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 _____	06/04/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section completed an annual and follow-up survey from June 3, 2021 to June 4, 2021.	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: FOLLOW-UP TO TYPE A1 VIOLATION. The Type A1 Violation was abated. Non-compliance continues. Based on interviews and record reviews, the facility failed to ensure the primary care physician (PCP) was notified for 1 of 5 sampled residents related to referral for a swallow evaluation including a modified barium swallowing study (Resident #2). The findings are: Review of Resident #2's current FL2 dated 01/01/21 revealed diagnoses included atrial fibrillation, weakness, reduced mobility, dementia with behaviors, and cognitive communication deficit. Review of Resident #2's physician's orders dated 04/21/21 revealed there was an order from the PCP for a referral for Resident #2 to a speech therapist for a swallow evaluation to include a modified barium swallowing study.	D 273		

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 _____	06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 1	D 273		

Review of Resident #2's record and progress notes revealed there was no documentation a speech therapy evaluation or modified barium swallowing study had been completed.

Telephone interview with Resident #2's family member on 06/04/21 at 10:04am revealed:
-Resident #2 was previously receiving hospice services and hospice ordered a pureed diet and nectar thickened liquids.
-In April 2021, hospice discontinued services for Resident #2.
-He did not know why the current PCP ordered the speech referral.
-Prior to today (06/04/21), he knew nothing about the speech therapy referral.
-Someone from the facility called him today to ask about allowing Resident #2 to participate in the speech evaluation.

Telephone interview with Resident #2's PCP on 06/04/21 at 1:54pm revealed:
-Resident #2 was discharged from hospice on 04/19/21.
-Initially, hospice ordered the pureed diet with nectar liquids.
-The facility staff informed him that Resident #2 was still coughing and choking when consuming nectar liquids.
-He did not see Resident #2's meals prepared and did not observe if her liquids were nectar consistency.
-He ordered a speech evaluation with modified barium swallowing study because he was concerned about aspiration.
-Not having the study done could possibly cause the resident's death which was his main concern.

Interview with the medication aide (MA) on 06/04/21 at 8:50am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 2 -She did not know Resident #2 had an order for a speech evaluation. -When the PCP left orders they were given to the Director. -The Director was responsible for ensuring orders were implemented and referral appointments were made. -The Director had been out of work for almost 3 weeks. -The Administrator was covering for the Director. Interview with the Administrator-in-Charge (AIC) on 06/04/21 at 5:15pm revealed: -She was not aware there was an order for Resident #2 for a speech therapy evaluation. -The Director was responsible for ensuring referral appointments were made with the appropriate agency. -Resident #2's referral for speech therapy evaluation should have been faxed to the correct vendor to be scheduled. -The Director should have followed up to make sure the referral was scheduled. Based on observations, records reviews and interviews, it was determined that Resident #2 was not interviewable.	D 273		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff.	D 296		

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 _____	06/04/2021

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 296	Continued From page 3	D 296		

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to have a matching therapeutic menu for 1 of 5 sampled residents with a physician's order for a pureed diet (#2).

The findings are:

Review of Resident #2's current FL2 dated 01/01/21 revealed:
- Diagnoses included atrial fibrillation, weakness, reduced mobility, dementia with behaviors, and cognitive communication deficit.
-There was no diet listed on the FL2.

Review of Resident #2's physician's orders revealed:
-There was an order dated 04/21/21 for a pureed diet and continue nectar thick liquids.
-There was an order dated 04/28/21 for nectar thick liquids and pureed diet.

Review of the therapeutic diet list posted in the kitchen dated 01/21/21 revealed Resident #2 was to be served a pureed diet. Nectar thick liquids were not documented on the diet list.

Observation of the kitchen on 06/03/21 at 9:45am revealed:
-There was a seven-day week-at-glance menu posted in the kitchen for Spring/Summer 2015.
-There were no therapeutic diet menus in the kitchen.
-The regular meal scheduled on the menu for today (06/03/21) menu consisted of pork roast, baked beans, stewed cabbage, cornbread and banana pudding.

