Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	=1ED
		HAL029010	B. WING		R- 09/0	C 3/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CDAVCOA	LODGEK OF WELCOME	6781 OLD U	JS HWY 52			
GRATSUN	I CREEK OF WELCOME	LEXINGTO	N, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 000}	Initial Comments		{D 000}			
	The Adult Care Licens follow-up survey on 0	sure Section conducted a 9/01/21 - 09/03/21.				
{D 358}	10A NCAC 13F .1004 Administration	(a) Medication	{D 358}			
	(a) An adult care hon preparation and admi prescription and non-by staff are in accorda(1) orders by a licens which are maintained	Medication Administration ne shall assure that the nistration of medications, prescription, and treatments ance with: sed prescribing practitioner in the resident's record; and on and the facility's policies				
	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 5 sampled residents (Resident #1) related to an insomnia medication.					
	The findings are:					
	behaviors, chronic ob (COPD), trigeminal ne hypothyroidismThere was an order f treat sleep disorders) every night at bedtime	vascular dementia with structive pulmonary disease euralgia, and for temazepam (used to 15mg take 2 capsules e.				
	05/07/21 revealed an	1's physician order dated order for temazepam 30mg at bedtime as needed.				

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

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL029010	B. WING		R-C 09/03/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	,
			JS HWY 52		
GRAYSON	I CREEK OF WELCOME	LEXINGTO	N, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{D 358}	Continued From page	÷1	{D 358}		
{D 358}	Review of Resident # administration record revealed: -There was an entry f capsules every night 8:00pmThere was document administered from 07. Review of Resident # revealed: -There was an entry for capsules every night 8:00pmThere was document administered from 08. Observation of Resident # 1:00pmThere was document administered from 08. Observation of Resident # 1:00pmThere were no temain availableThere was one casse with 11 of 16 capsules with 11 of 16 capsules 08/12/21The directions on the administer 1 capsules 1:00pmThe scheduled temain 1:00pm.	1's medication (MAR) for July 2021 for temazepam 15mg take 2 at bedtime scheduled for station all doses had been /01/21 to 07/31/21. 1's MAR for August 2021 for temazepam 15mg take 2 at bedtime scheduled for station all doses had been /01/21 to 08/31/21. ent #1's medication on hand in revealed: zepam 15mg capsules sette of temazepam 30mg is remaining dispensed on the temazepam label read to at bedtime as needed. with a representative at the marmacy on 09/01/21 at order for temazepam 15mg or night at bedtime scheduled in zepam order was last filled in tity of 12 capsules as of refills.	{D 358}		
	order for temazepam	armacy had received an 30mg take 1 tablet as ut the scheduled order			

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remained the same.

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Division of	of Health Service Regu	liation				
	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
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			B. WING		R-	
		HAL029010	D. WING		09/0	3/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STAT	TE, ZIP CODE		
		6781 OLF	US HWY 52			
GRAYSON	N CREEK OF WELCOME					
		LEXINGI	ON, NC 27295			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE
TAG	REGULATORT OR L	LSC IDENTIFTING INFORMATION)	TAG	DEFICIENCY)	MAIL	DATE.
				,		
{D 358}	Continued From page	e 2	{D 358}			
		vas dispensed on 05/07/21				
	for a quantity of 16 ca	•				
		vas dispensed on 07/15/21				
	for a quantity of 16 ca	apsules.				
	-Temazepam 30mg w	vas dispensed on 08/12/21				
	for a quantity of 16 ca	apsules.				
	-Temazepam was pre	escribed for Resident #1 due				
	to a sleep disorder.					
	'					
	Telephone interview v	with Resident #1's hospice				
		/21 at 12:03pm revealed:				
	1 -	acy dispensed an 8-day				
		15mg on 05/27/21 from				
		kup which is all they could				
	-	eeded a new prescription.				
		ve been any temazepam				
	from 06/12/21 through					
		nany gaps throughout that				
		t #1 was not administered				
	1	g every night at bedtime as				
	ordered.					
		with a triage nurse with				
	Resident #1's hospice	e provider on 09/02/21 at				
	11:30am revealed:					
	-The facility's contract	ted pharmacy was				
	responsible for filling	Resident #1's temazepam				
	order and billing hosp					
	-The hospice pharma					
		esident would not miss any of				
	her medication.	,				
		the contracted facility				
		azepam that had been				
	dispensed.	azepani inai nau been				
		on on tomozonom for 2				
		en on temazepam for 2				
	years.					
		ginally ordered as needed				
	but was changed to n	ightly on 03/19/21.				
	İ				1	1

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Interview with Resident #1's hospice nurse on

