Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION :	(X3) DATE COMP	SURVEY
			A. BOILDING	•	,	₹
		HAL029010	B. WING			3/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GRAYSO	N CREEK OF WELCO	OME	OUS HWY 52 ON, NC 272			
(X4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	COMPLETE DATE
{D 000}	Initial Comments		{D 000}			
		ensure Section conducted a n 09/01/21 - 09/03/21.				
{D 358}	10A NCAC 13F .10 Administration  10A NCAC 13F .10 (a) An adult care hypreparation and adprescription and no by staff are in acco (1) orders by a lice which are maintain (2) rules in this Seand procedures.  This Rule is not measured based on observative reviews, the facility medications as orderesidents (Resident medication.  The findings are:  Review of Resident 01/01/21 revealed: -Diagnoses include behaviors, chronic (COPD), trigeminal hypothyroidismThere was an ordereat sleep disorderevery night at bedti	104(a) Medication 104 Medication Administration from shall assure that the ministration of medications, in-prescription, and treatments redance with: Insed prescribing practitioner ed in the resident's record; and ction and the facility's policies  et as evidenced by: ions, interviews, and record failed to administer ered for 1 of 5 sampled to 41 related to an insomnia  et #1's current FL2 dated and vascular dementia with obstructive pulmonary disease ineuralgia, and  er for temazepam (used to rs) 15mg take 2 capsules	{D 358}	The Administrator/Director shall assure the preparation and administration of medications, prescription and non-prescription, and treatments by staff accordance with: orders by a licensed prescribing practitioner which are main the resident's record; DHSR rules a facility's policies. Training with Medic Aides/Supervisors on 9-17-21 including review of facility medication ordering and procedures. Documentation of the will be kept at the facility for review. Administrator/Director will monitor maps periodically to ensure medication being administered according to rule NCAC 13F .1004(a). Monitoring will be using a monitoring tool designed by the Administrator. Administrator/Director monitor for compliance weekly X 3, by X 3, monthly X 3, then quarterly there Documentation will be kept at the factor review.	are in d intained and the ation ng policy aining The edication ns are 10A be done he will iweekly eafter.	10/6/21
Division of H	ealth Service Regulation		<u> </u>			
LABORATJÓR	Y DIRECTOR'S OR <b>F</b> ROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

P3VF12

**ADMINISTRATOR** 

10/7/2021

If continuation sheet 1 of 36

Division of Health Service Regulation						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		HAL029010	B. WING		79/0	2 3/2021
		11AL023010			1 09/0	3/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRAYSO	ON CREEK OF WELCO	OME	US HWY 52 ON, NC 272			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
{D 358}	Continued From pa	ge 1	{D 358}			
	Review of Resident	#1's medication		****		
		rd (MAR) for July 2021		****		
	revealed:	, ,		****		
		y for temazepam 15mg take 2				
		nt at bedtime scheduled for		****		
	8:00pm.			****		
		entation all doses had been 07/01/21 to 07/31/21.		****		
	auministered nom t	37/01/21 to 07/31/21.		***	**	
	Review of Resident revealed:	#1's MAR for August 2021			****	
	-There was an entry capsules every nigh	y for temazepam 15mg take 2 nt at bedtime scheduled for		THIS		
		entation all doses had been 08/01/21 to 08/31/21.		PAGE		
	Observation of Res	ident #1's medication on hand		INTENTIONALLY		
		nazepam 15mg capsules		LEFT		
		ssette of temazepam 30mg les remaining dispensed on		BLANK		
		the temazepam label read to le at bedtime as needed.		****		
	Talambana internitiva			****		
		with a representative at the pharmacy on 09/01/21 at		****		
	3:34pm revealed:	phannacy on 09/01/21 at		****		
		n order for temazepam 15mg		****		
		ery night at bedtime scheduled				
	for 8:00am.			****		
		nazepam order was last filled		***		
	Resident #1 was ou	uantity of 12 capsules as			****	
		harmacy had received an				
		m 30mg take 1 tablet as				
		but the scheduled order				

Division of Health Service Regulation

remained the same.

STATE FORM P3VF12 If continuation sheet 2 of 36

ווטופועום	of Health Service Re	egulation				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		HAL029010	B. WING		09/0	3/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAVSC	ON CREEK OF WELCO	OME 6781 OLD	US HWY 52	!		
GRAISC	N CKEEK OF WELCO	LEXINGTO	ON, NC 272	95		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIMED TO THE APPROFIME	D BE	(X5) COMPLETE DATE
{D 358}	Continued From pa	ge 2	{D 358}	****		
	-Temazepam 30mg	was dispensed on 05/07/21		****		
	for a quantity of 16 capsules.			****		
	-Temazepam 30mg for a quantity of 16	was dispensed on 07/15/21		****		
		was dispensed on 08/12/21		****		
	for a quantity of 16			****		
		prescribed for Resident #1 due		***	**	
	to a sleep disorder.				****	
	pharmacist on 09/0 -The hospice pharm	w with Resident #1's hospice 2/21 at 12:03pm revealed: nacy dispensed an 8-day		THIS		
	their emergency ba	nm 15mg on 05/27/21 from ckup which is all they could needed a new prescription.		PAGE		
		ave been any temazepam		INTENTIONALLY		
	would prove Reside	many gaps throughout that ent #1 was not administered mg every night at bedtime as		LEFT		
	ordered.			BLANK		
		v with a triage nurse with ice provider on 09/02/21 at		****		
	-The facility's contra	acted pharmacy was		****		
		g Resident #1's temazepam		****		
	order and billing ho	spice. nacy provided backup		****		
		resident would not miss any of		****		
	her medication.	141		***	**	
	pharmacy for all ter dispensed. -The resident had b	ed the contracted facility mazepam that had been been on temazepam for 2			****	
		originally ordered as needed onightly on 03/19/21.				
	Interview with Resid	dent #1's hospice nurse on				

