STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 454	Continued From page 72 Based on record review, and observation of Resident #5 on 02/22/19, it was determined the resident was not interviewable.	D 454		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present to meet the needs of the residents in the Special Care Unit (SCU) on the third shift for 10 of 11 third shifts sampled for 11 days from February 1, 2019 to February 20, 2019. The findings are: The facility was licensed by the Division of Health Service Regulation for a Special Care Unit with a capacity of 16 beds. Review of the facility resident census dated 02/01/19 revealed: -There was a SCU census of 14 residents, which required 11.2 staff hours on third shift. -Review of individual time cards dated 02/01/19	D 465	← Fusout TYPE B Violation HMP 3-25-19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 465	Continued From page 73	D 465		

revealed 8 staff hours were provided on third shift, leaving the shift short 3.2 hours.

Review of the facility resident census dated 02/02/19 revealed:
-There was a SCU census of 14 residents, which required 11.2 staff hours on third shift.
Review of individual time cards dated 02/02/19 revealed 8 staff hours were provided on third shift, leaving the shift short 3.2 staff hours.

Review of the facility resident census dated 02/03/19 revealed:
-There was a SCU census of 14 residents, which required 11.2 staff hours on third shift.
-Review of individual time cards dated 02/03/19 revealed 8 staff hours were provided on third shift, leaving the shift short by 3.2 staff hours.

Review of the facility resident census dated 02/04/19 revealed:
-There was a resident census of 14 residents, which required 11.2 staff hours ion third shift.
-Review of individual time cards dated 02/04/19 revealed 8 staff hours were provided on third shift, leaving the shift short by 3.2 staff hours.

Review of the facility resident census dated 02/09/19 revealed:
-There was a SCU census of 15 residents, which required 12 staff hours on third shift.
-Review of individual time cards dated 02/09/19 revealed 8 staff hours were provided on third shift, leaving the shift short 4 staff hours.

Review of the facility resident census dated 02/10/19 revealed:
-There was a SCU census of 15 residents, which required 12 staff hours on third shift.
-Review of individual time cards dated 02/10/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 465	Continued From page 74	D 465		

revealed 8 staff hours were provided on third shift, leaving the shift short 4 staff hours.

Review of the facility resident census dated 2/11/2019 revealed:
-There was a SCU census of 15 residents, which required 12 staff hours on third shift.
-Review of individual time cards dated 02/11/19 revealed 8 staff hours were provided on third shift, leaving the shift short 4 staff hours.

Review of the facility resident census dated 02/18/19 revealed:
-There was a SCU census of 16 residents, which required 12.8 staff hours on third shift.
-Review of individual time cards dated 02/18/19 revealed 8 staff hours were provided on third shift, leaving the shift short 4.8 staff hours.

Review of the facility resident census dated 02/19/19 revealed:
-There was a SCU census of 16 residents, which required 12.8 staff hours on third shift.
-Review of individual time cards dated 02/19/19 revealed 8 staff hours were provided on third shift, leaving the shift short 4.8 staff hours.

Review of the facility resident census dated 02/20/19 revealed:
-There was a SCU census of 16 residents, which required 12.8 staff hours on third shift.
-Review of the individual time cards dated 02/20/19 revealed 8 staff hours were provided on third shift, leaving the shift short 4.8 staff hours.

Interview with a personal care aide (PCA) on 2/21/19 at 12:15am revealed:
-She started working on the Special Care Unit (SCU) about 4 months ago.
-Normally only one PCA worked on the SCU from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	C 02/22/2019

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 465	Continued From page 75 11:00pm-7:00am. -She would call the PCA on the Assisted Living Unit (ALU) if she needed help. -On 3rd shift, the PCA from the ALU stayed on the SCU for an hour. -The PCA from the ALU would notify the RCC if the residents on the SCU required medication. Interview with a Medication Aide in the SCU on 02/22/19 at 9:25am revealed: -The facility Director is responsible for scheduling staff. -There were usually 2 aides scheduled for 3rd shift in the SCU. -If someone called out, the facility Director was notified and the Director and/or staff called to find other staff to come in to help. -Some staff worked double shifts to cover "call-outs". -Staff worked hard to meet the needs of the residents. Interview with the Director on 2/22/19 at 10:05am revealed: -The facility director was responsible for staff scheduling. -There had been several staff that quit since the first of the year. -She tried to schedule more staff than required so they would not be short if staff called out. -When staff informed her of a call out, she attempted to get other staff to come in to cover. -There were times when some staff worked double shifts. -She helped out on the floor if she is able to do so when they were short staffed.	D 465	The Facility failed to assure the minimum number of staff were present at all times on the third shift to meet the needs of residents residing in the Special Care Unit (SCU) on 10 of 11 third shifts sampled over 11 days from February 1, 2019 to February 28, 2019. The facility's failure to provide sufficient staffing to meet the needs of the SCU residents in the SCU was detrimental to the health, safety and well-being of the residents and constitutes a TYPE B Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 03/05/19 for this Violation. Correction Date for the TYPE B Violation shall not exceed April 8, 2019.	4/8/19
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train	D 468		