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Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6781 OLD US HWY 52 LEXINGTON, NC 27295 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A. BUILDING: B. WING B. WING PREFIX (IV) STATE, ZIP CODE FREFIX (EACH CORRECTION OF CORRECTION SHOULD BE COM TAG CROSS-REFERENCED TO THE APPROPRIATE DEFINITION OF CORRECTION SHOULD BE COM TAG CROSS-REFERENCED TO THE APPROPRIATE DEFINITION OF CORRECTION SHOULD BE COM TAG CROSS-REFERENCED TO THE APPROPRIATE DEFINITION OF CORRECTION SHOULD BE COM TAG CROSS-REFERENCED TO THE APPROPRIATE DEFINITION OF CORRECTION SHOULD BE COM TAG CROSS-REFERENCED TO THE APPROPRIATE DEFINITION OF CORRECTION SHOULD BE COM TAG CROSS-REFERENCED TO THE APPROPRIATE DEFINITION OF CORRECTION SHOULD BE COM TAG CROSS-REFERENCED TO THE APPROPRIATE DEFINITION OF CORRECTION SHOULD BE COM TAG CROSS-REFERENCED TO THE APPROPRIATE DEFINITION OF CORRECTION SHOULD BE COM TAG CROSS-REFERENCED TO THE APPROPRIATE DEFINITION OF CORRECTION SHOULD BE COM TAG CROSS-REFERENCED TO THE APPROPRIATE DEFINITION OF CORRECTION SHOULD BE COM TAG CROSS-REFERENCED TO THE APPROPRIATE DEFINITION OF CORRECTION SHOULD BE COM TAG CROSS-REFERENCED TO THE APPROPRIATE DEFINITION OF CORRECTION SHOULD BE COM TAG CROSS-REFERENCED TO THE APPROPRIATE DEFINITION OF CORRECTION SHOULD BE COM TAG CROSS-REFERENCED TO THE APPROPRIATE DEFINITION OF CORRECTION SHOULD BE COMPT.		NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6781 OLD US HWY 52 LEXINGTON, NC 27295 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
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LEXINGTON, NC 27295 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM CRACK TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE D	CD AVCOL	N ODEEK OF WELCOME	6781 OLD	US HWY 52		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE D	GRAYSON	IN CREEK OF WELCOME	LEXINGTO	N, NC 27295		
	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
(D 358) Continued From page 3 09/01/21 at 11:59am revealed: -The resident had complained that she had not been sleeping well and her sleeping pill had not been working, -She instructed the resident that she could also request her anti-anxiety medication at the same time she took her temazepam to help get some sleep. Interview with Resident #1 on 9/02/21 at 11:12am revealed: -She had not been sleeping well for several months because the sleeping pill was not workingNot sleeping well caused her not to care about anythingShe did not do well participating with any activities because she was so tired and just wanted them to be overIt made her irritable and short with staff and generally upset with everyoneShe had gotten to the point she just went to eat her meals and came right back to her room to lay down and rest. Telephone interview with the facility contracted provider on 09/02/21 at 11:44am revealed: -He used to be the primary care provider for Resident #1Resident #1 had been off and back on hospice services a few timesHe had signed the FL2 and 6-month orders for Resident #1 because he thought she had discharged from hospice servicesHe wrote an order for temazepam 30mg as needed at bedtime on 05/07/21 for Resident #1 because she needed a new prescription and he thought she was on his servicesHe thought that when he received requests to	{D 358}	O9/01/21 at 11:59am -The resident had corbeen sleeping well arbeen workingShe instructed the rerequest her anti-anxietime she took her temsleep. Interview with Reside revealed: -She had not been slemonths because the workingNot sleeping well caranythingShe did not do well pactivities because she wanted them to be over the sleeping well caranythingShe had gotten to the her meals and came down and rest. Telephone interview was provider on 09/02/21 -He used to be the provider on 09/02/21 -He used to be the provider with the services a few timesHe had signed the Form Resident #1 because discharged from hospus the wrote an order form eeded at bedtime or because she needed thought she was on her services.	revealed: mplained that she had not ad her sleeping pill had not esident that she could also bety medication at the same hazepam to help get some int #1 on 9/02/21 at 11:12am reeping well for several sleeping pill was not used her not to care about everyone, and short with staff and reveryone. re point she just went to eat right back to her room to lay with the facility contracted at 11:44am revealed: imary care provider for en off and back on hospice L2 and 6-month orders for he thought she had bice services. r temazepam 30mg as 105/07/21 for Resident #1 a new prescription and he is services.	{D 358}	DEL KOLENOTY	

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOWIDER.	A. BUILDING: _			
		HAL029010	B. WING		R-C 09/03/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
GRAYSON	I CREEK OF WELCOME		US HWY 52			
			ON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLE	
{D 358}	Continued From page	e 4	{D 358}			
	resident had been dis	charged from hospice.				
	Telephone interview v nurse practitioner on revealed:	vith Resident #1's hospice 09/02/21 at 2:46pm				
	 -She assessed the re -Originally, the reside medication for sleep. 	nt was on a different				
	medication for sleep, but it did not work so we changed her to temazepam. -The last couple times she saw the resident, she could tell she was not resting well because she was tired, had increased agitation, and tearfulness.					
	wrote a prescription for	e contracted facility provider or the resident on 05/07/21				
	out of temazepam ref	of refills. otified that the resident was ills and needed a new order ne hospice nurse informed				
	her that she needed s	•				
	facility on 05/27/21. -If the resident had no	•				
	•	ed she would show signs of and more depressed with was what she had				
	documented on her la	en made aware of the				
	resident needing refill -She expected the face					
	comfortable.	ou to resident				
	(MCUC) on 09/02/21					
	-She regularly passed residents in memory of	care unit.				
	-She had noticed the Resident #1 had beer	past few months that n lying in bed a lot more than				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R-C
		HAL029010	B. WING		09/03/2021
NAME OF B	ROVIDER OR SUPPLIER	etdeet /	ADDRESS, CITY, STAT	E ZIR CODE	
NAME OF F	ROVIDER OR SUFFLIER		.D US HWY 52	E, ZIF CODE	
GRAYSON	CREEK OF WELCOME		TON, NC 27295		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
TAG REGULATORY OR L		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	XIAIE
{D 358}	Continued From page	. 5	{D 358}		
(5 000)	Continued From page		[[5 000]		
	she used to.				
		eat and then went straight			
	back to her room and				
	I	articipating in activities like			
	she used to.				
	-Resident #1 did not h	-			
	temazepam available				
	-Resident #1 had son				
	ordered as needed th	at sne nad used to eduled dose on 09/01/21.			
		d out cycle fill medications ure all medications were on			
	the medication cart.	ule all medications were on			
		y Resident #1 did not have			
	any scheduled temaz				
		onal care aide (PCA) on			
	09/02/21 at 12:45 rev				
		n more tired lately and had			
		in activities for the past 3			
	months.				
		ked harshly to staff but she			
	did not mean anything	g by it.			
	Interview with the Inte	erim Director on 09/02/21 at			
	12:55 pm revealed:				
	-The MA on duty ched	cked cycle fill medications to			
	ensure all medication	s were available as			
	compared to the MAF	₹.			
	-The MAs checked th	e medication dosage and			
	ensured the as neede	ed medications were			
	available.				
	-The MAs also counte				
		cycle fill to ensure the			
	count was matched t				
		o follow up on any missing			
	medications and call t	the provider for orders as			

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needed.

-Medication carts were audited on 08/27/21 for

expired medications and to ensure all

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL029010	B. WING	B. WING		3/ 2021
NAME OF D					1 09/0	5/2021
NAIVIE OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA US HWY 52	TE, ZIP CODE		
GRAYSON	I CREEK OF WELCOME		ON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 358}	Continued From page	e 6	{D 358}			
	-The MCUC complete Memory Care Unit medication cart every problemsThe specific and call the residents in the farman and call the farman	ministrator on 09/02/21 at ty provider could see any of acility. The problems with the hospice ling and signing medication of the facility provider signed 1. The macy nurse audited the 13 months. The pharmacy nurse audited 8/27/21 to ensure ailable and did not find any to follow up on any missing the provider for orders as a responsibility to ensure				
D 363	10A NCAC 13F .1004 Administration	H(f) Medication	D 363			
	(f) If medications are in advance, the follow implemented to keep the point of administracontamination and sp (1) Medications are d package such as unit labeled with the name strength in the sealed package of medicatio and kept enclosed in	ispensed in a sealed dose and multi-paks that is e of each medication and package. The labeled ns is to remain unopened				