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Division of Health Service Regulation STATE FORM

P3VF12 If continuation sheet 3 of 36

DIVISION	Of Fleatill Service 136	galation			_	
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMPI	
, , , , , , , , , , , , , , , , , , , ,	or correction	BERTH TO THE TREMBER	A. BUILDING:	<del></del>		
		HAL029010	B. WING		09/0	3/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
		6781 OLD	US HWY 52			
GRAYSC	ON CREEK OF WELCO	DME LEXINGT	ON, NC 272	95		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETE DATE
{D 358}	Continued From pa	ge 3	{D 358}	****		
	09/01/21 at 11:59ar			****		
		complained that she had not		****		
	been sleeping well and her sleeping pill had not			****		
	been working.			****		
		resident that she could also		****		
		xiety medication at the same emazepam to help get some		***	***	
	sleep.	and the state of t			****	
	revealed:	dent #1 on 9/02/21 at 11:12am		THIS		
		sleeping well for several		THIS		
		e sleeping pill was not		DACE		
	working.			PAGE		
		caused her not to care about		INITENITIONIALLY		
	anythingShe did not do wel	I participating with any		INTENTIONALLY		
		she was so tired and just		LEET		
	wanted them to be	over.		LEFT		
		e and short with staff and		DI ANUC		
	generally upset with	n everyone. the point she just went to eat		BLANK		
		e right back to her room to lay		****		
	down and rest.			****		
	Telephone intension	v with the facility contracted		****		
		11 at 11:44am revealed:		****		
	•	primary care provider for		****		
	Resident #1.	· · · · · · · · · · · · · · · · · · ·		****		
	-Resident #1 had be services a few time	een off and back on hospice		***	***	
		s. FL2 and 6-month orders for		^^^	****	
		se he thought she had			****	
	discharged from ho	spice services.				
		for temazepam 30mg as				
		on 05/07/21 for Resident #1				
	thought she was on	ed a new prescription and he				
		nen he received requests to				
		orders for a resident, the				

Division of Health Service Regulation

STATE FORM P3VF12 If continuation sheet 4 of 36

DIVISION	Of Fleatur Service 136	galation				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE S	
7.1.12 1 2 11 1	0. 0020		A. BUILDING:	<del></del>		
		HAL029010	B. WING		09/0	3/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CDAVEC	N CREEK OF WELCO	6781 OLD	US HWY 52	!		
GRATSC	IN CREEK OF WELCO	LEXINGTO	ON, NC 272	95		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{D 358}	Continued From pa	ge 4	{D 358}	****		
	resident had been o	discharged from hospice.		****		
				****		
		v with Resident #1's hospice n 09/02/21 at 2:46pm		****		
	revealed:	11 09/02/21 at 2.40pm		****		
		resident every 60 days.		****		
		dent was on a different		**:	***	
	changed her to tem	p, but it did not work so we			****	
		nes she saw the resident, she				
		not resting well because she		THIS		
	was tired, had incre tearfulness.	eased agitation, and				
		esident on 07/14/21.		PAGE		
		he contracted facility provider				
	wrote a prescription because she was o	n for the resident on 05/07/21 ut of refills.		INTENTIONALLY		
	-She had not been	notified that the resident was				
		refills and needed a new order		LEFT		
		the hospice nurse informed d some temazepam.		DI ANII		
	-A hospice nurse de	elivered temazepam to the		BLANK		
	facility on 05/27/21.			****		
		not been receiving her ered she would show signs of		****		
	•	ss, and more depressed with		****		
	tearfulness and tha			****		
	documented on her	· last visit. ·een made aware of the		****		
		fills on her temazepam.		****		
	-She expected the	facility to administer		**:	***	
		ered to keep the resident			****	
	comfortable.					
	Interview with the M	lemory Care Unit Coordinator				
		21 at 12:30 revealed:				
	<ul> <li>She regularly pass residents in memor</li> </ul>	ed medications to the				
		ie past few months that				
		en lying in bed a lot more than				

