides (PCAs) pulled air, and took the resident				
	the 1st and 2nd shift r -The reason for the do had a Velcro restraint -Staff on the first and	nber 1 through 8th, 2016 on revealed: ocument was Resident #6				
	shift PCA revealed: -A strap was put arou the resident up in the -The chair was leaned from sliding downThe strap was also u from sliding downResident #2 had the strap when the reside unitThe Director of Oper document the residen minutesResident #2 was usu breakfast and gotten before lunchResident #2 sleeps a to get up, the strap wa from sliding down and	up one hour to 30 minutes a lot, and made no attempt as used to keep the resident d to the side in the chair.				
	Interviews on 12/09/1 with the RCC reveale	6 at 10:00 am and 10:34 am d:				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			D. MINIO			
		HAL029010	B. WING		12/12/20	016
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
GRAYSON	I CREEK OF WELCOME		US HWY 52			
			N, 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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE C	(X5) COMPLETE DATE
D 482	Continued From page	e 25	D 482			
	was so "out of it" you understand when con-Resident #2 used the keep him from sliding the resident had loss muscle strengthResident #2 had the admission to the SCU-She was unaware if resident's use of the vito the SCU. Second interview on RCC revealed: -Resident #2 slid dow back wheelchair and keep the resident from Resident #2 was total staff for all his health the resident mostly to get out of bedThe Director of Oper document every 30 m	nmunicating with him. e "lap belt" (Velcro strap) to pout of the chair because of pelvic and lower body Velcro scrap prior to J. the physician assessed the Velcro strap since he moved 12/09/16 at 3:01 pm with the In and to the side in his high the straps were used to m sliding. ally dependent on facility care needs. slept and made no attempts				
	#2's family member re -The resident used to and there was a fear strap was orderedLately, Resident #2's feet were weak from a was unable to bear w	of the resident falling, so the semuscles in his legs and non-use, and the resident reight on his legs and feet.				
	Resident #2 was alwa-Staff had told him that	nt every other day, and ays sleep when he visited. at sometimes Resident #2				

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observed that.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _			
		HAL029010	B. WING		12/1	2/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GRAYSON	I CREEK OF WELCOME		US HWY 52			
			N, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 482	Continued From page	26	D 482			
	wheelchair when he was leaned the head of the	ays put in the high back vas up, and facility staff e chair back and propped up he could not get up, if he				
	Refer to interview on 12/09/16 at 4:00 pm v Operations.	12/07/16 at 3:38 pm and with the Director of				
	Refer to interview on the RCC.	12/09/16 at 10:34 am with				
	Refer to interview on 12/09/16 at 3:15 pm with the second shift PCA.					
	Refer to facility's restr	raint policy.				
	at 9:37 am revealed: -Resident #2 was lyin -The resident was poswall and his back was inches from the half s	sitioned with his face to the spositioned four to six				
	-Resident #2 was slee	vas toward the wall and his				
	PCA revealed: -Resident #2 slept a letter resident to eatThe Director of Oper initial they had checket	at 11:52 am with a first shift ot, they usually had to wake ations instructed staff to ed on Resident #2 every 30 ident was up in his high				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL029010	B. WING		12/12/2016	
	ROVIDER OR SUPPLIER	6781 OLD	DRESS, CITY, STA US HWY 52 DN, NC 27295	TE, ZIP CODE		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPL	LETE
D 482	rolling out of the bed a for residents with side -Resident #2 was seld much, other than sleet Interview on 12/09/16 revealed; -Resident #2 had a good help with pressure por -Resident #2 had 1 sithe right side against falling out of bed. Interview on 12/09/16 #2's family member reducted -He would be concernabled bed onto the floor. Attempted interview of bed on the resident #2's phyphone call prior to exide termined that Resident #2's phyphone call prior to exide termined that Resident #2's phyphone call prior to exide termined that Resident #2's phyphone call prior to exide termined that Resident #2's phyphone call prior to exide termined that Resident #2's phyphone call prior to exide termined that Resident #2's phyphone call prior to exide termined that Resident #2's phyphone call prior to exide termined that Resident #2's phyphone call prior to exide termined that Resident #2's phyphone call prior to exide termined that Resident #2's phyphone call prior to exide termined that Resident #2's phyphone call prior to exide the resident #2's phyphone phyphone phyphon	o keep Resident #2 from and staff did nothing special e rails. dom awake, and did not do eping. o at 10:00 am with the RCC el cushion in the chair to ints. de rail on the left side and the wall to keep him from o at 2:45 pm with Resident evealed: he resident try to get out of the resident try to get out of the difference on 12/07/16 ysician revealed no return ting the survey. ew, and observation it was dent #2 was not	D 482			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL029010	B. WING		12	/12/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
GRAYSON	CREEK OF WELCOME		D US HWY 52 FON, NC 27295				
	CHAMADY CT			DDOVIDEDIO DI ANI OF	CORRECTION	T	
(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 1 DEFICIENC	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE	
D 482	Continued From page	28	D 482				
	Refer to facility's restr	raint policy.					