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUILDING: _			
		HAL029010	B. WING		R-0	3/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GRAYSON	CREEK OF WELCOME	6781 OLD U				
		LEXINGTO	N, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 363	Continued From page	2 7	D 363			
	until the medications resident. If the multi-resident's name, it do in a capped or sealed (2) Medications not dilabeled package as sof this Paragraph are container that identifie each medication prepname; (3) A separate contain and each planned admedications and labe Subparagraph (1) or (4) All containers are separate tray or other the planned time for a	are administered to the pak is also labeled with the es not have to be enclosed container; ispensed in a sealed and pecified in Subparagraph (1) kept enclosed in a sealed es the name and strength of eared and the resident's her is used for each resident ministration of the led according to (2) of this Paragraph; and placed together on a device that is labeled with administration and stored in sonly accessible to staff as				
	reviews, the facility far prepared for administring a sealed container strength of each med up to the point of administrom contamination as sampled residents (Roman The findings are: Observations on 09/0 Memory Care Unit (Morevealed:	ns, interviews, and record iled to ensure medications ration in advance were kept that identified the name and ication prepared, identified hinistration and protected				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL029010	B. WING		R- 09/0	C 3/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GRAYSO	CREEK OF WELCOME		JS HWY 52 N, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 363	-No administration tim -The cups were not so name and strength of 1. Review of Residen 04/25/21 revealed: -Diagnoses included and hypertensionThere was an order of tablet three times a day Observation of the Mamedication room cour revealed: -There was a cup labor initials which containe pudding sitting on the residents' medications -The Memory Care Up picked up the cup and administered the medication administered the medication administrate there was an entry for three times a day sch 8:00 am, 12:00 pm ar Based on observation reviews it was determinerviewable. Refer to interview with 4:15pm.	sident's initials on the side. hes were on the cups. healed and did not identify the heach medication. It #8's current FL2 dated Idementia, atrial fibrillation, For quetiapine 25mg one hay. Hemory Care Unit (MCU) her on 09/01/21 at 4:07pm Heled with Resident #8's head a medication mixed with he counter with 2 other her is. hit Coordinator (MCUC) he took it to Resident #8 and helication. I's September 2021 hation record (MAR) revealed her quetiapine 25mg one tablet hed took it to administration at	D 363			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R-C
		HAL029010	B. WING		09/03/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
GRAYSON	I CREEK OF WELCOME		US HWY 52 ON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 363	Continued From page	9	D 363		
	Refer to the interview 09/02/21 at 4:50pm.	with the Administrator on			
	04/25/21 revealed:	t #9's current FL2 dated dementia, atrial fibrillation,			
	hypertension, and dia				
	-There was an order for baclofen 10mg one tablet three times a day. Observation of the Memory Care Unit (MCU) medication room counter on 09/01/21 at 4:13pm revealed:				
	initials which contained mixed with pudding si	eled with Resident #9's ed a crushed medication itting on the counter with 2			
		nit Coordinator (MCUC) d took it to Resident #9 and			
	there was an entry for	ation record (MAR) revealed r baclofen 10mg one tablet eduled for administration at			
		ns, interviews, and record nined Resident #9 was not			
	Refer to interview with 4:15pm.	h a MCUC on 09/01/21			
	Refer to interview witl 09/01/21 at 4:20pm.	h the Interim Director on			
	Refer to the interview 09/02/21 at 4:50pm.	with the Administrator on			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
		HAL029010	B. WING		I	R-C 0/03/2021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE	1 30	700/2021
CD AVCO	LODGEK OF WELCOME		US HWY 52	,		
GRAYSUI	N CREEK OF WELCOME	LEXINGT	ON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 363	Continued From page	e 10	D 363			
	06/01/21 revealed: -Diagnoses included osteoporosis, and hyp	oothyroidism. for acetaminophen 500mg				
	medication room cour revealed: -There was a cup lab- initials which containe mixed with pudding si other residents' medic -The Memory Care U	nit Coordinator (MCUC) d took it to Resident #10 and				
	there was an entry for tablet three times a d	ation record (MAR) revealed r acetaminophen 500mg one				
		ns, interviews, and record nined Resident #8 was not				
	Refer to interview with 4:15pm.	h a MCUC on 09/01/21				
	Refer to interview witl 09/01/21 at 4:20pm.	h the Interim Director on				
	Refer to the interview 09/02/21 at 4:50pm.	with the Administrator on				
	Refer to interview with Coordinator (MCUC)	h a Memory Care Unit on 09/01/21 4:15pm.				

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Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R-C
		HAL029010	B. WING		09/03/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE	
OD AVOOL	LODEEK OF WELCOME	6781 OLD	US HWY 52		
GRAYSON	I CREEK OF WELCOME	LEXINGT	ON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 363	Continued From page	e 11	D 363		
	-She pre-poured med	lications to help save time.			
		p with the resident's initials.			
		ations for the residents one			
		the MAR for each resident,			
	-	ation to the MAR, and			
		ns in the cup labeled with			
	each residents' initials	s only and moving to the			
	next resident.				
	-	pudding and were not			
		entify the name and strength			
	of each medication.				
		at medications had to be			
	and strength.	th each medication name			
	-She pre-poured the r	medications with the			
		go administer by carrying all			
	3 cups in her hand go				
	resident.	g			
	-She had been trained	d not to pre-pour			
	medications.				
		ot supposed to pre-pour			
	medications as the fa	cility did not allow it.			
	Interview with the Interview 4:20pm revealed:	erim Director on 09/01/21 at			
		ns had been pre-poured as			
		counter in the MCUC.			
	-The MAs had been to				
	medications.				
	-She expected medic	ations to be given when they			
	were due and not pre	-poured.			
		ministrator on 09/02/21 at			
	4:50pm revealed:	ne had been pre poured			
		ns had been pre-poured terim Director saw them she			
	reported it to her imm				
	•	usly been told they were not			

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allowed to pre-pour medications.