Division of Health Service Regulation

STATE FORM P3VF12 If continuation sheet 5 of 36

Division	Division of Health Service Regulation					
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
					R	
		HAL029010	B. WING		09/0	3/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAYSO	N CREEK OF WELCO	OMF The state of t	US HWY 52 ON, NC 272			
	OLIMAN DV OTA		1		ON!	(1.6-)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{D 358}	Continued From pa	ge 5	{D 358}	****		
	she used to.			****		
		to eat and then went straight		****		
	back to her room a	nd laid back down. participating in activities like		****		
	she used to.	participating in activities like		****		
		t have any scheduled		****		
		le for administration				
		ome temazepam 30mg		**	***	
		that she had used to			****	
		cheduled dose on 09/01/21.  ged out cycle fill medications				
		nsure all medications were on		THIS		
	the medication cart					
	-She did not know wany scheduled tema	why Resident #1 did not have azepam available.		PAGE		
	Interview with a per 09/02/21 at 12:45 re	sonal care aide (PCA) on evealed:		INTENTIONALLY		
	not been participati	een more tired lately and had ng in activities for the past 3		LEFT		
	monthsResident #1 also to did not mean anyth	alked harshly to staff but she ing by it.		BLANK		
				****		
		nterim Director on 09/02/21 at		****		
	12:55 pm revealed:	ecked cycle fill medications to		****		
		ons were available as		****		
	compared to the MA			****		
		the medication dosage and		****		
		ded medications were		**	***	
	available. -The MAs also cou	ated the number of			****	
		ith cycle fill to ensure the			00000	
		the dispensing log.				
		s to follow up on any missing				
		ll the provider for orders as				
	needed.	ioro auditod on 00/27/24 for				
	-iviedication carts w	ere audited on 08/27/21 for				

expired medications and to ensure all

STATE FORM 6899 If continuation sheet 6 of 36 P3VF12

Division of Health Service Regulation						
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL029010	B. WING		R <b>09/03/2021</b>	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GRAYSO	N CREEK OF WELCO	)MF	US HWY 52 ON, NC 272			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
{D 358}	Continued From pa	ge 6	{D 358}	****		
	medications were a	vailable and matched orders.		****		
	-The MCUC completed her own audit on the			****		
	Memory Care Unit medication cart.			****		
	Interview with the A	dministrator on 09/02/21 at		****		
	1:05pm revealed:			****		
	the residents in the	cility provider could see any of		***	**	
		me problems with the hospice			****	
		efilling and signing medication				
	orders, so the contracted facility provider signed orders for Resident #1.			THIS		
	<ul> <li>The contracted phenomedication cart even</li> </ul>	armacy nurse audited the		PAGE		
		acted pharmacy nurse audited				
	medications were a	n 08/27/21 to ensure rvailable and did not find any		INTENTIONALLY		
		s to follow up on any missing Ill the provider for orders as		LEFT		
		eir responsibility to ensure		BLANK		
<b>5</b>				****		
D 363	10A NCAC 13F .10 Administration	04(t) Medication	D 363	****		
	Administration			****		
		04 Medication Administration		****		
		re prepared for administration owing procedures shall be		****		
	implemented to kee	ep the drugs identified up to		****		
	•	stration and protect them from		***		
	contamination and (1) Medications are	spillage: dispensed in a sealed			****	
	package such as u	nit dose and multi-paks that is				
	strength in the seal package of medica and kept enclosed	me of each medication and ed package. The labeled tions is to remain unopened in a capped or sealed beled with the resident's name,		SEE PAGE 8 FOR RESPON	NSE	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.		F	,
		HAL029010	B. WING			3/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY,	STATE, ZIP CODE		
GRAYSO	ON CREEK OF WELCO	OME	US HWY 52 ON, NC 272			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 363	until the medication resident. If the mul resident's name, it in a capped or seal (2) Medications not labeled package as of this Paragraph a container that ident each medication proname; (3) A separate containd each planned a medications and la Subparagraph (1) of (4) All containers a separate tray or oth the planned time for a locked area which	as are administered to the ti-pak is also labeled with the does not have to be enclosed ed container; dispensed in a sealed and a specified in Subparagraph (1) re kept enclosed in a sealed ifies the name and strength of epared and the resident's administration of the	D 363	The Administrator/Director shall assu the preparation and administration of medications, prescription and non-prescription, and treatments by staff a accordance with rule 10A NCAC 13F .1004(f). If medications are prep administration in advance, they will be prepared as indicate 1-4 in rule 13F . DHSR rules and regulations. Training Medication Aides/Supervisors on 9-1 including review of facility policy on prepouring medications was discussed Documentation of training will be kept facility for review. The Administrator/ will monitor medication pass periodical ensure medications are being administrator documentation of the Administrator. Administrator/Director will monitor for compliance weekly X 3, biweekly X 3 monthly X 3, then quarterly thereafter Documentation will be kept at the fact review.	are in ared for e 1004(f), with 7-21 ed. t at the Director ally to stered 04(f). oring	10/6/21
	reviews, the facility prepared for admin in a sealed contains strength of each mup to the point of a from contamination sampled residents  The findings are:  Observations on 09 Memory Care Unit revealed:	et as evidenced by: ions, interviews, and record failed to ensure medications istration in advance were kept er that identified the name and edication prepared, identified dministration and protected and spillage for 3 of 3 (Residents #8, #9, and #10).  0/01/21 at 4:00pm of the (MCU) medication room ication cups of pudding with				