	02/10/16 revealed: -Diagnoses included a diabetes, symbolic dy anemia, and hyperlipit -Disorientation was cousing a wheelchair, a and bladder. Review of Resident # physician's order for "physician on 12/16/15 Review of Resident # -A facility form signed 12/18/15The form documente hospital bed, it was thand comfort reasons, get tangled up in or trails will not be used a	onstant, semi-ambulatory nd incontinent with bowel 1's record revealed a side rails," signed by the					
	authorization and Car physician on 07/06/16 -Resident #1 required eating, toileting, ambu grooming, and transfe	orevealed: I extensive assistance with Ulation, bathing, dressing, erring. Elated to the resident's need					
	Observation on 12/07 #1 revealed the reside wheelchair, in the fac	7/16 at 9:37 am of Resident					

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
			B. WING		l	
		HAL029010	B. WING		12/1	12/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		6781 OLD	US HWY 52			
GRAYSON	I CREEK OF WELCOME		ON, NC 27295			
	OUR MAR DV OT			550 W550 51 AU 05 00555510		T
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 482	Continued From page	e 29	D 482			
	#1's room revealed tv	vo 1/2 side rails were				
	attached to the resident's bed.					
		511.C 500.				
	 Interview on 12/08/16	3 at 3:06 pm and 3:15 pm				
	with a second shift Po					
		n-ambulatory and needed				
		with bathing and dressing.				
		ails were put up to keep the				
	resident from rolling of					
		concerns because the				
	resident could not tra					
	-The resident moves	•				
	-The resident moves	around in the bed.				
	Interview on 12/09/16	at 10:34 am with the RCC				
	revealed:					
		person assist, because the				
	resident did not walk,	•				
		pe redirect a lot because she				
		nd was confused about				
	commands.					
		neelchair against her bed				
		the resident from getting out				
	of bed and falling.	3 3				
		et tangled up in the sheets				
	and blanket.					
	-She was not sure if t	he resident was caught				
		s and side rail she could get				
	herself out.	ŭ				
	-She was unable to re	ecall the resident				
	experiencing falls sind	ce admission to the facility in				
	2014.	•				
	Interview on 12/08/16	at 3:03 pm with Resident				
	#1's guardian reveale					
		clined since her admission				
	to the facility in 2014.					