Observation of Resident #2's lunch meal service

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 _____	06/04/2021

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 296	Continued From page 4 on 06/03/21 at 11:30am revealed: -Resident #2 was served ground meat that was dry and crumbly, pureed beans, and pureed cabbage. -Resident #2 received feeding assistance from a personal care aide (PCA). -The PCA attempted to feed Resident #2 a teaspoonful of the ground pork roast meat. -Resident #2 told the PCA the meat was dry. -The PCA mixed the ground meat with the pureed beans and cabbage before feeding it to Resident #2. -Resident #2 consumed 60% of her meal. Based on observations, record reviews and interviews, it could not be determined if Resident #2 was served the appropriate diet due to there were no therapeutic menus available for staff guidance at the facility. Interview with the Dietary Manager (DM) on 06/03/21 at 9:19am revealed: -The facility only had regular seven-day week-at-glance menus. -There were no menus for therapeutic diets. -She prepared therapeutic diets as ordered based on her self-knowledge of the diet. -Resident #2 was ordered a pureed diet and she did not need a menu for guidance as to how to prepare pureed foods. Interview with the Administrator-in-Charge on 06/04/21 at 5:15pm revealed: -There should be menus in the kitchen. -She did not know where they were located, but they should be there. -She was not aware the DM did not follow the therapeutic diet menus when preparing meals. -She expected the DM to follow orders for diets as ordered.	D 296		

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 _____	06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 296	Continued From page 5 Based on observations, record reviews and interviews, it was determined Resident #2 was not interviewable.	D 296		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure therapeutic diets were served as ordered by the resident's physician for 2 of 3 sampled residents (#2 and #5) who had orders for nectar thickened liquids and pureed diet (#2) and an order for thickened liquids with no consistency (#5). The findings are: 1. Review of Resident #2's current FL2 dated 01/01/21 revealed: - Diagnoses included atrial fibrillation, weakness, reduced mobility, dementia with behaviors, cognitive communication deficit. -There was no diet listed on the FL2. Review of Resident #2's physician's orders revealed:	D 310		

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 _____	06/04/2021

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 310	Continued From page 6	D 310		

-There was an order dated 04/21/21 for a pureed diet and continue nectar thick liquids.
-There was an order dated 04/28/21 for nectar thick liquids and pureed diet.

Review of the therapeutic diet list posted in the kitchen dated 01/21/21 revealed Resident #2 was to be served a pureed diet. Nectar thick liquids were not documented on the diet list.

Observation of the kitchen on 06/03/21 at 9:45am revealed:
-There was a seven-day week-at-glance menu posted in the kitchen for Spring/Summer 2015.
-There were no therapeutic diets in the kitchen.
-The regular meal on the menu scheduled for today (06/03/21) consisted of pork roast, baked beans, stewed cabbage, cornbread and banana pudding.

Observation of Resident #2's lunch meal service on 06/03/21 at 11:30am revealed:
-Resident #2 was served ground meat that was dry and crumbly, pureed beans, and pureed cabbage.
-Resident #2 was served 6 ounces of water that was not thickened to nectar consistency.
-Resident #2 was served 8 ounces of tea that was thickened less than nectar consistency.
-Resident #2 received feeding assistance from a personal care aide (PCA).
-The PCA attempted to feed Resident #2 a teaspoonful of the ground pork roast meat.
-Resident #2 told the PCA the meat was dry.
-The PCA mixed the ground meat with the pureed beans and cabbage before feeding it to Resident #2.
-Resident #2 consumed 60% of her meal.
-The PCA handed Resident #2 the glass of tea that was not thickened to nectar consistency to

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 _____	06/04/2021

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 310	Continued From page 7	D 310		

drink.
-Resident #2 consumed 80% of the tea.
-The PCA handed Resident #2 the glass of water that was not thickened to nectar consistency.
-Resident #2 took two swallows of water and did not drink any more water.

Observation of the refrigerator on 06/03/21 at 9:51am revealed:
-There was a one-gallon pitcher of water that did not appear to be thickened.
-There was a one-gallon pitcher of tea that that did not appear to be thickened.
-There was a one-gallon pitcher of orange juice that did not appear to be thickened.

Review of manufacturer's thickening instructions on the container of thickener on 06/03/21 at 10:01am revealed:
-To obtain nectar consistency in 4 ounces of liquid add one squirt.
-To obtain nectar consistency in 8 ounces of liquids add 2 squirts.
-To obtain nectar consistency in one-gallon of liquid (64 ounces) there needed to 16 squirts of thickener used.
-The directions on the container of thickener were to follow the usage chart, dispense appropriate amount of gel thickener into beverage and stir briskly for 30 seconds.

Telephone interview with Resident #2's family member on 06/04/21 at 10:04am revealed:
-Resident #2 was previously receiving hospice services and hospice ordered a pureed diet and nectar thickened liquids.
-He did not know if the diet was ordered as a result of tests completed or the Resident #2 had difficulty consuming foods.