	of Fleatiff Service IN				1	
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
1					F	<b>?</b>
		HAL029010	B. WING	<del></del>		3/2021
NAME OF 5	PROVIDER OR SUPPLIER	CTDEET ADI	DECC OITY	STATE ZID CODE	-	
NAME OF F	TNOVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
GRAYSO	N CREEK OF WELCO	)MF	US HWY 52			
		LEXINGIC	ON, NC 272			
(X4) ID		TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG	,	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIES		DATE
		1		DEFICIENCY)		
D 363	Continued From pa	ae 8	D 363			
D 000	Continued i form pa	ge o	D 000	****		
	medication in each.					
		resident's initials on the side.		****		
		times were on the cups.		****		
		sealed and did not identify the		****		
	name and strength	of each medication.		****		
	1 Review of Reside	ent #8's current FL2 dated		****		
	04/25/21 revealed:	sin #0 0 carrent i EE aatoa		***	**	
		d dementia, atrial fibrillation,			****	
	and hypertension.				^^^^	
		er for quetiapine 25mg one				
	tablet three times a	day.		THIS		
		Memory Care Unit (MCU)		PAGE		
	revealed:	ounter on 09/01/21 at 4:07pm		1710=		
		abeled with Resident #8's		INTENTIONALLY		
		ned a medication mixed with		INTENTIONALLY		
		ne counter with 2 other				
	residents' medication			LEFT		
	-The Memory Care	Unit Coordinator (MCUC)				
		and took it to Resident #8 and		BLANK		
	administered the m	edication.				
	Daview of David out	#41a Cantamba: 0004		****		
		:#1's September 2021 tration record (MAR) revealed		****		
		for quetiapine 25mg one tablet		****		
		cheduled for administration at		****		
	8:00 am, 12:00 pm					
	, . <u></u>			****		
	Based on observati	ons, interviews, and record		****		
		rmined Resident #8 was not		***	**	
	interviewable.				****	
	Dafanta lata and an	ith - MOLIO 00/04/04				
		vith a MCUC on 09/01/21				
	4:15pm.					
	Refer to interview w	vith the Interim Director on				
	09/01/21 at 4:20pm					

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Division of Health Service Regulation STATE FORM

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE : COMPI	
		HAL029010	B. WING		R 09/0	3/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 03/0	0/2021
		6781 OLD	US HWY 52			
GRAYSC	ON CREEK OF WELCO	DME LEXINGTO	ON, NC 2729	95		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
D 363	Continued From pa	ige 9	D 363	****		
	Refer to the intervie	ew with the Administrator on		****		
	09/02/21 at 4:50pm	1.		****		
	2. Review of Reside	ent #9's current FL2 dated		****		
	04/25/21 revealed:			****		
	<ul> <li>-Diagnoses include hypertension, and of</li> </ul>	d dementia, atrial fibrillation,			***	
		er for baclofen 10mg one tablet			****	
	three times a day.					
		Memory Care Unit (MCU) ounter on 09/01/21 at 4:13pm		THIS		
		abeled with Resident #9's ined a crushed medication		PAGE		
	mixed with pudding other residents' me	sitting on the counter with 2 dication.		INTENTIONALLY		
		Unit Coordinator (MCUC) and took it to Resident #9 and		LEFT		
	administered the m	edication.		BLANK		
		t #9's September 2021				
		stration record (MAR) revealed for baclofen 10mg one tablet		****		
	three times a day s	cheduled for administration at		****		
	8:00 am, 12:00 pm	and 4:00 pm.		****		
		ions, interviews, and record		****		
	reviews it was dete interviewable.	rmined Resident #9 was not		****		
	interviewable.			**	***	
	Refer to interview v 4:15pm.	vith a MCUC on 09/01/21			****	
	Refer to interview v 09/01/21 at 4:20pm	vith the Interim Director on				
	Refer to the interview 09/02/21 at 4:50pm	ew with the Administrator on				

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Division of Health Service Regulation STATE FORM