		ails were used to help the				
	resident reposition he					
		o longer was able to use the				
		oning then she was okay with				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL029010	B. WING		12/	12/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GRAYSON	CREEK OF WELCOME		US HWY 52 DN, NC 27295			
	OLIMAN DV OT		<u> </u>	DDOUIDEDIO DI ANI OF CODDE	OTION	
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 482	Continued From page	e 30	D 482			
	the facility removing the Resident #1 had no in facility. She feels that the resupper body strength in line in the resident was called in the resident from the resident was called in	hem. ncidents of falls at the sident does not have the like she used to. If at 4:35 pm with the second de rails, which were used to in falling out of the bed. Itry to get up but rolled in her laught between the side rail luid not get herself out. If at 11:48 am with the first side rails that were used to rom falling out of bed. In move much when in the bed like staff turning her on her dent feared falling out of the facility, Resident #2 had a broken hip; now the resident of bed. It werbally tell her she was bed, but the resident yelled ded to reposition the resident				
	broken hipResident #1 had not the facility. Based on record revie	falls since her admission to ew, observation and attempt , it was determined Resident				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND FLAN OF CORRECTION IDENTIFICATION NUMBER.		A. BUILDING:		COMPLETED		
		HAL029010	B. WING		12/1	2/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GRAYSON	I CREEK OF WELCOME		JS HWY 52 N, NC 27295			
24.1.15	CLIMMADV CT.		1	DDOVIDED'S DI AN OF CORRECTION	N .	0.50
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 482	Continued From page	e 31	D 482			
		ria telephone on 12/07/16 ysician revealed no return ting the survey.				
	Refer to interview on 12/09/16 at 4:00 pm v Operations.	12/07/16 at 3:38 pm and with the Director of				
	Refer to interview on the RCC.	12/09/16 at 10:34 am with				
	Refer to interview on second shift PCA.	12/09/16 at 3:15 pm with the				
	Refer to facility's restr	raint policy.				
	D. Review of Resident revealed:	nt #7's current FL-2 06/08/16				
	-Diagnoses included senile dementia-Alzheimer's type, abnormal gait, mental disorder, muscle weakness, and joint painShe was intermittently confused.					
	07/30/16 revealed:	7's current care plan dated ision with ambulation and				
	-She had a Licensed (LHPS) Personal Cara administered through	health Professional Support e Task of medications injections. nd requires redirection by				
	Review on 12/09/16 or revealed: -There was no documminute checks noted -There was 4 falls door	of Resident #7's record nentation on the every 30 per the facility's policy. cumented this year to date an emergency room visit				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		1141 020040	B. WING		40/4	0/0046
		HAL029010			12/1	2/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GRAYSON	CREEK OF WELCOME	6781 OLD U				
	I	LEXINGTO	N, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 482	Continued From page	2 32	D 482			
	including: a closed he contusion, a hip and p with ambulation and s pelvis contusion and sutures and glue. -A signed physicians bed rails due to fall risA restraint form signs side rails for mobility getting out of bed but restraint. Observation of Reside am revealed: -She was lying in bedThe bed was position the wallThe opposite of the but up positionA wheelchair was loo bottom 1/3 of the bed	ead injury with a forehead pelvis injury resulting in pain standing, minor hip and facial lacerations requiring order dated 07/13/16 for half sk. ed by POA for the use of aid in repositioning and not to be used as a ent #7 on 12/09/16 at 10:34				
	Care Coordinator (RC -The side rail is in the wheelchair was place resident was in bed to falling out of the bedThe resident could n it was up to the staff t the resident could get -She has seen the resident and over wheelchairThe resident is not p bed independently, so	dup position and the dagainst the bed when the prevent the resident from the ot let the side rails down and to let the side rails down so to out of bed. Sident attempt to get out of the bed rails or the hysically able to get out of the wheelchair is parked of the bed so they can				

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6781 OLD US HWY S2 LEXINGTON, NC 27295 CANYSON CREEK OF WELCOME SUMMARY STATEMENT OF DEPOSITIONS (EACH DEPOSITION OF LISO DEPOSITION OF PRESENCE OF TAIL (EACH DEPOSITION OF LISO DEPOSITION OF PRESENCE OF TAIL (EACH DEPOSITION OF LISO DEPOSITION OF PRESENCE OF TAIL (EACH DEPOSITION OF LISO DEPOSITION OF PRESENCE OF TAIL (EACH DEPOSITION OF LISO DEPOSITION OF PRESENCE OF TAIL (EACH DEPOSITION OF LISO DEPOSITION OF PRESENCE OF TAIL (EACH DEPOSITION OF LISO DEPOSITION OF PRESENCE OF TO THE APPROPRIATE 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 (velero belts) and the downs". She feels that placing the resident in the bed with the siderail was in the up position and the end of the siderail 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 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 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 irsk and was not physically	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER GRAYSON CREEK OF WELCOME (761 ID JS HWY 52 LEXINGTON, NC 27295 CONTINUED THE PROVIDER'S PLAN OF CORRECTION SPOULD BE (PEACH DEPROVENCY MUST BE PRECEDED BY PULL TAGE OF CORRECTION SPOULD BE (PEACH DEPROVENCY MUST BE PRECEDED BY PULL TAGE OF CORRECTION SPOULD BE (PEACH CORRECTION SPOULD BE COMPLETE TAGE OF CORRECTION SPOULD BE COMPLETE ON SPOULD BE CROSS-REPERVANCE OF SPOULD BE COMPLETE ON SPOULD BE CROSS-REPERVANCE OF SPO	AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPL	ETED