-She expected all medications to be given when

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			_		R-C	,
		HAL029010	B. WING		1	3/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GRAYSON	I CREEK OF WELCOME	6781 OLD U				
			N, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 363	Continued From page	e 12	D 363			
	due and not pre-pour	ed in advance.				
D 367	10A NCAC 13F .1004 Administration	(j) Medication	D 367			
	(j) The resident's med record (MAR) shall be following: (1) resident's name; (2) name of the medic (3) strength and dosa administered; (4) instructions for addor treatment; (5) reason or justificate medications or treatmed documenting the result (6) date and time of a (7) documentation of medications or treatmed omission, including refusion (8) name or initials of the medication or treasignature equivalent to	any omission of the sents and the reason for the sefusals; and, the person administering atment. If initials are used, a to those initials is to be intained with the medication				
	reviews, the facility fa medication administra	ns, interviews, and record				
	The findings are:					
	1. Review of Residen 01/01/21 revealed:	t #1's current FL2 dated				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			(X3) DATE SURVEY COMPLETED	
	HAL029010	B. WING		R- 09/0	-C 03/2021	
NAME OF PROVIDER OR SUPPLIE	R STREET A	DDRESS, CITY, STATE	, ZIP CODE			
GRAYSON CREEK OF WELD	6781 OL	D US HWY 52				
ORATOON ORLER OF WEEK	LEXING	ON, NC 27295				
PREFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
behaviors, chror (COPD), trigemi hypothyroidismThere was an of treat sleep disornight at bedtime Review of Resid 05/07/21 reveale administer 1 tab Review of Resid administration revealed: -There was an etablets every nig 8:00amThere was doct administered from Review of Resid revealed: -There was an etablets every nig 8:00amThere was an etablets every nig 8:00amThere was doct administered from Observation of Fon 09/01/21 at 4	aded vascular dementia with nic obstructive pulmonary disease nal neuralgia, and order for temazepam (used to ders) 15mg take 2 tablets every dent #1's physician order dated an order for temazepam 30mg let at bedtime as needed. Sent #1's medication ecord (MAR) for July 2021 dentry for temazepam 15mg take 2 ght at bedtime scheduled for aumentation all doses had been m 07/01/21 to 07/31/21. Sentry for temazepam 15mg take 2 ght at bedtime scheduled for aumentation all doses had been m 08/01/21 to 08/31/21. Resident #1's medication on hand :00pm revealed:	D 367				
availableThere was one with 11 of 16 tab -The directions of administer 1 cap Telephone interv	cassette of temazepam 30mg slets remaining. On the temazepam label read to osule at bedtime as needed.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
						D C
		HAL029010	B. WING			R-C 9 /03/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE		
		6781 OLD	US HWY 52			
GRAYSO	N CREEK OF WELCOME	LEXINGTO	ON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 367	Continued From page	: 14	D 367			
	take 2 tablets every n for 8:00am. -The scheduled temal on 05/12/21 for a qual Resident #1 was out con 05/07/21, the phoorder for temazepam needed at bedtime, by remained the same. -Temazepam 30mg w for a quantity of 16 callowed a remaining to 16 callowed a remaining with the same of the sam	of refills. armacy had received an 30mg take 1 tablet as ut the scheduled order as dispensed on 05/07/21 apsules. as dispensed on 07/15/21 apsules. as dispensed on 08/12/21				
	pharmacist on 09/02/2 -The primary pharmacist on 09/02/2 -The primary pharmacisted the hospice pharmacy pharmacisted through 05/12/2 -The primary pharmacisted from 5/13/21 the primary pharmacisted from 5/13/21 the primary pharmacisted from 5/29/21 through 06/03 -The hospice pharmacy an 5/29/21 through 06/03 -The hospice pharmacy pharmacisted from 5/29/21 through 06/03 -The hospice pharmacy pharmacisted from 5/29/21 through 06/03 -The hospice pharmacisted from 5/29/21 through 06/03	cy dispensed a 16-day 30mg on 05/07/21 and armacy and it should have arough 05/28/21. cy dispensed a 6-day supply on 05/12/21 and billed the d it should have lasted from 3/21. cy dispensed an 8-day 15mg on 05/27/21 from aup which is all they could eeded a new prescription. It				

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STATEMENT	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R-C
		HAL029010	B. WING		09/03/2021
		0.70.57		TE 710 000E	
NAME OF P	ROVIDER OR SUPPLIER	STREETAL	DDRESS, CITY, STA	ITE, ZIP CODE	
GPAVSON	CREEK OF WELCOME	6781 OLI	O US HWY 52		
OKATOO	TORLLIN OF WELCOME	LEXINGT	ON, NC 27295		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	(- /
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE
				DEFICIENCY)	
D 367	Cantinual Francisco	- 45	D 367		
D 301	Continued From page	# 10	D 307		
	-There would not hav	e been any temazepam			
	from 06/12/21 through				
		cy dispensed a 15-day			
		15mg on 06/22/21 and			
		armacy and it should have			
	lasted from 06/22/21	•			
		e been any temazepam			
	from 07/07/21 through				
		cy dispensed a 16-day			
		30mg on 07/15/21 and			
	billed the hospice pha	armacy and it should have			
	lasted from 07/15/21	through 07/30/21.			
	-There would not hav	e been any temazepam			
	from 07/31/21 through	h 08/11/21.			
	-The primary pharma	cy dispensed a 16-day			
		30mg on 08/12/21 and			
		armacy and it should have			
		through 08/27/21 if they had			
	been administered as				
		nany gaps throughout that			
		t #1 was not administered			
		ery night at bedtime as			
	ordered.				
	•	with a triage nurse with			
	-	e provider on 09/02/21 at			
	11:30am revealed:				
	-The facility's contrac	ted pharmacy was			
	responsible for filling	Resident #1's temazepam			
	order and billing hosp	pice.			
	-The hospice pharma	icy provided backup			
		sident would not miss any of			
	her medication.	•			
		the contracted facility			
		azepam that had been			
	dispensed.	,			
		en on temazepam for 2			
		on on temazopam for z			
	years.	ginally ordered as pooded			
		ginally ordered as needed			
	but was changed to n	iigniiy on 03/19/21.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			D 0
		HAL029010	B. WING			R-C 9/03/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
CDAVSO	N CREEK OF WELCOME	6781 OLI	D US HWY 52			
GRATSU	N CREEK OF WELCOME	LEXINGT	ON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From page	e 16	D 367			
	O9/01/21 at 11:59am -The resident had corbeen sleeping well arbeen workingShe instructed the rerequest her Xanax at temazepam to help g Interview with Residerevealed: -She had not been slemonths because the -Not sleeping well caranything. She did not do well processes was so overIt made her irritable agenerally upset with e-She has gotten to the	esident that she had not esident that she could also the same time she took her et some sleep. Ent #1 on 9/02/21 at 11:12am eeping well for several sleeping pill quit working. used her not to care about earticipating with any activities tired and just wanted it to be and short with staff and				
	provider on 09/02/21 -He had signed the F Resident #1 because off hospice servicesHe wrote an order for needed at bedtime or because she needed thought she was on h -He thought that whe	n he received requests to orders for a resident, the				
	Telephone interview v	vith Resident #1's hospice 09/02/21 at 2:46pm				

