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GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on November 20-21, 2019.	{D 000}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the physician for 1 of 5 sampled residents (#2) regarding laboratory tests not completed in October 2019. The findings are: Review of Resident #2's current FL-2 dated 03/30/19 revealed diagnoses included weakness, abnormal gait, and localized edema. Review of Resident #2's record revealed: -There was a physician's order dated 10/23/19 for a complete blood count, comprehensive metabolic panel, lipids, and thyroid stimulating hormone level. -There were no laboratory results collected in October 2019. -There was no documentation concerning the laboratory tests ordered 10/23/19.	{D 273}		

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{D 273}	Continued From page 1 Interview with Resident #2 on 11/21/19 at 10:07 am revealed: -She typically had labs drawn by a representative from a laboratory company every six months. -She had her potassium and thyroid laboratory tests done to monitor the levels. -She recalled the physician seeing her at the end of October 2019 and he told her that her labs would be drawn in October 2019. -She did not have her labs drawn after the physician told her in October 2019. Telephone interview with a representative from the facility contracted laboratory company on 11/21/19 at 10:18 am revealed: -There were no orders for Resident #2 in the computer system for October 2019. -The orders were picked up by the laboratory courier. -The courier brought the orders back to the laboratory and the results of the laboratory samples were sent to the facility electronically. Telephone interview with Resident #2's physician on 11/21/19 at 11:15 am revealed: -He ordered labs for Resident #2 on 10/23/19 and the laboratory test included completed blood count, comprehensive metabolic panel, lipids, and a thyroid stimulating hormone level. -He did not receive the laboratory results from the laboratory company but the facility received residents' laboratory test results. -He reviewed the results when he visited the facility on Wednesdays of each week. -He had not reviewed any laboratory results for Resident #2 recently. -He was not notified by the facility that Resident #2's October 2019 laboratory tests were not collected or completed.	{D 273}		

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{D 273}	Continued From page 2 Interview with the medication aide (MA) on 11/21/19 at 10:30 am revealed: -All residents' laboratory orders were placed into the laboratory notebook by the MA on duty during the physician's visit. -When the laboratory courier came on Thursdays, the orders were picked up from the notebook. -The laboratory results were emailed to the Director. -She was given the laboratory results by the Director and she placed the results into a folder for the physician to review on Wednesdays of each week. -She had not seen or been given any laboratory orders for Resident #2. -She had not discussed Resident #2's laboratory orders with the physician. -She had not documented any notes concerning Resident #2's laboratory tests. Interview with the Director on 11/21/19 at 11:00 am revealed: -The physician gave her all laboratory orders and she completed a laboratory requisition online. -She printed out the requisition form and placed it in the laboratory notebook so that the laboratory courier knew which labs to draw for residents. -She did not know Resident #2's labs were not done from 10/23/19. -There was no documentation of Resident #2's refusal of labs and she did not know who she spoke with at the laboratory company. -She had a process that she used to ensure all laboratory orders were completed by looking at the results provided by the laboratory company and comparing it to a spreadsheet containing laboratory orders for residents. -She made the laboratory spreadsheet. -She was responsible for ensuring the physician	{D 273}		

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{D 273}	Continued From page 3 was notified when labs were not completed as ordered. Interview with the Assistant Administrator on 11/21/19 at 11:45 am revealed: -She expected labs to be completed as ordered by the physician within 7 to 10 days after the physician's order. -If the laboratory test was not completed, she expected the Director to notify the physician to determine what would be done next for the resident. -She did not know Resident #2's laboratory test were not completed from October 2019. -The Director was responsible for ensuring the physician was notified when laboratory tests were not completed.	{D 273}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 1 of 2 residents (#6) observed during the 8:00 am medication pass on 11/21/19 related to an antihistamine and two supplements.	{D 358}		