CRAYSON CREEK OF WELCOME CANADACT STATEMENT OF DEFICIENCIES DELINIGTON, NC 27295			HAL029010	B. WING		12/1	2/2016
CALL D CONTINUE CALL CONTINUE CALL CONTINUE CALL	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
D 482 Continued From page 33 -The resident of side rails down sorther resident from exiting and/or falling out of the bedThe eight and the wheelchair in the bed with the siderail could not earlier the side rails down and it was up to the staff to let the side rails down so the resident could get out of bedThe resident could get out of bedThe resident could get out of bed and or of bed independentlyThe resident could get out of bed and or of bed independently because she is a high risk for failing out of the bedThe resident could get out of bedThe resident could not let the side rails down and it was up to the staff to let the side rails down so the resident is or the wheelchairThe resident could get out of bedThe resident could get out of bed rails down so the resident is not physically and locked at the end of the side rails on the wheelchairThe resident could get out of bed around or over the bed rails or the wheelchair is parked and locked at the end of the bed so they can keep her from getting out of the bedThe resident is not physically able to get out of bedThe resident is a fall risk and was not physically			6781 OLD U	JS HWY 52			
PRETIX TAG REQULATORY OR LSC IDENTIFYING INFORMATION) 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 (velcrobelts) and tie downs". -She feels that placing the resident in the bed with the siderail open 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 could not 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 whelchair. -The resident could get out of bed. -She had never seen the resident attempt to get out of bed independently, so the whelchair is parked and locked at the end of the bed so they can keep her from getting out of the bed. -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 could of the bed. -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 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 to the first the can be a fall risk and	GRAYSON	I CREEK OF WELCOME	LEXINGTO	N, NC 27295			
-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 so the resident could get out of bed. -She had never seen the resident attempt 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 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	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETE
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.	D 482	-The resident is a fall capable of walking which did not allow her to an because she is a high hold her weight alone. The resident moves a she does not consider the wheel chair at the the side of the bed to exiting and/or falling of the siderail up and the end of the siderail for help but can see that dementia could be at the side rail was in the wheel chair was place resident was in bed to falling out of the bed. The resident could not was up to the staff the resident could get she had never seen out of bed around or owheelchair. -The resident is not provided in the properties of walking which capable of walking which did not allow her to an because she was a high capable of walking which capable of walking wa	risk and was not physically here she wanted to, but staff inbulate independently in risk for falls and could not a around in the bed. er side rails or positioning of a end of the side rails, along prevent the resident from but of bed a restraint. intints as "lap belts (velcro in ing.) g the resident in the bed with a wheelchair placed at the ces the resident to call for with the resident having risk for injury. 6 at 3:15 pm with a lant (PCA) revealed: the up position and the lad against the bed when the lad against the bed rails down and lad to let the side rails down so to out of bed. The resident attempt to get lad the lad	D 482	DETIGIENCY)		

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DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED	
		HAL029010	B. WING		12/1	2/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
TO THE OT THE	to vibert of tool i eleft		US HWY 52			
GRAYSON	I CREEK OF WELCOME		ON, NC 27295			
	CLIMMA DV CT		-	DDOMDEDIC DI ANI OF CODDECTIO	N1	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE
				DEFICIENCY)		
D 482	Continued From page 34		D 482			
	has been known to "s	coot" to the bottom of the				
	bed to get out.					