P3VF12 If continuation sheet 10 of 36

Division of Health Service Regulation		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING:	COMPLETED	
	R	
HAL029010 B. WING	09/03/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
6781 OLD US HWV 52		
GRAYSON CREEK OF WELCOME  LEXINGTON, NC 27295		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT	TION (X5)	-
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO	ULD BE COMPLETE	Έ
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPI	OPRIATE DATE	
521.0.2.00.7		
D 363 Continued From page 10 D 363 *****		
3. Review of Resident #10's current FL2 dated		
06/01/21 revealed: *****		
-Diagnoses included dementia, glaucoma, *****		
osteoporosis, and hypothyroidism.		
-There was an order for acetaminophen 500mg		
one tablet three times a day.	****	
Observation of the Memory Care Unit (MCU)	****	
medication room counter on 09/01/21 at 4:12pm	****	
revealed:		
-There was a cup labeled with Resident #10's THIS		
initials which contained a crushed medication		
mixed with pudding sitting on the counter with 2		
other residents' medication.		
-The Memory Care Unit Coordinator (MCUC) picked up the cup and took it to Resident #10 and INTENTIONALLY		
administered the medication.		
Review of Resident #10's September 2021		
medication administration record (MAR) revealed		
there was an entry for acetaminophen 500mg one BLANK		
tablet three times a day scheduled for		
administration at 8:00 am, 12:00 pm and 4:00		
pm. ****		
Based on observations, interviews, and record *****		
reviews it was determined Resident #8 was not *****		
interviewable. ****		
*****		
Refer to interview with a MCUC on 09/01/21	****	
4:15pm.	****	
Refer to interview with the Interim Director on		
09/01/21 at 4:20pm.		
Refer to the interview with the Administrator on		
09/02/21 at 4:50pm.		
Defer to interview with a Mamony Care Unit		
Refer to interview with a Memory Care Unit Coordinator (MCUC) on 09/01/21 4:15pm.		

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Division of Health Service Regulation STATE FORM

P3VF12 If continuation sheet 11 of 36

Division of Health Service Regulation						
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	:	COMP	LETED
					_	
			D WING		F	
		HAL029010	B. WING	<del></del>	09/0	3/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DDESS CITY (	STATE, ZIP CODE		
INAIVIE OF	FROVIDER OR SUFFLIER					
GRAYSO	N CREEK OF WELCO	)MF	US HWY 52			
0.0.00		LEXINGTO	ON, NC 272	95		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				DEFICIENCY)		
D 363	Continued From pa	ne 11	D 363	****		
D 000	Continued From pa	ge 11	B 000	****		
	-She pre-poured me	edications to help save time.				
		cup with the resident's initials.		****		
		lications for the residents one		****		
		ng the MAR for each resident,		****		
		ication to the MAR, and				
		ions in the cup labeled with		****		
		als only and moving to the		***	**	
	next resident.	ale only and moving to the			****	
		d pudding and were not				
		identify the name and strength				
	of each medication	-		THIS		
		hat medications had to be		11110		
				-		
		with each medication name		PAGE		
	and strength.	P				
		e medications with the		INTENTIONALLY		
		d go administer by carrying all		INTENTIONALLY		
		going from resident to				
	resident.			LEFT		
	-She had been train	ned not to pre-pour				
	medications.					
	-She knew she was	not supposed to pre-pour		BLANK		
	medications as the	facility did not allow it.				
		•		****		
	Interview with the Ir	nterim Director on 09/01/21 at		****		
	4:20pm revealed:					
	-She knew medicat	ions had been pre-poured as		****		
		e counter in the MCUC.		****		
	-The MAs had beer	n told not to pre-pour		****		
	medications.	i F				
		lications to be given when they		****		
	were due and not p	•		***	**	
	ado dila liot p				****	
	Interview with the A	dministrator on 09/02/21 at				
	4:50pm revealed:	anning ator on 00/02/21 at				
		ions had been pre-poured				
		Interim Director saw them she				
	reported it to her im	-				
		iously been told they were not				
	allowed to pre-pour					
	-She expected all m	nedications to be given when				