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 _____	06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 310	Continued From page 8 Interview with the personal care aide (PCA) feeding Resident #2 on 06/03/21 at 12:15pm revealed: -She usually worked 5 days per week and provided feeding assistance to Resident #2 each day she worked. -She noticed that some days Resident #2 coughed and choked when consuming beverages. -She did not know the consistency ordered for Resident #2's beverages and she knew something had been added to the resident's beverages because they were not as thin as regular beverages. -When Resident #2 coughed she usually told the resident to slow down and take her time when drinking liquids. -Resident #2 did not cough at every meal. -Resident #2's choking was not like strangling or difficulty breathing it was more like a deep cough. -She patted the resident on the back and rubbed in circular motion to help the resident when coughing. -Resident #2's meats always looked like they did today, crumbly and dry. -She mixed the meat with the other foods on the resident's plate, so the meat was softer and easier for the resident to swallow. Telephone interview with Resident #2's PCP on 06/04/21 at 1:54pm revealed: -He knew Resident #2 was ordered a pureed diet with nectar thick liquids by a prior PCP. -The facility staff told him Resident #2 was still coughing and choking when consuming nectar liquids. -He did not see Resident #2's meals prepared and did not observe if her liquids were nectar consistency. -If the resident's liquids were not the correct	D 310		

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 _____	06/04/2021

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 310	Continued From page 9	D 310		

consistency that may cause coughing and choking.
-He was concerned about Resident #2 developing aspiration pneumonia which could result in death.

Interview with the Dietary Manager (DM) on 06/04/21 at 8:40am revealed:
-Resident #2 was previously on a mechanical soft diet and was recently changed to a pureed diet.
-When she prepared Resident #2's meal today she blended the meat with a little water.
-She had been trying to get the consistency of Resident #2's food like baby food, but she was unable to get the consistency of the meat like baby food consistency.
-When she started working at the facility one and one-half years ago the cook trained her how to prepare pureed meals.
-No other training had been provided to her related to preparing pureed meals.

Interview with the dietary aide (DA) on 06/03/21 at 9:55am and 2:10pm revealed:
-When she started working at the facility over one years ago there were directions posted in the kitchen how thicken liquids.
-The directions were for honey thick liquids.
-She was told by the previous cook that nectar thick liquids were not as thick as honey thick liquids.
-She developed her own process of thickening liquids by putting less thickener in the liquids that she prepared for nectar consistency.
-She did not read the instructions on the side of the thickener container.
-No one showed her how to thicken liquids.
-She had no training related to preparing thicken liquids.

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 _____	06/04/2021

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 310	Continued From page 10	D 310		

Interview with the Administrator-in-Charge on 06/04/21 at 5:00pm revealed:
-She expected Resident #2's liquids to be thickened to the consistency ordered.
-The DM was responsible for making sure everyone was served the correct ordered.
-The Director was supposed to go over the correct way to prepare and serve diets with the DM.
-As far as she knew the Director was supposed to train the DM the correct way to prepare pureed meals and thickened liquids.
-The Director should have trained the DA how to correctly prepared thickened liquids.

Based on observations, record reviews and interviews, it was determined Resident #2 was not interviewable.

2. Review of Resident #5's FL2 dated 04/25/21 revealed:
-Diagnoses including dementia, delirium, esophageal reflux and heart disease.
-There was an order for a regular diet.

Review of Resident #5's physician's order dated 05/12/21 revealed:
-"Please start pt on thickened liquids.".
-No consistency was documented.

Observation of the lunch meal on 06/03/21 at 11:30am revealed:
-Resident #5 was eating a chicken salad sandwich and banana pudding.
-An opened bottle of water was sitting on her table beside her chair.
-The water was not thickened.

Interview with the personal care aide (PCA) on

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 _____	06/04/2021

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 310	Continued From page 11 06/03/21 at 11:37am revealed: -She did not know if Resident #5 was still ordered thickened liquids. -Dietary aides prepared resident meals and delivered the meals and thickened liquids on a cart to the special care unit for staff to hand out. Interview with a second PCA on 06/03/21 at 11:38am revealed: -Resident #5 was to have thickened liquids. -Dietary aides usually sent the thickened liquids for residents on the cart with meals to the special care unit. -Resident #5 may have had a bottle of water without thickener in her room from previous family visits. Based on observation, record review and interview it was determined Resident #5 was not interviewable. Observation on 06/03/21 at 11:45am during lunch meal revealed: -A dietary aide delivered 4 glasses of thickened liquids to the special care unit nurses' station. -She informed the PCA the drinks were "regular thickener". -The liquids appeared very thin when the glass was tilted from side to side. Review of manufacturer's thickening instructions on the container of thickener on 06/03/21 at 10:01am revealed: -To obtain nectar consistency in 4 ounces of liquid add one squirt. -To obtain nectar consistency in 8 ounces of liquids add 2 squirts. -To obtain nectar consistency in one-gallon of liquid (64 ounces) there needed to 16 squirts of thickener used.	D 310		

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 _____	06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 310	Continued From page 12	D 310		

-The directions on the container of thickener were to follow the usage chart, dispense appropriate amount of gel thickener into beverage and stir briskly for 30 seconds.