Federation To be inserted

jwp 3.25.19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	C 02/22/2019

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D 482	Continued From page 84 prevent Resident #17 from sliding out of the wheelchair. -She just found out on 02/21/19. -She would get an order for the lap belt on 02/22/19. Telephone interview with the primary care physician (PCP) on 02/22/19 at 8:59am revealed: -He knew Resident #17 needed an order for a lap belt to prevent resident from sliding out of the wheelchair. -He did not remember when or who notified him that Resident #17 needed an order for a lap belt. -He gave the staff a verbal order for a lap belt. -He did not know the order required a medical need for the lap belt, the length of time the restraint should be used, and the time intervals the restraint was to be checked and released.	D 482		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations	D912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D912	Continued From page 85 related to ~~controlled substances~~, infection control prevention for sharing glucometers, medication administration and ~~implementation.~~ special care unit staffing. HAP 3.25.19 The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 3 of 4 residents (#8, #18, #19) observed during the medication passes including errors with medications related to an anti-psychotic (#8), potassium and fish oil supplements, a laxative and an antihistamine eye drop (#18), crushing and administering a medication that should not be crushed (#18), and not watching medications being administered (#19); and 1 of 7 sampled resident (#7) related to an anti-anxiety medication. [Refer to Tag 0358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. 3 ~~2.~~ Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control (CDC) and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 3 of 6 diabetic residents sampled (Residents #20, #21, and #22) with orders for blood sugar monitoring resulting in sharing of glucometers between residents. [Refer to Tag 0932 G.S.131D4.4A(b) Adult Care Home Infection Prevention Requirements (Type B Violation)].	D912 insert →	#2. Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present to meet the needs of the residents in the Special Care Unit (SCU) on the third shift for 10 of 11 sampled nights sampled for 11 days from February 10 to February 20, 2019. [Refer to Tag 0465 10A NCAC 13F .1308(a) Special Care Unit Staffing (Type B Violation).] HAP 3/25/19	
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection	D932		

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D 454	Continued From page 72 Based on record review, and observation of Resident #5 on 02/22/19, it was determined the resident was not interviewable.	D 454		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present to meet the needs of the residents in the Special Care Unit (SCU) on the third shift for 10 of 11 third shifts sampled for 11 days from February 1, 2019 to February 20, 2019. The findings are: The facility was licensed by the Division of Health Service Regulation for a Special Care Unit with a capacity of 16 beds. Review of the facility resident census dated 02/01/19 revealed: -There was a SCU census of 14 residents, which	D 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 465	Continued From page 73	D 465		

required 11.2 staff hours on third shift.
-Review of individual time cards dated 02/01/19 revealed 8 staff hours were provided on third shift, leaving the shift short 3.2 hours.

Review of the facility resident census dated 02/02/19 revealed:
-There was a SCU census of 14 residents, which required 11.2 staff hours on third shift.
Review of individual time cards dated 02/02/19 revealed 8 staff hours were provided on third shift, leaving the shift short 3.2 staff hours.

Review of the facility resident census dated 02/03/19 revealed:
-There was a SCU census of 14 residents, which required 11.2 staff hours on third shift.
-Review of individual time cards dated 02/03/19 revealed 8 staff hours were provided on third shift, leaving the shift short by 3.2 staff hours.

Review of the facility resident census dated 02/04/19 revealed:
-There was a resident census of 14 residents, which required 11.2 staff hours ion third shift.
-Review of individual time cards dated 02/04/19 revealed 8 staff hours were provided on third shift, leaving the shift short by 3.2 staff hours.

Review of the facility resident census dated 02/09/19 revealed:
-There was a SCU census of 15 residents, which required 12 staff hours on third shift.
-Review of individual time cards dated 02/09/19 revealed 8 staff hours were provided on third shift, leaving the shift short 4 staff hours.