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<u>Division c</u>	<u>of Health Service Regu</u>	ılation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	≣TED
					R-0	C
		HAL029010	B. WING		1	3/2021
		TIAL023010			1 03/0	3/2021
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CDAVCON	I CDEEK OF WELCOME	6781 OLD	US HWY 52			
GRATSON	I CREEK OF WELCOME	LEXINGTO	ON, NC 27295			
(X4) ID	SUMMARY ST.	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PRÉFIX	,	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	KEGULATURT OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RAIE	DATE
			+	<i>,</i>		
D 367	Continued From page	e 17	D 367			
	revealed:					
		es she saw the resident, she				
		t resting well because she				
	was tired, had increas	•				
	tearfulness.	seu agitation, and				
	-She last saw the res	ident on 07/1 <u>4/</u> 21				
		e contracted facility provider				
		for the resident on 05/07/21				
	because she was out					
		otified that the resident was				
		fills and needed a new order				
		he hospice nurse informed				
	her that she needed s					
		some temazepam.				
	Interview with the Me	emory Care Unit Coordinator				
	(MCUC) on 09/02/21					
	, ,	past few months that				
		n lying in bed a lot more than				
	she used to.	,				
	-Resident #1 did not I	have any scheduled				
	temazepam available	_				
	-Resident #1 had son					
	ordered as needed th	· · · · · · · · · · · · · · · · · · ·				
		neduled dose on 09/01/21.				
	-The MA who change	ed out cycle fill was supposed				
	_	ions were on the medication				
	cart.					
	-She did not know wh	ny Resident #1 did not have				
	any scheduled temaz					
	-She believed the MA	ARs were accurate as she				
	only administered me	edication if the medication				
	was available.					
		erim Director on 09/02/21 at				
	12:55 pm revealed:					
		cked cycle fill to ensure all				
		ailable as compared to the				
	MAR.					
	-They checked the m	nedication dosage, ensured				

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the as needed medications were available, and