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{D 358}	Continued From page 4 The findings are: The medication error rate was 10.7% (percent) as evidenced by the observation of 3 errors out of 28 opportunities during the 8:00 am medication pass on 11/21/19. 1. Review of Resident #6's current FL2 dated 02/13/19 revealed diagnoses included anemia, anxiety, arthritis, asthma, sleep apnea, B12 deficiency, stage 3 chronic kidney disease, coronary artery disease, and depression. Review of Resident #6's subsequent physician's orders dated 09/01/19 revealed an order for loratadine (an antihistamine used to treat allergies) 10 mg daily. Observation of medication administration for Resident #6 on 11/21/19 at 7:48 am revealed: -The morning medication aide (MA) prepared 1 nasal spray and 15 oral medications that did not include one loratadine 10 mg tablet. -The MA administered the medications to the resident. -The MA documented medication administration on the November 2019 MAR. Review of Resident #6's November 2019 Medication Administration Record (MAR) revealed: -There was an entry for loratadine 10 mg daily to be administered at 8:00 am. -Loratadine 10 mg was documented as administered on 11/21/19. Observation of Resident #6's medications on hand on 11/21/19 at 09:54 am revealed: -Loratadine 10 mg tablets were available for	{D 358}		

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{D 358}	Continued From page 5	{D 358}		

administration.
-There was no printed label with directions for medication administration on the loratadine bottle.
-Resident #6's name and "8AM" were handwritten on the loratadine bottle.
-Resident #6's loratadine medication was in an over-the-counter container.

Interview with the medication aide (MA) administering Resident #6's medications during the morning medication pass on 11/21/19 at 9:45 am revealed:
-She did not administer Resident #6's loratadine on the morning of 11/21/19.
-She "normally" administered loratadine to Resident #6 every morning but she missed the administration on the morning of 11/21/19.
-She documented on the November 2019 MAR that she administered Resident #6's loratadine on 11/21/19.
-Since she did not administer loratadine to Resident #6 on 11/21/19, she should have circled her initials on 11/21/19 and wrote on the back of the November 2019 MAR that the medication was not administered and the reason it was not administered.

Interview with the Director on 11/21/19 at 10:00 am revealed:
-She did not know loratadine was not administered to Resident #6 on the morning of 11/21/19.
-If a medication was not administered to a resident, the MA should document the medication was not administered on the MAR by the MA circling their initials and writing the reason the medication was not administered to the resident on the back of the MAR.

Interview with a representative from the facility's

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contracted pharmacy on 11/21/19 at 10:11 am revealed:
-Loratadine 10 mg daily was the current order for Resident #6.
-The pharmacy was notified in August 2019 (exact date unknown) that Resident #6's family would supply loratadine.
-Resident #6 was prescribed loratadine for allergies and he may become symptomatic, such as having increased nasal drainage, if loratadine was not administered as ordered.

Interview with Resident #6's family member on 11/21/19 at 10:26 am revealed:
-He supplied Resident #6's loratadine to the facility.
-He did not know the exact date loratadine was delivered to the facility, but it had been a couple of months.

Interview with Resident #6 on 11/21/19 at 10:41 am revealed:
-He did not know all the medications that were administered to him daily.
-He had allergies and he did not know if he took an oral medication for allergies on 11/21/19 because his medications were mixed together in a cup.
-His allergies peaked in the spring and fall, and he did not have an increase in nasal drainage any more than usual with allergies in the fall.

Interview with the Administrator on 11/21/19 at 11:45 am revealed:
-She did not know loratadine was not administered to Resident #6 and was documented administered by the MA on 11/21/19.
-She expected MAs to follow the MAR so they did not miss medication administrations.
-If a medication was not administered, she

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expected MAs to circle their initials on the MAR, document the reason the medication was not administered on the back of the MAR, and notify the PCP.

Refer to the interview with the MA administering Resident #6's medications during the morning medication pass on 11/21/19 at 9:45 am.

Refer to the interview with the Director on 11/21/19 at 10:00 am.