		er side rails or positioning of				
		end of the side rails, along				
		prevent the resident from				
	exiting and/or falling of	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					
		keep the resident in the bed				
	at the facility.	en many times but only once				
		ot have enough strength to				
		ip in the bed or to get herself				
	side rail.	ed between the mattress and				
		ed about falling out of bed				
	and getting a broken					
		e side rails to keep from				
		stated that she could get				
	trapped in the sheets	and blankets trying to get				
	out if staff does not le	t the side rail down.				
	Refer to interview on	12/07/16 at 3:38 pm and				
	12/09/16 at 4:00 pm v	vith the Director of				
	Operations.					
	Refer to interview on the RCC.	12/09/16 at 10:34 am with				
	Refer to interview on second shift PCA.	12/09/16 at 3:15 pm with the				
	Refer to facility's restr	raint policy.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING			
		HAL029010	B. WING		12/12/	2016
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GRAYSON	CREEK OF WELCOME		US HWY 52			
			ON, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 482	Continued From page	e 35	D 482			
	E. Review of Resident 04/26/16 revealed: -Diagnoses included of depressive disorder, it gaitThe resident was serintermittently confuse. Review of Resident # 08/01/16 revealed: -She required supervitransfersShe had no Licensed Support (LHPS) Persident # 04/30/16 revealed: -She was confused at -She was ambulatoryShe had no LHPS ta. Review of resident #8 Assessment of Special revealed: -She had occasionally to understandShe had occasionally to understandShe required limited. Interview and observation 12/09/16 at 10:34 am -She was lying in bed -The bed was position the wallThe opposite of the bosition.	dementia, disorientation, nistory of falls, and abnormal mi-ambulatory and d. 8's current care plan dated ision with ambulation and d health Professional onal Care Tasks noted. 8's LHPS Evaluation dated times. and required no assistance. sked noted. 8's Pre-admission Screening al Care Unit dated 04/26/16 by disorientation and inability wandering. assistance with ambulation. ation with Resident #8 on revealed: ned with one side against oned had a bed rail in the up				
	-She was lying in bed -The bed was position the wall. -The opposite of the b position. -A wheelchair was loo	ned with one side against				

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-Resident #8 stated that she cannot put down the

side rail and the staff has to let her out.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		HAL029010	B. WING		12	2/12/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
GRAYSON	N CREEK OF WELCOME	6781 OL	D US HWY 52			
ONATOO	TORLER OF WELGOINE	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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 482	Continued From page	36	D 482			
	and gets out that way	ots to the bottom of the bed ". he bottom of the bed often.				
	Review of Resident # revealed a signed phy 08/03/16 for side rails					
	revealed a facility forr	8's record on 12/09/16 n signed by POA for the use ty aid in repositioning and not to be used as a				
	revealed: -A resident care note 11/30/16 with docume being able to walk an assistance, not wantii person assistance, re bedroom, resident co without assistance an legs wont hold her up bathroom, getting up put words together an	entation of: resident #8 not d needing 2 person ng to stand even with a 2 sident found in floor in ntinuing to get up and walk d falling a lot because her anymore, a fall in the and stumbling, not able to				
	additional assessmen since 08/01/16.	t or care plan documented				
	Care Coordinator (RC -The side rail was in t wheelchair was place resident was in bed to falling out of the bedThe resident could no	he up position and the d against the bed when the p prevent the resident from the tot let the side rails down and to let the side rails down so				

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DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (D PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLE	- IED
		HAL029010	B. WING		12/1	2/2016
			1		1 12/1/	2/2010
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
GRAYSON	I CREEK OF WELCOME		US HWY 52			
		LEXINGTO	ON, NC 27295			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		COMPLETE DATE
IAG	TREGOLITION ON E		IAG	DEFICIENCY)		
D 100			5 400			
D 482	Continued From page	2 37	D 482			
	-She has seen the res	sident 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				
		of the bed so they can				
	keep her from getting					
	-The resident was a fa					
		walking where she wanted				
	to, but staff did not all					
	· · · · · · · · · · · · · · · · · · ·	se she was a high risk for				
	falls and could not ho	_				
		ble of becoming trapped				
		and side rail and could get				
		ers trying to get out of bed				
	and then could fall.					