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R-	_
		HAL029010	B. WING		1	3/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GRAYSON	I CREEK OF WELCOME	6781 OLD U				
			N, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page	e 18	D 367			
D 367	counted the controlled cycle fill to ensure the ensure nothing happed. Medication carts were expired medications were available. The SCUC complete medication cart. When a MA did not at they were supposed to MAR and document won the back of the MA-she expected all MA and they were supposed to the medication carts on the back of the MA-she expected all MA and the supposed to the medication carts on the facility's contract medication carts on the medication carts on the medication cart every. The contracted pharm medication cart every are supposed to the medication cart every. She expected MARs MAs to document who was not administered to the contracted pharm medication cart every. Review of Residen the was not administered to the contracted pharm medication cart every and the contracted pharm medication cart every. Review of Residen the was not administered to the contracted pharm medication cart every and the contracted pharm medication cart every are supposed to the contracted pharm medication cart every and the contracted pharm medication cart every are supposed to the contracted pharm medication cart every and the contracted pharm medication cart every supposed to the contracted pharm medication cart every are supposed to the contracted pharm medication cart every are supposed to the contracted pharm medication cart every supposed to the contracted pharm medicat	d substances that came with e count was correct to ened during transit. The audited on 08/27/21 for and to ensure all ailable and matched orders. The defendence of the rown audit on her administer a medication, to circle their initials on the why it was not administered AR. The rown audit on the why it was not administered at the pharmacy nurse audited 8/27/21 to ensure ailable and did not find any enacy nurse audited the and amount and the and why a medication of the en and why a degenerative are copply, and degenerative are copply, and degenerative are corder dated 08/10/21 for im (used to treat infection) daily for seven days.	D 367			
	take one tablet twice	daily for seven days. 2's August 2021 medication				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING		R-C
		HAL029010	B. WING		09/03/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
GRAYSON	I CREEK OF WELCOME		US HWY 52		
	OLIMAN DV OT		ON, NC 27295	DROWDERIO PLAN OF CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 367	Continued From page	e 19	D 367		
D 367	-There was no typed Septra-DS/trimethopr daily for seven daysThere was no docum Septra-DS/trimethopr August 2021. Telephone interview with the facility's contracted 4:33pm revealed ther Septra-DS/trimethopr 08/10/21. Interview with the Res (RCC) on 09/01/21 at -The facility had a cas Septra-DS/trimethopr of 08/10/21Septra-DS/trimethopr of 08/10/21Septra-DS/trimethopr of 08/10/21Septra-DS/trimethopr of 08/10/21 at 5:30pm reshe administered the Resident #2 during the Resident #2 during the She did not know who documented on the Moreon and added or change -She expected all MAINTERING INTERIOR INTE	or written entry for im take one tablet twice mentation that im was administered in with a representative from ad pharmacy on 09/01/21 at e was a quantity of 14 im tablets dispensed on sident Care Coordinator assette of the im on hand during the week of 08/10/21. Perim Director (ID) on evealed: e Septra-DS/trimethoprim to be week of 08/10/21. The week of 08/10/21 at the medication was not 1/4. The week of 08/10/21 at the medication was not 1/4. The week of 08/10/21 at the medication was not 1/4. The week of 08/10/21 at 1/4. The week 1	D 367		
	medication was not a 3. Review of Residen	dministered. t #3's FL2 dated 01/01/21			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		HAL029010	B. WING		I	R-C ∂ /03/2021
		11AE029010			08	70372021
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	E, ZIP CODE		
GRAYSO	N CREEK OF WELCOME		D US HWY 52			
	T	LEXING	TON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From page	20	D 367			
	cognitive communical fibrillationThere was an order once a day used to tree	for citalopram 20mg 1 tablet eat behaviors.				
		3's 01/01/2021 revealed an Omg 1 tablet once a day.				
	Review of Resident #3's medication administration record (MAR) for August 2021 and September 2021 revealed an entry for citalopram 20mg 1 tablet once a day documented as given from 08/27/21 through 09/02/21. Observation of Resident #3's medications on hand on 09/02/21 revealed a cartridge containing 8 tablets labeled citalopram 10mg 1 tablet every day dispensed on 08/27/21.					
	Based on observatior interview, it was deter interviewable.	n, record review and rmined Resident #3 was not				
	the facility's contracted 10:38am revealed: -A verbal order from F provider was received 08/26/21 to change conce a day to citalopre. The pharmacy printed end of the previous means of the previous means of the previous of	italopram 20mg 1 tablet ram 10mg 1 tablet every day. rd MARs for the facility at the				
	2021.	new MAR in September r Resident #3's citalopram				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
					R-C
		HAL029010	B. WING		09/03/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STATE	E, ZIP CODE	
GRAYSO	N CREEK OF WELCOME	6781 OLD	US HWY 52		
OINAIOOI	TORLER OF WELGOINE	LEXINGT	ON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 367	Continued From page	21	D 367		
	was missed somehow the September 2021	v and was not changed on MAR.			
	Interview with a medion 09/02/21 at 11:45am	revealed:			
	-The MAs checked m delivered by pharmac medication cart.	edication cartridges before adding them to the			
	•	or Administrator were w orders or changes to the			
	MARIf something was inc				
	could call the provide				
		the needed medication cribed the order or change			
	Telephone interview v 09/02/21 at 12:05pm	vith the hospice provider on revealed:			
	citalopram dose of 20				
		dication aide (MA) on verbal order to pharmacy to b's citalopram from 20mg			
	once a day to 10mg of -The facility's MAs too and faxed them to the	ok verbal/telephone orders			
	09/02/21 at 12:15pm				
		er taking a verbal order from #3's citalopram 20mg to			
	-When MAs received	verbal orders, they wrote			
		lity's order sheets and gave rector of Administrator to			
	-When orders were ve	erified, the Interim Director, added or changed orders			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL029010	B. WING		R-C 09/03/2021
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	00/00/2021
GRAYSOI	N CREEK OF WELCOME		US HWY 52		
		LEXINGTO	N, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 367	Continued From page	22	D 367		
	on the MAR.				
	(MA) on 09/02/21 at 3 -She performed the c cartridges during the exchange on 08/27/2 -She noticed Residen instead of 20mgShe thought she work contact the hospice p she did not attempt to -It was common pract order would add it to -She did not change to thought the MA who to change the MAR the -She was then on lea able to follow-up with Interview with Interim 10:40am revealed: -She did not know the order changed on 08/ -When hospice staff in change, they gave the Director or the Admin -MAs would go throug pharmacyIf a medication or a c resident, the MAs not the AdministratorThe Interim Director orders and added/cha Interview with the Adr 10:50am revealed: -She did not know Re changed on 08/26/21	hecks on medication pharmacy medication 1 around 9:30pm. It #3's citalopram was 10mg Ild not have been able to rovider that late at night, so o verify the order change. Itice for the MA who took the the MAR. In the MAR because she look the verbal order would next morning. In the MA who took the order. Director on 09/02/21 at In the MAR because she look the verbal order would next morning. In the MA who took the order. Director on 09/02/21 at In the MAR because she look the verbal order would next morning. In the MAR because she look the verbal order would next morning. In the MAR because she look the verbal order would next morning. In the MAR because she look the verbal order would next morning. In the MAR because she look the verbal order would next morning. In the MAR because she look the verbal order would next morning. In the MAR because she look the MAR because she look the verbal order would next morning. In the MAR because she look the MAR beca			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		5.0
		HAL029010	B. WING		R-C 09/03/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
GRAYSON	I CREEK OF WELCOME	6781 OLD U LEXINGTO	JS HWY 52 N, NC 27295		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	V (X5)
PREFIX TAG	•	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 367	Continued From page	23	D 367		