Refer to the interview with Resident #6's family member on 11/21/19 at 10:26 am.

Refer to the interview with the Administrator on 11/21/19 at 11:45 am.

2. Review of Resident #6's current FL2 dated 02/13/19 revealed there was an order for biotin 1,000 mcg (biotin is a dietary supplement)daily.

Review of Resident #6's subsequent physician's orders dated 09/01/19 revealed an order for biotin 1,000 mcg daily.

Observation of the medication administration for Resident #7 on 11/21/19 at 7:48 am revealed:
-The morning medication aide (MA) prepared 1 nasal spray and 15 oral medications that included one biotin 10,000 mcg tablet.
-The MA administered the medications to the resident.
-The MA documented medication administration on the November 2019 MAR.

Review of Resident #6's November 2019 Medication Administration Record (MAR) revealed:
-There was an entry for biotin 1,000 mcg daily to

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be administered at 8:00 am.
-Biotin 1,000 mcg was documented as administered on 11/21/19.

Observation of Resident #6's medications on hand on 11/21/19 at 09:54 am revealed:
-Biotin 10,000 mcg tablets were in a bottle and available for administration.
-There was no printed label with directions for medication administration on the biotin bottle.
-Resident #6's name and "8AM" were handwritten on the biotin bottle.
-Resident #6's biotin medication was in an over-the-counter container.

Interview with the medication aide (MA) administering Resident #6's medications during the morning medication pass on 11/21/19 at 9:45 am revealed:
-On 11/21/19, she administered a tablet from a bottle labeled biotin 10,000 mcg to Resident #6.
-She did not know the biotin 10,000 mcg dose she administered to Resident #6 on 11/21/19 did not match the dose on the MAR; the MAR entry was biotin 1,000 mcg.
-Resident #6's family member supplied the biotin to the facility because it was less expensive to use an outside source rather than the facility's contracted pharmacy.
-The MA working at the time the medication was delivered was responsible for ensuring the medication name and dose matched the order on the MAR.
-The MA administering the medication was responsible for ensuring the dose administered matched the dose on the MAR.

Interview with the Director on 11/21/19 at 10:00 am revealed:
-Resident #6's family member supplied Resident

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#6's biotin.
-She did not know the dosage of biotin administered to Resident #6 did not match the ordered dose.
-The MA working at the time Resident #6's biotin was delivered was responsible for checking the medication against the MAR.
-If the biotin dose did not match the MAR, the MA should have notified the Primacy Care Provider (PCP) for a new order or notified the family member of the incorrect dose and returned the medication to the family member.

Interview with a representative from the facility's contracted pharmacy on 11/21/19 at 10:11 am revealed:
-Biotin 1,000 mcg daily was the current order for Resident #6.
-The pharmacy was responsible for entering orders into the MAR.
-The pharmacy was notified in August 2019 (exact date unknown) that Resident #6's family would provide biotin.
-Biotin was a supplement and there was no negative outcome if the wrong dose was administered to Resident #6.

Interview with Resident #6's family member on 11/21/19 at 10:26 am revealed:
-He supplied Resident #6's biotin to the facility.
-He was never contacted by the facility staff regarding an incorrect dosage of a medication.
-He did not know the exact date the biotin was delivered to the facility, but it had been a couple of months.

Interview with Resident #6 on 11/21/19 at 10:41 am revealed:
-He did not know all the medications that were administered to him daily.