Review of the facility resident census dated 02/10/19 revealed:
-There was a SCU census of 15 residents, which

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D 465	Continued From page 74	D 465		

required 12 staff hours on third shift.
-Review of individual time cards dated 02/10/19 revealed 8 staff hours were provided on third shift, leaving the shift short 4 staff hours.

Review of the facility resident census dated 2/11/2019 revealed:
-There was a SCU census of 15 residents, which required 12 staff hours on third shift.
-Review of individual time cards dated 02/11/19 revealed 8 staff hours were provided on third shift, leaving the shift short 4 staff hours.

Review of the facility resident census dated 02/18/19 revealed:
-There was a SCU census of 16 residents, which required 12.8 staff hours on third shift.
-Review of individual time cards dated 02/18/19 revealed 8 staff hours were provided on third shift, leaving the shift short 4.8 staff hours.

Review of the facility resident census dated 02/19/19 revealed:
-There was a SCU census of 16 residents, which required 12.8 staff hours on third shift.
-Review of individual time cards dated 02/19/19 revealed 8 staff hours were provided on third shift, leaving the shift short 4.8 staff hours.

Review of the facility resident census dated 02/20/19 revealed:
-There was a SCU census of 16 residents, which required 12.8 staff hours on third shift.
-Review of the individual time cards dated 02/20/19 revealed 8 staff hours were provided on third shift, leaving the shift short 4.8 staff hours.

Interview with a personal care aide (PCA) on 2/21/19 at 12:15am revealed:
-She started working on the Special Care Unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 465	Continued From page 75	D 465		

(SCU) about 4 months ago.
-Normally only one PCA worked on the SCU from 11:00pm-7:00am.
-She would call the PCA on the Assisted Living Unit (ALU) if she needed help.
-On 3rd shift, the PCA from the ALU stayed on the SCU for an hour.
-The PCA from the ALU would notify the RCC if the residents on the SCU required medication.

Interview with a Medication Aide in the SCU on 02/22/19 at 9:25am revealed:
-The facility Director is responsible for scheduling staff.
-There were usually 2 aides scheduled for 3rd shift in the SCU.
-If someone called out, the facility Director was notified and the Director and/or staff called to find other staff to come in to help.
-Some staff worked double shifts to cover "call-outs".
-Staff worked hard to meet the needs of the residents.

Interview with the Director on 2/22/19 at 10:05am revealed:
-The facility director was responsible for staff scheduling.
-There had been several staff that quit since the first of the year.
-She tried to schedule more staff than required so they would not be short if staff called out.
-When staff informed her of a call out, she attempted to get other staff to come in to cover.
-There were times when some staff worked double shifts.
-She helped out on the floor if she is able to do so when they were short staffed.

The facility failed to assure the minimum number

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 465	Continued From page 76 of staff were present at all times on the third shift to meet the needs of residents residing in the Special Care Unit (SCU) for 10 of 11 third shifts sampled for 11 days from February 1, 2019 to February 20, 2019. The facility's failure to provide sufficient staffing to meet the needs of the residents in the SCU was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/25/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 8, 2019.	D 465		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to infection control prevention for sharing glucometers, medication administration, and Special Care Unit staffing. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 3 of 4 residents (#8, #18, #19) observed during the medication passes including errors with medications related to an anti-psychotic (#8), potassium and fish oil supplements, a laxative and an antihistamine eye drop (#18), crushing and administering a medication that should not be crushed (#18), and not watching medications being administered (#19); and 1 of 7 sampled resident (#7) related to an anti-anxiety medication. [Refer to Tag 0358 10A NCAC 13F .1004(a) Medication	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	C 02/22/2019

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D912	Continued From page 86 Administration (Type B Violation)]. 2. Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present to meet the needs of the residents in the Special Care Unit (SCU) on the third shift for 10 of 11 third shifts sampled for 11 days from February 1, 2019 to February 20, 2019. [Refer to Tag 0465 10A NCAC 13F .1308(a) Special Care Unit Staffing (Type B Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control (CDC) and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 3 of 6 diabetic residents sampled (Residents #20, #21, and #22) with orders for blood sugar monitoring resulting in sharing of glucometers between residents. [Refer to Tag 0932 G.S.131D4.4A(b) Adult Care Home Infection Prevention Requirements (Type B Violation)].	D912		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used	D932		