	the pharmacyIf MAs saw a dose of they notified the Interir -The Interim Director order in question and to matchThe pharmacy printe	rige day on 08/27/21 from rifrequency was incorrect, m Director or Administrator. or Administrator verified the added or changed the MAR d MARs for each month, but is between printing were the Interim Director.			
D 392		(a) Controlled Substances	D 392		
	(a) An adult care hon retrievable record of of documenting the rece disposition of controller records shall be main	Controlled Substances ne shall assure a readily controlled substances by ipt, administration and ed substances. These tained with the resident's order that there can be n.			
	reviews, the facility fa retrievable record that receipt, administration controlled substances	s, interviews, and record iled to ensure a readily t accurately reconciled the n, and disposition of for 1 of 5 residents ers for a narcotic sleep aid,			
	The findings are:				
	dementia with behavio	1's current FL2 dated gnoses included vascular ors, chronic obstructive COPD), trigeminal neuralgia,			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
					R-C
		HAL029010	B. WING		09/03/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		6781 OLD I	JS HWY 52		
GRAYSO	N CREEK OF WELCOME	LEXINGTO	N, NC 27295		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	
D 392	Continued From page	24	D 392		
	and hypothyroidism.				
	01/01/21 revealed the	treat sleep disorders) 15mg			
	on 09/01/21 at 4:00pr				
	available.	zepam 15mg capsules			
	-There was one cassette of temazepam 30mg with 11 of 16 capsules remaining.				
		e temazepam label read to at bedtime as needed.			
	Count Sheet (CSCS) capsules of temazepa	as dispensed on 08/12/21			
		vith a representative at the narmacy on 09/01/21 at			
	-Resident #1 had an	order for temazepam 15mg night at bedtime scheduled			
	on 05/12/21 for a qua	zepam order was last filled ntity of 12 capsules as			
	Resident #1 was out o				
	' '	armacy had received an 30mg take 1 tablet as			
	needed at bedtime, b	ut the scheduled order			
	remained the same.	les Alexande et la 10			
	needed was dispense	ake 1 capsule at bedtime as ed on 07/15/21 for a quantity			
	of 16 capsules.				
		ake 1 capsule at bedtime as			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPL	EIED
		HAL029010	B. WING		R- 09 /0	C 3/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CDAYSON	I CREEK OF WELCOME	6781 OLD (JS HWY 52			
GRAISON	TOREER OF WELCOME	LEXINGTO	N, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	25	D 392			
	of 16 capsules.	a CSCS to the facility with				
	pharmacist on 09/02/2 -The primary pharmacist on open as supply of temazepam billed the hospice pharmacisted from 07/15/21 -There would not have from 07/31/21 through a contracted pharmacist of temazepam billed the hospice pharmacist of the hospice pha	e been any temazepam n 08/11/21. macy dispensed a 16-day 30mg on 08/12/21 and armacy and it should have through 08/27/21 if they had ghtly. administered her ery night at bedtime as supply of temazepam dent. 1's medication				
	-There was an entry f capsules every night 8:00pmThere was document administered from 07There was an entry f capsule as needed at doses documented as 07/01/21 to 07/31/21.	or temazepam 30mg bedtime and there were no s administered from				
	temazepam 30mg dis for one capsule at be to the July 2021 MAR	s CSCS for Resident #1's spensed on 05/07/21 labeled dtime as needed compared revealed: om, temazepam 30mg was				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAL029010	B. WING		R-C 09/03/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
GRAYSON	I CREEK OF WELCOME	6781 OLD	JS HWY 52		
- CIVATOON	OKEEK OF WEEGOINE	LEXINGTO	N, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 392	documented as signed there were no initials medication (blank). -There was no CSCS for temazepam 30mg administered on the re 07/03/21 to 07/15/21. Review of the facility's temazepam 30mg discompared to the July -Temazepam 30mg wout on the CSCS and 07/16/21 to 07/31/21. -On 07/19/21 at 8:00p (MA) signature was neared administered administered at bedtin 08/31/21. -There was an entry ficapsules every night as:00pm. -There was documented administered at bedtin 08/31/21. -There was an entry ficapsule as needed at doses documented as 08/01/21 to 08/31/21. Review of the facility's temazepam compared revealed: -There was no CSCS documentation as sig	d out on the CSCS. om, temazepam 30mg was d out on the CSCS, but of the staff signing out the sheet available for review at bedtime documented esidents MAR from S CSCS for Resident #1's pensed on 07/15/21 2021 MAR revealed: as documented as signed the MAR daily from om, the medication aide's of the same as the MA who dinistration on the MAR. 1's MAR for August 2021 or temazepam 15mg take 2 at bedtime scheduled for tation temazepam was me from 08/01/21 to or temazepam 30mg bedtime and there were no s administered from	D 392		
		eeded from 08/01/21 to			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE Co		, , ,	E SURVEY PLETED
	HAL029010	B. WING			R-C 0/03/2021
NAME OF PROVIDER OR SUPPLIER		DDRESS, CITY, STATE	. ZIP CODE	1 33	
		O US HWY 52	,		
GRAYSON CREEK OF WELCOME	LEXINGT	ON, NC 27295			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
capsule at bedtime as 08/12/21 for 16 capsularity signed out at 8:00pm 08/28/21 to 08/31/21. On 08/29/21 at 8:00pm documented as signed documentation for the CSCS did not match administration on the Review of Resident # 2021 revealed: -There was an entry for capsules every night 8:00pm. -There was documented as doses documented as o9/01/21 to 09/02/21. Review of the facility's temazepam comparementation as sig 09/01/21 to 09/02/21. Interview with the Memondaries with the Memondaries of the some ordered as needed the CMCUC) on 09/02/21.	tepam 30mg labeled for one is needed dispensed on ales had documentation for each night starting on the each out on the CSCS, but the each staff documenting MAR. This MAR for September the staff documenting make 2 at bedtime scheduled for the each staff documenting make 2 at bedtime scheduled for the each staff documenting make 2 at bedtime scheduled for the scheduled for the scheduled for the scheduled for the scheduled from the scheduled for the sch	D 392			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	:TED
			B. WING		R-0	_
		HAL029010	b. WING		09/0	3/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GRAYSON	I CREEK OF WELCOME		US HWY 52			
		LEXINGTO	N, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	e 28	D 392			
	any scheduled temaz					
		w long she had been out of				
	her scheduled dose of temazepam.					
	Interview with the Adr	ministrator on 09/02/21 at				
		facility had some problems				
		e practitioner refilling and				
		ders, so the contracted				
	• •	an order for Resident #1's				
	temazepam refill.					
	Refer to interview with	h the Memory Care Unit				
		on 09/03/21 at 3:45pm.				
	(,					
		h the Interim Director on				
	09/02/21 at 12:55 pm	l .				
	Defer to intensions with	h the Administrator on				
	09/02/21 at 1:05pm.	if the Administrator on				
	00/02/21 at 1.00pm.					
	Refer to the interview 09/03/21 at 5:05pm.	with the Administrator on				
	2. Review of Resider 01/01/21 revealed:	nt #1's current FL2 dated				
		for alprazolam 0.25mg (used				
	to treat anxiety) twice					
		for alprazolam 0.25mg every				
	4 hours as needed.					
	Telenhone interview v	with Resident #1's contract				
		on technician on 09/03/21 at				
		prazolam 0.25mg dispensing				
	dates as follows:					
		was dispensed on 06/04/21				
	for 28 tablets.					
		was dispensed on 06/18/21				
	for 28 tablets.	was dispensed on 07/02/21				
	for 28 tablets.	was aisperised oil 01/02/21				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED
					R-C
		HAL029010	B. WING		09/03/2021
		11AL023010			1 09/03/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
CDAVEOR	I CDEEK OF WELCOME	6781 OLD	US HWY 52		
GRATSON	I CREEK OF WELCOME	LEXINGTO	N, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE COMPLETE
				DEFICIENCY)	
D 392	Continued From page	29	D 392		
	-Alprazolam 0.25mg v for 28 tablets.	was dispensed on 07/16/21			
	-Alprazolam 0.25mg was dispensed on 07/29/21 for 28 tablets.				
		vith Resident #1's hospice 21 at 3:05pm revealed:			
	[· · · ·	was dispensed on 08/16/21			
	for 15 tablets.	was dispensed on our forzi			
		was dispensed on 08/27/21			
	for 12 tablets.	,			
	Review of Resident #	1's medication			
	administration record revealed:				
	-There was an entry f	or alprazolam 0.25mg twice			
	daily for anxiety/agita				
	administration at 8:00	·			
		tation all doses had been			
	administered from 06				
		or alprazolam 0.25mg every			
		th no documentation for as			
	needed administration	n.			
	Review of the facility's	s Controlled Substances			
	Count Sheet (CSCS)	for Resident #1's			
	alprazolam 0.25mg co	ompared to the June 2021			
	MAR and July MAR re				
		dispensed on 06/04/21			
	labeled for one tablet				
		/05/21 to 06/18/21 matching			
	_	ned out on the CSCS.			
		dispensed on 06/18/21			
	labeled for one tablet				
		/19/21 to 06/30/21 matching			
		ned out on the CSCS.			
	•	t 8:00am when the staff			
		tration on the MAR did not g out alprazolam 0.25mg on			