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{D 358}	Continued From page 10 -His family member brought him some vitamins. Interview with Resident #6's Primary Care Provider (PCP) on 11/21/19 at 11:07 am revealed: -Resident #6 was ordered biotin as a supplement. -He was aware Resident #6's family member provided biotin. -He was not concerned that Resident #6 received biotin 10,000 mcg instead of the ordered dose of 1,000 mcg. -Resident #6 receiving the wrong dose of biotin had no negative outcome. Interview with the Administrator on 11/21/19 at 11:45 am revealed: -MAs were responsible for checking in medications supplied by residents' family members, and if the medication was incorrect, the MA clarified the order or brought the issue to the Director. -If the dose supplied by a family member was incorrect, the order should be changed by the PCP or the medication should not be accepted. -There was no system in place for checking in medications supplied by residents' family members and there was no documentation for checking in medications when the medication was supplied by residents' family members. -She did not know the biotin dose administered to Resident #6 was not the ordered dose. -If the biotin dose was not correct, the MA should have reported the issue to the Director. Refer to the interview with the MA administering Resident #6's medications during the morning medication pass on 11/21/19 at 9:45 am. Refer to the interview with the Director on 11/21/19 at 10:00 am.	{D 358}		

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{D 358}	Continued From page 11 Refer to the interview with Resident #6's family member on 11/21/19 at 10:26 am. Refer to the interview with the Administrator on 11/21/19 at 11:45 am. 3. Review of Resident #6's current FL2 dated 02/13/19 revealed there was an order for "calcium/vitamin D3 600/200 mg" (calcium with vitamin D3 is a dietary supplement) two times daily. Review of Resident #6's subsequent physician's orders dated 09/01/19 revealed an order for calcium 600 mg vitamin D3 200 mg two times daily. Observation of the medication administration for Resident #6 on 11/21/19 at 7:48 am revealed: -The morning medication aide (MA) prepared 1 nasal spray and 15 oral medications that included one calcium with vitamin D3 tablet. -The MA administered the medications to the resident. -The MA documented medication administration on the November 2019 MAR. Review of Resident #6's November 2019 Medication Administration Record (MAR) revealed: -There was an entry for calcium 600 mg vitamin D3 200 mg two times daily to be administered at 8:00 am and 8:00 pm. -Calcium 600 mg vitamin D3 200 mg was documented as administered on 11/21/19. Observation of Resident #6's medications on hand on 11/21/19 at 09:54 am revealed: -Calcium 600 mg with vitamin D3 20 mcg tablets were in a bottle and were available for	{D 358}		

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administration.
-There was no printed label with directions for medication administration on the calcium with vitamin D3 bottle.
-The front of the bottle was labeled "Calcium 600 with Vitamin D3".
-The ingredients listed on the back of the bottle were "Vitamin D3 20 mcg (800 IU)" and "Calcium 600 mg".
-Resident #6's name, "8AM", and "8PM" were handwritten on the calcium with vitamin D3 bottle.
-Resident #6's calcium with vitamin D was in an over-the-counter container.

Interview with the medication aide (MA) administering Resident #6's medications during the morning medication pass on 11/21/19 at 9:45 am revealed:
-On 11/21/19, she administered a calcium with vitamin D3 tablet from the bottle labeled "Calcium 600 with Vitamin D3" to Resident #6.
-She did not know the calcium with vitamin D3 dosage administered to Resident #6 did not match the dose on the MAR; the bottle's labeled ingredients were calcium 600 mg with vitamin D3 20 mcg, and the MAR entry was calcium 600 mg vitamin D3 200 mg.
-She did not look at the ingredients on the back of the medication bottle and only looked at the front label.

Interview with the Director on 11/21/19 at 10:00 am revealed:
-She did not know the dosage of calcium with vitamin D3 administered to Resident #6 did not match the ordered dose.
-Resident #6's family member supplied Resident #6's calcium with vitamin D3.
-If the vitamin D3 dose did not match the MAR, the MA should have notified the Primacy Care

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Provider (PCP) and gotten a new order or notified the family member of the incorrect dose and returned the medication to the family member.
-If the PCP did not want to change the order, the facility staff would get the medication from the pharmacy until the family member was able to supply the ordered medication.
-Resident #6's MAR (month unknown) was given to Resident #6's family member in order to purchase medication from an outside source (date unknown).