Division of Health Service Regulation

STATE FORM P3VF12 If continuation sheet 12 of 36

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		HAL029010	B. WING		09/0	3/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAYSON CREEK OF WELCOME			US HWY 52 ON, NC 272			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 363	Continued From pa	ge 12	D 363			
	due and not pre-po	ured in advance.				
D 367	(j) The resident's n record (MAR) shall following: (1) resident's name (2) name of the me (3) strength and do administered; (4) instructions for a or treatment; (5) reason or justific medications or tread documenting the redocumenting the redocumenting the redocumentation of medications or tread omission, including (8) name or initials the medication or tread ocumented and madministration recombased on observative reviews, the facility medication administration admin	04 Medication Administration nedication administration be accurate and include the ; dication or treatment order; sage or quantity of medication administering the medication eation for the administration of tments as needed (PRN) and sulting effect on the resident; f administration; of any omission of tments and the reason for the refusals; and, of the person administering reatment. If initials are used, a at to those initials is to be raintained with the medication rd (MAR).	D 367	The Administrator/Director shall ensur resident's medication administration re (MAR) shall be accurate and include the following: resident's name; name of the medication or treatment order; strengthedosage or quantity of medication administered; instructions for administ the medication or treatment; reason or justification for the administration of medications or treatments as needed and documenting the resulting effect or resident; date and time of administration documentation of any omission of medications and the reason for the oricluding refusals; and, name or initial person administering the medication of treatment. All MARs for every resident reviewed for accuracy by facility Direct 10-01-21. Training with Medication Aid Supervisors on 9-17-21 including reviewed facility medication policy and procedur Documentation of training will be kept facility for review. The Administrator/Director will monitor medication pass periodical ensure medications are being administ according to rule 10A NCAC 13F .100 Monitoring will be done using a monitor tool designed by the Administrator. Administrator/Director will monitor for compliance weekly X 3, biweekly X 3, X 3, then quarterly thereafter. Docume will be kept at the facility for review.	ecord he e h and ering (PRN) on the on; dications mission, s of the or th were tor on des/ ew of res. at the Director illy to tered 4(j). oring monthly	10/6/21
		ent #1's current FL2 dated				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE COMP	
			A. BUILDING.	<del></del>	_	
		HAL029010	B. WING		R <b>09/03/2021</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
GRAYSO	ON CREEK OF WELCO	OME	US HWY 52 ON, NC 2729			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 367	behaviors, chronic (COPD), trigeminal hypothyroidism.  -There was an order treat sleep disorder night at bedtime.  Review of Resident 05/07/21 revealed administer 1 tablet.  Review of Resident administration recorrevealed:  -There was an entrablets every night 8:00am.  -There was docume administered from Review of Resident revealed:  -There was an entrablets every night 8:00am.  -There was an entrablets every night 8:00am.  -There was docume administered from Review of Resident revealed:  -There was occume administered from Review of Resident revealed:  -There was occume administered from Review of Resident revealed:  -There was occume administered from Review of Resident revealed:  -There was one case on 09/01/21 at 4:00.  -There was one case with 11 of 16 tablets.  -The directions on administer 1 capsulations and resident revealed.	d vascular dementia with obstructive pulmonary disease neuralgia, and er for temazepam (used to rs) 15mg take 2 tablets every that "I's physician order dated an order for temazepam 30mg at bedtime as needed."  It "I's medication rd (MAR) for July 2021 y for temazepam 15mg take 2 at bedtime scheduled for entation all doses had been 07/01/21 to 07/31/21.  It "I's MAR for August 2021 y for temazepam 15mg take 2 at bedtime scheduled for entation all doses had been 08/01/21 to 08/31/21.  Sident #1's medication on hand 0pm revealed: nazepam 15mg capsules essette of temazepam 30mg	D 367	*****  *****  *****  *****  THIS  PAGE  INTENTIONALLY  LEFT  BLANK  ****  *****  *****  *****  *****  ****	***  ***  ***	

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
			B. WING		R <b>09/03/2021</b>	
		HAL029010	B. WINO		09/0	3/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAYSO	N CREEK OF WELCO	OME 6781 OLD	US HWY 52			
OIVAIOO	N OKELK OF WELOC	LEXINGTO	ON, NC 2729	95		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 367	Continued From pa	ae 14	D 367	****		
	•			****		
	3:34pm revealed:	pharmacy on 09/01/21 at		****		
		n order for temazepam 15mg		****		
		night at bedtime scheduled		****		
	for 8:00am.	g		****		
		nazepam order was last filled		***		
	on 05/12/21 for a quantity of 12 tablets as Resident #1 was out of refills.			***		
					****	
	-On 05/07/21, the pharmacy had received an order for temazepam 30mg take 1 tablet as					
	needed at bedtime, but the scheduled order			THIS		
	remained the same.					
		was dispensed on 05/07/21		PAGE		
	for a quantity of 16	capsules.				
		was dispensed on 07/15/21		INTENTIONALLY		
	for a quantity of 16			INTENTIONALLY		
		was dispensed on 08/12/21		LEET		
	for a quantity of 16	orescribed for Resident #1 due		LEFT		
	to a sleep disorder.					
				BLANK		
	Telephone interview	with Resident #1's hospice				
		2/21 at 12:03pm revealed:		****		
		nacy dispensed a 20-day		****		
	,	m 15mg on 04/22/21 and harmacy which should have		****		
	lasted through 05/1			****		
		nacy dispensed a 16-day		****		
		m 30mg on 05/07/21 and		****		
	billed the hospice p	harmacy and it should have		***		
	lasted from 5/13/21			***		
		nacy dispensed a 6-day supply			****	
		g on 05/12/21 and billed the and it should have lasted from				
	5/29/21 through 06/					
		nacy dispensed an 8-day				
		m 15mg on 05/27/21 from				
	their emergency ba	ckup which is all they could				
		needed a new prescription. It				
	should have lasted	from 06/04/21 through				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	E CONSTRUCTION	(X3) DATE :	
AND FLAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		HAL029010	B. WING	· · · · · · · · · · · · · · · · · · ·	09/0:	3/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ODAVOG	N ODEEK OF WELOO	6781 OLD	US HWY 52			
GRAYSU	ON CREEK OF WELCO	LEXINGTO	ON, NC 2729	95		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
D 367	Continued From pa	ge 15	D 367	****		
	06/11/21.	3		****		
		ave been any temazepam		****		
	from 06/12/21 throu			****		
	-The primary pharm	nacy dispensed a 15-day		****		
		m 15mg on 06/22/21 and		****		
		harmacy and it should have		***	***	
	lasted from 06/22/21 through 07/06/21There would not have been any temazepam				****	
	from 07/07/21 through 07/14/21.					
	-The primary pharmacy dispensed a 16-day			TILLO		
		m 30mg on 07/15/21 and		THIS		
		harmacy and it should have 1 through 07/30/21.		D4.05		
		ave been any temazepam		PAGE		
	from 07/31/21 throu			INITENITION   1   1   1   1   1   1   1   1   1		
		nacy dispensed a 16-day		INTENTIONALLY		
		m 30mg on 08/12/21 and				
		harmacy and it should have 1 through 08/27/21 if they had		LEFT		
	been administered					
		many gaps throughout that		BLANK		
		ent #1 was not administered				
	ordered.	every night at bedtime as		****		
	ordered.			****		
		wwith a triage nurse with		****		
		ice provider on 09/02/21 at		****		
	11:30am revealed:	acted pharmacy was		****		
		g Resident #1's temazepam		****		
	order and billing ho			***	***	
		nacy provided backup			****	
	temazepam so the her medication.	resident would not miss any of				
		ed the contracted facility				
	1	nazepam that had been				
	dispensed.	·				
		een on temazepam for 2				
	years.	originally ordered as pooded				
	- remazepam was c	originally ordered as needed				