Interview with the dietary aide (DA) on 06/03/21 at 9:55am and 2:10pm revealed:
-When she started working at the facility about one year ago there were directions posted in the kitchen how thicken liquids.
-The directions were for honey thick liquids.
-She developed her own process of thickening liquids by putting less thickener in the liquids that she prepared for nectar consistency.
-She did not read the instructions on the side of the thickener container.
-No one showed her how to thicken liquids.
-She had no training related to preparing thicken liquids.

Interview with the Dietary Manager (DM) on 06/04/21 at 8:40am revealed:
-Resident #5 was ordered thickened liquids, but did not specify a consistency.
-When she started working at the facility one and one-half years ago the cook gave her honey thickened liquids.
-No one had trained her on how to prepare thickened liquids.
-She just poured in thickener until the liquid looked like it was thickened.

Interview with the Administrator-in-Charge on 06/04/21 at 5:00pm revealed:
-She expected Resident #5's liquids to be thickened.
-The DM was responsible for making sure everyone was served the correct ordered thickened liquids.
-The Director was supposed to go over the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	06/04/2021

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 310	Continued From page 13 correct way to prepare and serve diets with the DM. -As far as she knew the Director was supposed to train the DM the correct way to prepare thickened liquids. -The Director should have trained the DA how to correctly prepared thickened liquids.	D 310		
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 administer medications as ordered for 1 of 3 residents (#6) observed during medication passes, including errors with medications for constipation, vitamin supplementation, and circulation; and for 1 of 5 residents sampled (#4) for record review including errors with administering an antibiotic eye drop after eye surgery. The findings are: 1. The medication error rate was 10% as evidenced by the observation of 3 errors out of 28 opportunities during the 8:00am medication pass on 06/04/21.	D 358		

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 _____	06/04/2021

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

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D 358	Continued From page 14 Review of Resident #6's current FL2 dated 02/01/21 revealed diagnoses included hypertension, chronic pain, osteoporosis, schizoaffective disorder. a. Review of Resident #6's current FL2 dated 02/01/21 and physician's orders dated 04/26/21 revealed an order for Miralax powder (used to treat constipation) 2 capfuls mixed in 16 ounces of fluid (water or juice) and take once daily. Observation of the morning medication pass on 06/04/21 at 7:58am revealed: -The medication aide (MA) prepared 12 oral medications, and one eye drop for administration to Resident #6. -The MA did not prepare Miralax 2 capfuls for administration. -The MA moved on from Resident #6 to administer another resident's medications. Review of Resident #6's June 2021 Medication Administration Record (MAR) on 06/04/21 at 9:11am revealed: -There was an entry for Miralax powder 2 capfuls mixed in 16 ounces of water or juice and take once daily for constipation. -Miralax powder was documented as administered at 8:00am on 06/04/21. Observation of medication on hand for administration for Resident #6 06/04/21 revealed there was a partial container of Miralax powder located in the bottom drawer of the medication cart. Interview with the MA on 06/04/21 at 12:00pm revealed: -She did not administer Resident #6's Miralax	D 358		

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 _____	06/04/2021

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D 358	Continued From page 15	D 358		

before the medication pass or after the medication pass on 06/04/21.
-She overlooked Miralax on the MAR when she prepared Resident #6's medications.
-Resident #6 routinely received Miralax for constipation.
-She documented administering the Miralax incorrectly.

Interview with Resident #6 on 06/04/21 at 1:00pm revealed:
-She did not receive Miralax today.
-She had an ongoing problem with constipation and taking Miralax helped her with going to the bathroom.

Interview with the Administrator-in-Charge (AIC) on 06/04/21 at 12:30pm revealed:
-MAs were responsible to administer medications as ordered on the MAR.
-MAs should be reading all the medications listed on the residents' MARs to ensure all medications were administered if ordered.

b. Observation of the morning medication pass on 06/04/21 at 7:58am revealed:
-The medication aide (MA) prepared 12 oral medications for administration to Resident #6.
-The MA prepared and added one Aspirin 81mg enteric coated (EC) tablet from a manufacturer's stock bottle not labeled with a resident's name to Resident #6's plastic souffle cup.

Review of Resident #6's physician's orders including the current FL2 dated 02/01/21 and physician's orders dated 04/26/21 revealed there was no physician's order for Aspirin 81mg (used to improve circulation.) enteric coated tablet for Resident #6.