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the CSCS; and one 076/01/21 at 8:00pm the

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	, ,	SURVEY PLETED
			A. BUILDING:			
		HAL029010	B. WING		l l	R-C / 03/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
			O US HWY 52			
GRAYSO	N CREEK OF WELCOME		ON, NC 27295			
040.1=	CLIMMA DV CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF COR	PRECTION	0.50
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 392	Continued From page	30	D 392			
	CSCS was not docum out the medication.	nented for the staff signing				
	Review of Resident # revealed:	1's MAR for July 2021				
	daily for anxiety/agita	am and 8:00pm.				
	-There was documentation all doses had been administered from 07/01/21 to 07/31/21.					
	-There was an entry f	or alprazolam 0.25mg every				
	4 hours as needed wi needed administration	th no documentation for as n.				
	-	s CSCS for Resident #1's				
	MAR revealed:	ompared to the July 2021				
		ng dispensed on 06/18/21;				
		m the staff who signed out				
		n the CSCS did not match				
	and on 07/01/21 at 8:	administration on the MAR;				
	incomplete for docum					
		lication according to the				
		dispensed on 07/02/21				
	labeled for one tablet					
		/04/21 to 07/15/21 matching				
	documentation as sig	ned out on the CSCS				
	except on 07/11/21 at	8:00am, the CSCS was				
	incomplete for docum					
		am compared to the MAR;				
		m and 8:00pm, the CSCS				
	•	e staff who administered				
	alprazolam compared					
		dispensed on 07/16/21				
	labeled for one tablet	-				
		/16/21 to 07/30/21 matching				
	documentation as sig except on 8 opportun					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		D 0
		HAL029010	B. WING		R-C 09/03/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
GRAYSON	CREEK OF WELCOME	6781 OLD U			
			N, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 392	Continued From page	31	D 392		
	match staff who docu alprazolam 0.25mg or -On 07/24/21 at 8:00a signed out alprazolan not match staff who don the MAROn 07/26/21 at 8:00a signed out alprazolan not match staff who don the MAROn 07/27/21 at 8:00a signed out alprazolan not match staff who don the MAROn 07/28/21 at 8:00a signed out alprazolan not match staff who don the MAR.	rration on the MAR did not mented as signed out in the CSCS. am and 8:00pm, staff who in 0.25mg on the CSCS did ocumented administration in am and 8:00pm, staff who in 0.25mg on the CSCS did ocumented administration in am and 8:00pm, staff who in 0.25mg on the CSCS did ocumented administration in am and 8:00pm, staff who in 0.25mg on the CSCS did ocumented administration in 0.25mg on the CSCS did ocumented administration in 0.25mg on the CSCS did ocumented administration			
	revealed: -There was an entry f daily for anxiety/agita administration at 8:00 -There was documen administered from 08 -There was an entry f 4 hours as needed wi needed administration Review of the facility's alprazolam 0.25mg of MAR revealed: -For alprazolam 0.25m for 28 tablets there wi 8:00am the staff who 0.25mg on the CSCS documenting adminis	tation all doses had been //01/21 to 08/30/21. for alprazolam 0.25mg every th no documentation for as n. S CSCS for Resident #1's compared to the August 2021 mg dispensed on 07/30/21 as one tablet 08/02/21 at signed out alprazolam did not match the staff			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPLI	
		HAL029010	B. WING		R- 09/0	C 3/2021
	ROVIDER OR SUPPLIER	6781 OLD U	RESS, CITY, STA JS HWY 52 N, NC 27295	TE, ZIP CODE	,	-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	out on the CSCS by a staff who documented (At 8:00am and 8:00p 08/15/21 and at 8:00p 08/17/21. -There was a CSCS is one tablet twice a day 08/20/21 for 15 tablet out on the CSCS by a staff who documented (at 8:00am and 8:00p and at 8:00am on 08/-There was no documalprazolam 0.25mg do 8:00pm on 08/27/21 a-There was a CSCS is one tablet twice a day 08/28/21 for 14 tablet out on the CSCS by a staff who documented (At 8:00pm on 08/29/2) on 08/29/21, and 8:00 Review of Resident # available for administ tablets available for administ tablets available for a 3:00pm matching the current CSCS. Interview with the Met (MCUC) on 09/03/21 -She could not find a dates of 08/13/21-08/on 09/02/21. -She knew the Reside	with a start date of s with 8 of 14 tablets signed a staff that did not match the d administration on the MAR om on 08/13/21, 08/14/21, om on 08/16/21 and sheet for alprazolam 0.25mg with a start date of s with 5 of 15 tablets signed a staff that did not match the d administration on the MAR on on 08/21/21, 08/22/21, 24/21. Inentation on a CSCS for occumented on the MAR for and 8:00am on 08/28/21. Sheet for alprazolam 0.25mg with a start date of s with 4 of 14 tablets signed a staff that did not match the d administration on the MAR 21, 8:00am and and 8:00pm 0pm on 08/31/21). 1's alprazolam 0.25mg ration revealed there were 2 dministration on 09/03/21 at quantity indicated on the	D 392			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION		SURVEY PLETED
			A. BOILDING		l .	2.0
		HAL029010	B. WING			R-C <u>/03/2021</u>
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GRAYSON	N CREEK OF WELCOME	6781 OLD	US HWY 52			
		LEXINGTO	ON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 392	Continued From page	e 33	D 392			
	Refer to interview with	h the Memory Care Unit on 09/03/21 at 3:45pm.				
	Refer to interview with the Interim Director on 09/02/21 at 12:55 pm. Refer to interview with the Administrator on 09/02/21 at 1:05pm. Refer to the interview with the Administrator on 09/03/21 at 5:05pm.					
	revealed: -The MA who change was supposed to ens the medication cartShe tried to complete times per week to ensavailable and CSCSs-She had not been at medications at the enno one to count withShe knew she was semedications each shi correct and the CSCS offDue to staffing issue	d out cycle fill medications ure all medications were on e medication cart audits 2 sure medications were were accurate and signed. Ole to count controlled d of her shift and there was upposed to count controlled ft to ensure the count was as had been properly signed s she had been tions on the assisted living				
	12:55 pm revealed: -The MA on duty checensure all medication compared to the MAF-They checked the medication the as needed medication.					

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CURRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R-C
		HAL029010	B. WING		09/03/2021
					,
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	
GRAYSON	CREEK OF WELCOME	6781 OLI	US HWY 52		
0.0		LEXINGT	ON, NC 27295		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	I
TAG	REGULATORT ORT	EGG IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	MAIL
			+		
D 392	Continued From page 34		D 392		
	correct to ensure noth	hing happened during			
	transit.	5 11			
	-She expected MAs to	o follow up on any missing			
		the provider for orders as			
	needed.				
	-Medication carts wer	re audited on 08/27/21 for			
	expired medications a				
		ailable and matched orders.			
	•	ed her own audit on her			
	medication cart.				
		cumentation on the CSCS			
		MA was supposed to sign			
	the medication out.				
	MAR.	e CSCS did not match the			
		aff were not signing off on			
		a controlled medication was			
	administered.				
		SCS to be accurate and			
	correspond with the N				
		any CSCSs as she was new			
	in that position.				
	Interview with the Adr	ministrator on 09/02/21 at			
	1:05pm revealed:				
	-The facility's contrac	ted pharmacy nurse audited			
	medication carts on 0	08/27/21 to ensure			
		ailable and did not find any			
	problems.				
		cumentation on the CSCS			
		MA was supposed to sign			
	the medication out.	- 0000 did = -tt-! !!			
	-She did not know the MAR.	e CSCS did not match the			
	-She did not know sta	aff were not signing off on			
	the CSCS each time	a controlled medication was			
	administered.				
		SCS to be accurate and			
	correspond with the N	MARs.			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
,		1527711 15711 1611 17611 18	A. BUILDING: _			
		HAL029010	B. WING		R-C 09/03/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GRAYSON	N CREEK OF WELCOME	6781 OLD U				
	I		N, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLE	
D 392	Continued From page	e 35	D 392			
D 392	Interview with the Adr 5:05pm revealed: -The staff were traine medications on the C administration on the medicationsShe did not know Re accurate compared to administration of cont (temazepam and alpr-The MCUC was resport controlled medications)The Administrator on audits for the MARS is the MCUC or the Interview thorough auditingThe facility had expesion shortages and the MC had been filling in the	d to sign out controlled SCS and document MAR when administering sident #1's CSCS were not to the resident's MAR for crolled medications azolam). Tonsible to ensure tracking ons was accurate. Tocasionally did random being complete but expected rim Director to do more	D 392			

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