		er side rails or positioning of				
		end of the side rails, along				
		prevent the resident from				
		out of bed constituted a				
	restraint.	into ao "lan halta (valoro				
	belts) and tie downs".	ints as "lap belts (velcro				
	•	g the resident in the bed with				
	· ·	e wheelchair placed at the				
	•	ces the resident to call for				
		with the resident having				
	dementia could be at					
	dementia dedia de at	non for injury.				
	Interviews on 12/09/1	6 at 3:15 pm with a				
	Personal Care Assista					
		he up position and the				
		d against the bed when the				
	· · · · · · · · · · · · · · · · · · ·	prevent the resident from				
	falling out of the bed.	•				
	-	ot let the side rails down and				
	it was up to the staff t	o let the side rails down so				
	the resident could get					
		the resident attempt to get				

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out of bed around or over the bed rails or the

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
741012741	or contraction	IDENTIFICATION NO.	A. BUILDING:		00.000	
		HAL029010	B. WING		12/1	2/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GRAYSON	I CREEK OF WELCOME	6781 OLD	JS HWY 52			
		LEXINGTO	N, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 482	bed independently, so and locked at the end keep her from getting -The resident is a fall capable of walking which did not allow her to an because she is a high hold her weight alone -The resident does musched chair at the the side of the bed to exiting and/or falling out -The bed against the up and the wheelchair keeps the resident in use the call bell for us how we are trained." Telephone interview of #8's Power of Attorner revealed: -Most of the resident's of bed, and changing with rails to prevent the of bed and falling at nusher communityThe resident is some "forgets" to call for as her ownThe resident "scoots get out and will climb end of the bedThe resident used the falling out of bed and	t physically able to get out of on the wheelchair is parked of the bed so they can out of the bed. Tisk and is not physically mere she wanted to, but staff imbulate independently in risk for falls and could not expected. To ear out of the bed. Tisk and is not physically mere she wanted to, but staff imbulate independently in risk for falls and could not expected. The state of the side rails, along prevent the resident from prevent the resident from out of bed a restraint. The bed and then they must is to help them out. "This is so to help them out. "This is so to help them out. "This is so to help them out out of the side rail out clothes and he was fine me resident from getting out clothes and he was fine me resident from getting out sight. The best on the bed to over the wheelchair at the expected and sistance and will try to do on to the bed to over the wheelchair at the expected and blankets trying to get the side rails to keep from stated that she could get and blankets trying to get	D 482			
	Refer to interview on	12/07/16 at 3:38 pm and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
	HAL029010	B. WING		12/12	2/2016
NAME OF PROVIDER OR SUP	PLIER STREE	T ADDRESS, CITY, STATE	E, ZIP CODE		
ODAYOON ODEEK OF W	6781 (OLD US HWY 52			
GRAYSON CREEK OF W	LEXIN	GTON, NC 27295			
PREFIX (EACH I	MMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL TORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 482 Continued Fr	om page 39	D 482			
12/09/16 at 4 Operations.	:00 pm with the Director of				
Refer to inter the RCC.	view on 12/09/16 at 10:34 am with				
Refer to intersecond shift	view on 12/09/16 at 3:15 pm with the PCA.				
Refer to facil	ty's restraint policy.				