Division of Health Service Regulation						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE : COMPI	
		HAL029010	B. WING		R 09/0	3/2021
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE			
		6781 OI D	US HWY 52	,		
GRAYSC	ON CREEK OF WELCO	)MF	ON, NC 2729			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 367	Continued From pa	ge 16	D 367	****		
	but was changed to nightly on 03/19/21.			****		
				****		
	Interview with Resident #1's hospice nurse on			****		
	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 Xanax at the same time she took her				****	
	temazepam to help					
				THIS		
		dent #1 on 9/02/21 at 11:12am				
	revealed:	sleeping well for several		PAGE		
		e sleeping pill quit working.				
		caused her not to care about		INTENTIONALLY		
	She did not do well because she was s	participating with any activities o tired and just wanted it to be		LEFT		
	overIt made her irritable generally upset with	e and short with staff and		BLANK		
		the point she just went to eat		****		
		e right back to her room to lay		****		
	down and rest.			****		
	Telephone interviev	with the facility contracted		****		
	provider on 09/02/2	1 at 11:44am revealed:		****		
		FL2 and 6-month orders for		****		
	off hospice services	se he thought she had come		***	***	
	-He wrote an order	for temazepam 30mg as			****	
		on 05/07/21 for Resident #1				
	thought she was on	ed a new prescription and he				
		nen he received requests to				
	sign FL2's and write	e orders for a resident, the				
	resident had come	off hospice.				
	Telephone interview	wwith Resident #1's hospice				

Division of Health Service Regulation

STATE FORM P3VF12 If continuation sheet 17 of 36

Division of Health Service Regulation						
STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	DENTIFICATION NUMBER:		:	COMPLETED	
		·			_	
			B. WING		R	
		HAL029010	D. WINC		09/0	3/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		6781 OLD	US HWY 52	•		
GRAYSO	ON CREEK OF WELCO	OME	ON, NC 272			
			<u> </u>	T		
(X4) ID	-	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIES		DATE
		· · · · · · · · · · · · · · · · · · ·		DEFICIENCY)		ı
D 207	0 C	17	D 007	****		
D 367	Continued From pa	ige 17	D 367			ı <b> </b>
	nurse practitioner on 09/02/21 at 2:46pm			****		ı .
	revealed:	11 00/02/21 31 21 12/21		****		ı
	-The last couple times she saw the resident, she			****		ı
	could tell she was not resting well because she			****		ı <b> </b>
	was tired, had increased agitation, and					ı
	tearfulness.			****		ı <b> </b>
		esident on 07/14/21.		***	**	ı <b> </b>
	-She did not know the contracted facility provider				****	ı
	wrote a prescription for the resident on 05/07/21					ı
	because she was out of refills.					ı
	-She had not been notified that the resident was			THIS		ı .
		refills and needed a new order				ı
		the hospice nurse informed		PAGE		ı .
		d some temazepam.		PAGE		ı
	1101 1101 1101	u 001110 to111020p2				ı
	Interview with the N	Memory Care Unit Coordinator		INTENTIONALLY		ı
		21 at 12:30 revealed:				ı
		ne past few months that		ıcc		ı
		een lying in bed a lot more than		LEFT		ı
	she used to.	7011 1711 19 111 12 12 12 12 12 12 12 12 12 12 12 12				ı
		ot have any scheduled		BLANK		ı
		ole for administration				ı
		some temazepam 30mg		****		ı
		that she had used to		and an and		ı
		scheduled dose on 09/01/21.		****		ı
		ged out cycle fill was supposed		****		ı
		ations were on the medication		****		ı
	cart.			****		ı
	-She did not know	why Resident #1 did not have		****		ı
	any scheduled tema					ı
		MARs were accurate as she		***	**	ı
	only administered r	medication if the medication			****	ı
	was available.					ı
						ı
	Interview with the Ir	nterim Director on 09/02/21 at				ı
	12:55 pm revealed:	:				ı
		necked cycle fill to ensure all				ı
		available as compared to the				
	MAR.	•				ı
	-They checked the	medication dosage, ensured				