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 _____	06/04/2021

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D 358	Continued From page 16 Review of Resident #6's June 2021 Medication Administration Record (MAR) on 06/04/21 at 9:11am revealed: -There was no entry for Aspirin 81mg enteric coated tablet for Resident #6. -There were MARs for Resident #6's roommate (family member with the same last name) in the front of the partitioned slot assigned to Resident #6 with an entry for Aspirin 81mg EC on one of the MARs. Interview with the MA observed during the medication pass on 06/04/21 at 12:00pm revealed: -She routinely used the residents' MARs to guide her in preparing medications for administration. -She did not realize Resident #6 had MARs for another resident mixed in the partitioned slot assigned to Resident #6 in the facility's MAR book. -She referred to one of Resident #6's roommate's MAR pages when she prepared Aspirin 81mg EC for administration to Resident #6. -She did not realize the residents' MARs were co-mingled until she reviewed the MARS with the surveyor. Interview with the Administrator-in-Charge (AIC) on 06/04/21 at 12:30pm revealed: -She had assisted medication staff with changing the residents' MARs from May 2021 to June 2021. -She placed Resident #6's June MARs and the roommates' (family member) June MARs in the same partitioned slot in the facility's MAR book but did not add another partition. -The MA had notified the AIC earlier today (06/04/21) that the MA had incorrectly administered medication belonging to Resident #6's roommate to Resident #6.	D 358		

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	HAL029010	A. BUILDING: _____ B. WING _____	06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 17 Interview with Resident #6 on 06/04/21 at 1:00pm revealed: -She did not know all her medications. -She did not know how many medications she received each time the MA gave her medications. -She felt no different today than any other day. Telephone interview with Resident #6's primary care provider (PCP) on 06/04/21 at 5:01pm revealed there should be no predictable negative outcome for Resident #6 receiving one dose of Aspirin 81mg EC not ordered for the resident. c. Observation of the morning medication pass on 06/04/21 at 7:58am revealed: -The medication aide (MA) prepared 12 oral medications for administration to Resident #6. -The MA prepared and added one multi-vitamin tablet from a manufacturer's stock bottle not labeled with a resident's name to Resident #6's plastic souffle cup. Review of Resident #6's physician's orders including the current FL2 dated 02/01/21 and physician's orders dated 04/26/21 revealed there was no physician's order for multi-vitamin tablet (used to supplement essential vitamins and minerals) for Resident #6. Review of Resident #6's June 2021 Medication Administration Record (MAR) on 06/04/21 at 9:11am revealed: -There was no entry for multi-vitamin tablet for Resident #6. -There were MARs for Resident #6's roommate (family member with the same last name) in the front of the partitioned slot assigned to Resident #6 with an entry for multi-vitamin on one of the MARs.	D 358		

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	HAL029010	A. BUILDING: _____ B. WING _____	06/04/2021

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D 358	Continued From page 18 Interview with the MA observed during the medication pass on 06/04/21 at 12:00pm revealed: -She routinely used the residents' MARs to guide her in preparing medications for administration. -She did not realize Resident #6 had MARs for another resident mixed in the partitioned slot assigned to Resident #6 in the facility's MAR book. -She referred to one of Resident #6's roommate's MARs when she prepared the multi-vitamin tablet for administration to Resident #6. -She did not realize the residents' MARs were co-mingled until she reviewed the MARs with the surveyor. Interview with the Administrator-in-Charge (AIC) on 06/04/21 at 12:30pm revealed: -She had assisted medication staff with changing the residents' MARs from May 2021 to June 2021. -She placed Resident #6's June MARs and the roommates' (family member) June MARs in the same partitioned slot in the facility's MAR book but did not add another partition. -The MA had notified the AIC earlier today (06/04/21) that the MA had incorrectly administered medication belonging to Resident #6's roommate to Resident #6. Interview with Resident #6 on 06/04/21 at 1:00pm revealed: -She did not know all her medications. -She did not know how many medications she received each time the MA gave her medications. -She felt no different today than any other day. Telephone interview with Resident #6's primary care provider (PCP) on 06/04/21 at 5:01pm	D 358		

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	HAL029010	A. BUILDING: _____ B. WING _____	06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 19	D 358		

revealed there should be no predictable negative outcome for Resident #6 receiving one dose of multi-vitamin not ordered for the resident.

2. Review of Resident #4's current FL2 dated 12/29/20 revealed diagnoses included anemia, anxiety, arthritis, and asthma.

Review of Resident #4's physician's orders dated 05/20/21 revealed an order for ofloxacin 0.3% eye drops (antibiotic eye drop used to treat or prevent infection) one drop in the left eye 4 times a day, begin one day prior to surgery and continue as directed.

Review of Resident #4's facility's physician encounter orders dated 05/26/21 revealed and order to begin drops today (05/26/21) per the attached post operative instructions.