Interview with a representative from the facility's contracted pharmacy on 11/21/19 at 10:11 am revealed:
-Calcium 600 mg with vitamin D3 200 mg was the current order for Resident #6.
-The pharmacy was responsible for entering orders into the MAR.
-The pharmacy was notified in August 2019 (exact date unknown) that Resident #6's family would provide calcium with vitamin D3.
-Calcium with vitamin D3 was a supplement and there was no negative outcome if the wrong dose was administered to Resident #6.

Interview with Resident #6's family member on 11/21/19 at 10:26 am revealed:
-He supplied the Resident #6's calcium with vitamin D to the facility.
-He was never contacted by the facility staff about an incorrect dosage of a medication.
-He did not know the exact date the calcium with vitamin D was delivered to the facility, but it had been a couple of months.

Interview with Resident #6 on 11/21/19 at 10:41 am revealed:
-He did not know all the medications that were administered to him daily.

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 _____	R 11/21/2019

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 358}	Continued From page 14 -His family member brought him some vitamins. Interview with Resident #6's Primary Care Provider (PCP) on 11/21/19 at 11:07 am revealed: -Resident #6 was ordered calcium with vitamin D3 as a supplement. -He was aware Resident #6's family member provided calcium with vitamin D3. -He was not concerned that Resident #6 received vitamin D3 20 mcg instead of the ordered dose of vitamin D3 200 mg. -There was no negative outcome for Resident #6 receiving the wrong dose of vitamin D3. Interview with the Administrator on 11/21/19 at 11:45 am revealed: -MAs were responsible for checking in medications supplied by residents' family members, and if the medication was incorrect, the MA should have clarified the order or brought the issue to the Director. -If the dose supplied by a family member was incorrect, the order should be changed by the PCP or the medication should not be accepted. -There was no system in place for checking in medication supplied by residents' family members and there was no documentation for checking in medications when the medication was supplied by residents' family members. -She did not know the calcium with vitamin D3 dose administered to Resident #6 was not the ordered dose. -If the calcium with vitamin D3 dose was not correct, the MA should have reported the issue to the Director. Refer to the interview with the MA administering Resident #6's medications during the morning medication pass on 11/21/19 at 9:45 am.	{D 358}		

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 358}	Continued From page 15 Refer to the interview with the Director on 11/21/19 at 10:00 am. Refer to the interview with Resident #6's family member on 11/21/19 at 10:26 am. Refer to the interview with the Administrator on 11/21/19 at 11:45 am. Interview with the medication aide (MA) administering Resident #6's medications during the morning medication pass on 11/21/19 at 9:45 am revealed: -With each medication administration, she read the MAR, compared the MAR with the medication, administered the medication to the resident, and signed the MAR. -The Director was responsible for auditing the medication carts, resident records, and MARs. -She was not responsible for auditing the medication carts, resident records, and MARs. -She did not know the last time Resident #6's MAR and medications were audited. -If there was an issue with a medication, the MA should report the issue to the Director. -She was responsible for keeping the MAR book organized, ensuring MAs documentation was correct, ensuring medication were in stock, and notifying the family and the pharmacy if medications need to be filled. Interview with the Director on 11/21/19 at 10:00 am revealed: -She was responsible for auditing the medication carts, resident records, and MARs. -She randomly audited every two weeks and she did not know the last time Resident #6's medication, record, and MAR were audited. -MAs were responsible for administering medications and ensuring all medications were	{D 358}		

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 358}	Continued From page 16 administered as ordered. Interview with Resident #6's family member on 11/21/19 at 10:26 am revealed: -He purchased "non-prescription" medications from an outside source because the medications were less expensive compared to the facility's contracted pharmacy. -He received a MAR from the facility staff in order to know what medication and dose to purchase (date unknown). Interview with the Administrator on 11/21/19 at 11:45 am revealed: -The MAs were responsible administering medications as ordered by the PCP. -MAs were responsible for documenting medication administration on the MAR. -She expected MAs to follow the MAR when administering medications.	{D 358}		