4:00 pm with -She did not full side rails -She had bee were not resi told herShe was aw against the s rail to block t and fallingShe was aw restraint prot considered re -She did not resident's be bottom of the -She did con became tang tried to get o the side rails -Staff had be 2 residents h restraints or -Per the facil checks on all	en previously told that ½ bed rails raints, but was unable to recall who have staff were placing the wheelchair de of the bed, at the end of the side he residents from exiting the bed have facility staff did not follow becol because ½ rails were not estraints. Consider a wheelchair beside a did, at the end of a side rail to the bed to be a restraint. Sider it an issue if the residents led in the sheets and blankets and all of the bed over the wheelchair or the trained to use restraints because ad lap buddies, which were a hazard. The trained to be a nestraints did two residents with restraints.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7.1.15 . 27.11 .		152111111071110111102111	A. BUILDING: _	A. BUILDING:		
		HAL029010	B. WING		12/1	2/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
GRAYSON	CREEK OF WELCOME		US HWY 52			
			ON, 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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 482	Continued From page	e 40	D 482			
	alternatives to restrain	d. nentation for the use of nts because she had not was unaware of the type of				
	revealed: -All residents have to because of the side ra-The facility used side getting out of bed and-When the residents with the side rails upThe wheelchair was bed, at the end of the from getting out of the -Residents could get	e rails to keep residents from I falling. were in bed staff always put parked at the end of the bed rail to keep the resident				
	shift PCA revealed: -Wheelchairs were ke bed, placed at the energister resident from getting -Residents could get covers and could get -Residents could also	caught up in the sheets and				
	-Restraints cannot be convenience, and car symptoms such as co or abusive and injurio othersAlternatives must be	s restraint policy revealed: used for discipline or staff n only be applied for medical onfusion with the risk of falls us behaviors to self or tried before the use of d documented such as:				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE S A. BUILDING:			
			A. BOILDING	The Boile Silver.		
		HAL029010	B. WING		12/	12/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GRAYSON	N CREEK OF WELCOME		US HWY 52			
		LEXINGTO	N, 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 482	assist, frequent monit family involvement, or -Physician restraint or to application of restraints, type of restraints, type of restrestraint is to be used must be checked, loo signature of physician -A consent for physician -A consent for physician of benefits and risk shresident and/or reside -A restraint assessmed developedStaff shall document oversight record. The facility failed to or complete physician's and care planning, an alternatives to restraint their wheelchair (Reside rails and the reside #7 and #8). The facility residents put resident falling over the wheelcaught between the numbich was detrimentative residents and con	store mobility, devices that soring by staff, pain control, communication. Inder must be obtained prior saints, and must include the same, medical reason for traint to be used, time period lift, time intervals the restraint sened, and removed, in san restraint use that consist shall be signed by the ent representative. Ent and care plan shall be on the restraint use Consistently obtain a corder, provide assessment and document attempted ints, strapping 2 residents to idents #2 and #6), and using dent's wheelchair to keeping and getting out of bed for ents (Residents #1, #2, #6, try's failure to monitor the is at substantial risk of chairs or smothering getting mattresses and bed rails all to the health and safety of estitutes a Type B Violation.	D 482			
	charts and orders for	d Supervision will pull all the physician to see on detailed orders according				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDIEAN	or contribution	IDENTIFICATION NOMBER.	A. BUILDING: _		OOM! LETED	
		HAL029010	B. WING		12/12/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GRAYSON	I CREEK OF WELCOME		US HWY 52			
			N, 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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 482	Continued From page	e 42	D 482			
D042	restraintsThe Director will institute documentation of resired ocumentation of resired documentation. CORRECTION DATE SHALL NOT EXCEED	ure the nurse assesses all aints and makes adequate FOR THE B VIOLATION D JANUARY 26, 2017.	D040			
D912	G.S. 131D-21(2) Dec	laration of Residents' Rights	D912			
	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.					
	reviews, the facility fa received care and ser appropriate, and in co	ns, interviews and record iled to ensure residents rvices which were adequate, ompliance with relevant s and rules and regulations				
	The findings are:					
	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					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		HAL029010	B. WING		12	2/12/2016
	ROVIDER OR SUPPLIER	6781 OL	NDDRESS, CITY, STAT D US HWY 52 TON, NC 27295	re, zip code		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D912	for 5 of 5 sampled res #6, #7 and #8) with re	e 43 sidents (Residents #1, #2, estraints. [Refer to Tag 482, (a) (Type B Violation).]	D912			

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