Review of subsequent physician's one day post surgery instruction dated 05/27/21 revealed instructions to administer ofloxacin drops one drop 4 times a day and a return appointment date of 06/04/21.

Review of Resident #4's May 2021 Medication Administration Record (MAR) revealed:
-There was a handwritten entry dated 05/20/21 for ofloxacin 0.3% in the left eye 4 time daily, begin 1 day prior to surgery on the MAR.
-There were lines drawn through days prior to 05/25/21 with "start order" handwritten, and 05/25/21 marked with horizontal lines on the MAR.
-There was documentation ofloxacin drops were administered on 05/25/21 at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There was documentation handwritten for "order finished" in the area after 05/25/21 on the MAR.

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 _____	06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 20 -From 05/26/21 through 05/31/21, there was no subsequent documentation on the May 2021 MAR for administration of ofloxacin 0.3% one drop 4 times a day as ordered on the 05/26/21 facility encounter sheet dated 05/26/21 and the one day post surgery instructions dated 05/27/21. Review of Resident #4's June 2021 MAR revealed: -There was an entry for ofloxacin 0.3% eye drops one drop in the left eye 4 times a day, begin one day prior to surgery and continue as directed. -Ofloxacin was scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm daily. -Ofloxacin was documented for administration 8:00am, 12:00pm, 4:00pm, and 8:00pm daily from 06/01/21 to 06/03/21 and at 8:00am on 06/04/21. Observation of medications on hand for administration to Resident #4 on 06/04/21 at 10:15am revealed there was no ofloxacin 0.3% eye drops on the medication cart, treatment cart, or in medication backup/overstock available for administration. Interview with Resident #4 on 06/04/21 at 10:15am revealed: -He had not received ofloxacin 0.3% (the antibiotic eye drop with a tan top used the day before surgery) since he had his surgery. -He had received another eye drop with a pink top (a steroid eye drop ordered on 05/21/21 to be used also) 4 times a day since his surgery. -He received a second eye drop this morning (white top for allergy), 06/04/21 at 8:00am but he had not requested the allergy eye drop. -He was scheduled to be seen at the eye clinic today and would talk with the nurses to clarify which drops to continue.	D 358		

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 _____	06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 21	D 358		

-He did not have any eye drops in his room for administering because he had not been able to see well enough to administer eye drops after he had a hemorrhage in his left eye resulting in the need for surgery last week(05/26/21).

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 06/04/21 at 10:35am revealed:
-The pharmacy dispensed a 5ml bottle ofloxacin 0.3% drops on 05/21/21 with instructions for one drop in the left eye 4 times a day, begin one day prior to surgery and continue as directed.
-The facility would be responsible to do a manual entry on the May 2021 MAR for Resident #6.
-The pharmacy sent preprinted MARs for June 2021 with an entry for ofloxacin 0.3% eye drops and instruction for one drop in the left eye 4 times a day, begin one day prior to surgery and continue as directed.
-The 5ml bottle of ofloxacin 0.3% eye drops should last at least 14 days; the resident should have not run out and there were 2 refills ordered originally.
-There was no record of the facility returning an ofloxacin eye drops for Resident #4.

Interview with a morning shift medication aide (MA) on 06/04/21 at 12:10pm revealed:
-She had entered the information for Resident #4's eye drops on the May 2021 MAR.
-She had not seen the order for post surgery eye drops until today (6/04/21).
-She could not locate the bottle of ofloxacin 0.3% eye drops Resident #4 had available to use on 05/25/21.
-She did not know if the resident received ofloxacin 0.3% after surgery.
-There was no documentation for return of Resident #4's ofloxacin 0.3% eye drops to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 22	D 358		

contract pharmacy for credit.
-There was no ofloxacin eye drops to administer to Resident #4 on the medication cart, treatment cart, or overstock.

Telephone interview with a Supervisor/MA on 06/04/21 at 12:00pm revealed:
-She saw paperwork for Resident #4's ofloxacin 0.3% eye drops 4 times a day after surgery on 05/27/21.
-She was not sure why the new order was not put on the May 2021 MAR after the 05/27/21 follow-up appointment.
-She saw ofloxacin 0.3% eye drops on the medication cart top drawer on 05/27/21 she worked.
-She thought ofloxacin 0.3% eye drops was to be used prior to the surgery only.

Interview with the a second morning shift MA on 06/04/21 at 1:00pm revealed:
-She administered eye drops to Resident #4 this morning.
-She documented she administered ofloxacin 0.3% to Resident #4 at 8:00am.
-After reviewing medications, she realized she administered Resident #4's olopatadine 0.1% eye drops (used for allergies as needed) ordered 04/20/21 instead of ofloxacin 0.3% eye drops.
-She was not able to locate ofloxacin 0.3% drops on the cart for Resident #4 at 10:45am.
-She did not realize Resident #4 had 2 eye drops that started with an "o" and since there was no ofloxacin 0.3% eye drops to help her decide which eye drops to administer, she overlooked not administering ofloxacin eye drops.

Review of Resident #4's follow-up with the eye surgeon encounter form on 06/04/21 at 2:45pm revealed orders to discontinue ofloxacin 0.3% eye

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 _____	06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 23 drops since there was no sign of infection and it could not be determined if the resident had been administered the eye drops as ordered. Interview with the Administrator-in-Charge (AIC) on 06/04/21 at 3:00pm revealed: -When a medication order was received, the MA supervisor on duty was responsible to enter the order on the resident's MAR, and fax the order to the pharmacy, or ensure the Resident Care Coordinator or Memory Care Coordinator entered the order on the resident's MAR. -If ofloxacin 0.3% eye drops were not continued on the May 2021 MAR for Resident #4, then there was no way to determine if the medication was administered as ordered. -Resident #4 was dependable for knowing if his medications were administered. -The facility had not had staff to audit and double check orders and medication administration routinely for more than 2 weeks.	D 358		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health	D 612		

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 _____	06/04/2021

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 612	Continued From page 24	D 612		

department, the specific guidance or directives shall be implemented by the facility.

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

Based on observations, interviews, and record reviews, the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) and the facility's infection control policy were implemented and maintained to provide protection to the residents during the global coronavirus (COVID-19) pandemic and to reduce the risk of transmission and infection of respiratory illness as related to the facility's use of personal protective equipment (PPE) by staff when entering the room of a COVID-19 positive resident and wearing face masks when in a health care facility.

The findings are:

Review of the Center for Disease Control (CDC) guidelines for the prevention and spread of the coronavirus in a long-term care (LTC) facility dated 02/10/21 revealed:
The facility should also have a plan and mechanism to regularly communicate with residents, family members, and Health Care Personnel (HCP), including if cases of COVID-19 are identified in the facility.
-HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection.
-HCP should wear well-fitting source control at all

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 _____	06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 612	Continued From page 25	D 612		

times while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers.
-Put on clean, non-sterile gloves upon entry into the patient room or care area. Change gloves if they become torn or heavily contaminated. Remove and discard gloves before leaving the patient room or care area, and immediately perform hand hygiene.
-Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area.

Review of the North Carolina Department of Health and Human Services (NCDHHS) guidelines for prevention and spread of the coronavirus in LTC facilities dated 03/31/21 revealed:
-Ensure the facility policies comply with the latest guidance and educate staff about any policy changes.
-Educate and monitor staff on the appropriate and consistent use of PPE in line with the guidance regarding coronavirus.

Review of the facility's infection control policy "ICP" on 06/11/21 titled "Amendment to current Infection Control Plan effective 09/05/2020" revealed:
-"Source Control Measures-mask wearing, ..., signage, observation redirection reminders by co-workers and administrative staff and training."
-"**EMPLOYEES AND ALL NON-EMPLOYEE VISITORS ARE REQUIRED TO WEAR FACE MASKS OVER THE MOUTH AND NOSE WHILE INSIDE THE FACILITY**"
-"If a resident is showing signs of COVID-19,...The resident will be placed in a

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 _____	06/04/2021

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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 612	Continued From page 26 quarantine room..." Observation upon entrance to the facility on 06/03/21 at 8:15am revealed a staff came to the the front door of the facility without wearing a facemask and instructed the surveyors to self screen. Observation of the Special Care Unit (SCU) on 06/03/21 at 8:30am revealed: -There was a table containing disposable gowns,masks, face shields, shoe covers and hand sanitizer outside the SCU entrance. -A sign posted on the SCU entrance door reading "Quarantine Area" "FACE MASK REQUIRED BEYOND THIS POINT". -There was a staff wearing a mask and donning a gown and gloves outside the SCU doors and then entering the SCU. -There was a second staff entering and exiting resident rooms wearing the same gown and gloves. -There were no signs on any resident door in the SCU to indicate isolation and required PPE. Interview with a personal care aide (PCA) on 06/03/21 at 08:35am revealed: -Staff wore gowns and gloves while in the SCU because one resident was positive for COVID-19. -She did not know which resident was positive for COVID-19. -The medication aides (MA) kept a list of residents who had COVID-19 due to privacy concerns. Interview with the Resident Care Coordinator (RCC) on 06/03/21 at 8:40am revealed: -She was working the SCU as a MA that day. -The resident residing in room 304 was Covid-19 positive but asymptomatic and on her 9th day of	D 612		

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 _____	06/04/2021

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D 612	Continued From page 27	D 612		

isolation.
-The resident remained mostly in her room, but would occasionally need to be redirected.
-She was told by the Administrator-in-Charge (AIC) to place quarantine signs on the entrance to the SCU.
-She was not told to place an isolation sign on room 304 where the resident who was positive for COVID-19 resided.
-She did not have the Infection Control Policy accessible to her.
-The staff were still required to self screen and wear facemasks in the facility.

Interview with housekeeping staff on 06/03/21 at 8:52am revealed:
-She knew the resident residing in room 304 was positive for COVID-19.
-All staff gowned and gloved outside the SCU doors before entering the unit.
-She did not know she was supposed to dispose of personal protective equipment (PPE) before leaving room 304.
-She did not know she should not go into other resident rooms wearing the same PPE she wore in a resident's room who was COVID-19 positive.

Observation on 06/03/21 at 10:00 revealed a PCA walking in the hall by the dining room wearing a mask below her nose.

Observation on 06/04/21 at 2:00pm revealed the Maintenance Supervisor talking to a PCA in the doorway of resident room 203 wearing a facemask below his chin.

Observation 06/04/21 at 3:05pm revealed a member of the housekeeping staff walking in the hall by the Activity room without a facemask.

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D 612	Continued From page 28 Interview with the AIC on 06/03/21 at 9:30am revealed: -She had an Infection Control Policy for the facility's standard policy and COVID-19 but would have to print it. -It is still the facility's policy for employees to wear masks in the facility. -It is still the facility's policy to place signs on resident rooms when in isolation. -There were isolation signs on room 304 for COVID-19 isolation, but the other residents in the SCU wander and may have pulled them down. -She did not know who took the isolation signs off of room 304 where the resident who was COVID-19 positive resides. _____ The facility's failed to ensure the recommendations and guidance established by the Centers for Disease Control (CDC), The North Carolina Department of Health and Human Services (NCDHHS) were implemented and maintained to provide protection of residents during the global pandemic of COVID-19 related to the screening of staff in the facility and staff not wearing appropriate PPE when caring for COVID-19 positive and negative residents. This failure was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on June 03, 2021 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED July 19, 2021	D 612		

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D914	Continued From page 29	D914		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents were free from neglect as related to the facility's infection prevention and control program. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) and the facility's infection control policy were implemented and maintained to provide protection to the residents during the global coronavirus (COVID-19) pandemic and to reduce the risk of transmission and infection of respiratory illness as related to the facility's use of personal protective equipment (PPE) by staff when entering the room of a COVID-19 positive resident and wearing face masks when in a health care facility. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. [Refer to Tag D612, 10A NCAC 13F .1801(c) Infection Prevention and Control Program (Type B Violation)].	D914		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency	D935		

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D935	Continued From page 30 G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered	D935		

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D935	Continued From page 31	D935		

by the Division of Health Service Regulation in accordance with subsection (c) of this section.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 6 staff sampled (Staff E) who administered medications had passed the written medication aide exam within 60 days of completing the medication clinical skills evaluation.

The findings are:

Review of Staff E's, medication aide (MA) personnel record revealed:
-Staff E was hired on 01/04/21.
-There was a certificate of completion dated 12/30/20 for the 5-hour state approved medication aide training for Staff E.
-There was a certificate of completion dated 02/03/21 for the 10-hour state approved medication aide training for Staff E.
-There was documentation of a medication clinical skills competency validation checklist completed for Staff E dated 12/30/21.
-There was no documentation Staff E had successfully passed the written medication aide exam.

Review of residents' medication administration records (MARs) revealed at various times Staff E documented administration of medication administered on 04/27-28/21 and 06/04/21 including insulin administration.

Interview with Staff E on 06/04/21 at 4:25pm revealed:
-Staff E identified her initials on the MARs.
-She frequently worked at the facility because the facility was short staffed.

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D935	Continued From page 32 -On 03/19/21, she took the written medication aide exam but failed the exam. -After failing the written medication aide exam, she continued to administer medications to residents at the facility because the facility was short staffed. -Her 60-day time limit for taking the written medication aide exam ended in March 2021. -She was scheduled to take the written medication aide exam on 06/09/21. -When she administered medications, no other medications aide was present with her. Interview with the Administrator-in-Charge on 06/04/21 at 4:55pm revealed: -Staff E took the written medication aide exam in March 2021 and failed the exam. -Staff E completed the 5-hour and the 10-hour medication aide training prior to taking the written medication aide exam in March 2021. -Staff E completed the medication clinical skills competency in December 2020. -Staff E's 60-days from date of hire was March 2021. -Staff E continued to work as MA administering medications to the residents because the facility was short staffed.	D935		