Division of Health Service Regulation STATE FORM

DIVISION	Division of Health Service Regulation					
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	-ETED
					R	
		HAL029010	B. WING	<del></del>		3/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DDRESS, CITY, STATE, ZIP CODE			
TW WILL OF T	THOUBER OR GOLF EIER		US HWY 52	•		
GRAYSO	ON CREEK OF WELCO	)MF	OS 11W1 32 ON, NC 2729			
(VA) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	-	PROVIDER'S PLAN OF CORRECTION	)NI	()(5)
(X4) ID PREFIX		MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
				DEI ICIENCI)		
D 367	Continued From pa	ge 18	D 367	****		
	the as needed medications were available, and			****		
	counted the controlled substances that came with			****		
	cycle fill to ensure the count was correct to			****		
	ensure nothing happened during transit.			****		
	-Medication carts were audited on 08/27/21 for					
	expired medications and to ensure all			****		
	medications were available and matched orders.			***	**	
	-The SCUC completed her own audit on her				****	
	medication cart.					
	-When a MA did not administer a medication,			THIS		
	they were supposed to circle their initials on the			11110		
	MAR and document why it was not administered on the back of the MAR.			DAGE		
		MARs to be accurate.		PAGE		
	'					
	Interview with the A	dministrator on 09/02/21 at		INTENTIONALLY		
	1:05pm revealed:					
	-The facility's contra	acted pharmacy nurse audited		LEFT		
		08/27/21 to ensure				
	problems.	vailable and did not find any		BLANK		
	•	armacy nurse audited the		BE/ (IVI)		
	medication cart eve			****		
		Rs to be accurate and for the		****		
	MAs to document w	when and why a medication				
	was not administere	ed.		****		
				****		
		ent #2's current FL2 dated		****		
		diagnoses that included I stenosis, chronic pain		****		
		na, chronic obstructive		***	**	
		(COPD), and degenerative			****	
	disc disease.	,, -9				
		:#2's record revealed there				
		cian's order dated 08/10/21 for				
		prim (used to treat infection)				
	take one tablet twic	e daily for seven days.				
	Review of Resident	:#2's August 2021 medication				

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Division of Health Service Regulation STATE FORM

DIVIDION	of Fleatill Service IN	galation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					_	
			D WINC		R	
		HAL029010	D. WING		09/03	3/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY. S	STATE, ZIP CODE		
		6781 OLD	US HWY 52			
GRAYSO	N CREEK OF WELCO	)MF	ON, NC 272			
			-			
(X4) ID		TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG	•	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		DATE
1710		,	1710	DEFICIENCY)		
				****		
D 367	Continued From pa	ge 19	D 367	****		
	administration reco	rd (MAR) revealed:		****		
	administration record (MAR) revealed:			****		
	-There was no typed or written entry for			****		
	Septra-DS/trimethoprim take one tablet twice					
	daily for seven days.			****		
	-There was no documentation that Septra-DS/trimethoprim was administered in			****		
		prim was administered in		***	**	
	August 2021.				****	
	Telephone interview	with a representative from				
	Telephone interview with a representative from the facility's contracted pharmacy on 09/01/21 at 4:33pm revealed there was a quantity of 14 Septra-DS/trimethoprim tablets dispensed on					
				THIS		
				11110		
	•	prim tablets dispensed on				
	08/10/21.			PAGE		
	Interview with the D	looident Caro Coordinator				
		Resident Care Coordinator		INTENTIONALLY		
		at 5:20pm revealed:		INTENTION (LET		
	-The facility had a c					
		prim on hand during the week		LEFT		
	of 08/10/21.					
		oprim was administered as		DI ANIZ		
	ordered during the	week of 08/10/21.		BLANK		
	1.42	A saint Director (ID)				
		nterim Director (ID) on		****		
	09/01/21 at 5:30pm			****		
		the Septra-DS/trimethoprim to		****		
		the week of 08/10/21.		destrated		
		why the medication was not		****		
	documented on the			****		
		rator-in-Charge verified orders		****		
		ged them on the MAR.		***	**	
	-She expected all M	IARs to be accurate.		^^^		
					****	
		dministrator on 09/02/21 at				
	1:05pm revealed:					
		Septra-DS/trimethoprim was				
	not on Resident #2'					
		Rs to be accurate and for the				
	medication aides to	document when and why a				
	medication was not					

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Division of Health Service Regulation STATE FORM

DIVISION	OF FIGARITY SETVICE INC	guiation				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
					R	•
		HAL029010	B. WING			3/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRAYSO	N CREEK OF WELCO	OME	US HWY 52			
		LEXINGTO	ON, NC 272	95		
(X4) ID		TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
D 367	Continued From pa	go 20	D 367	****		
D 301	Continued From page 20		D 307	****		
		ent #3's FL2 dated 01/01/21		****		
	revealed:			****		
	-Diagnoses including dementia with behaviors,					
	cognitive communication deficit and atrial fibrillation.			****		
	-There was an order for citalopram 20mg 1 tablet			****		
	once a day used to treat behaviors.			***	**	
				****		
	Review of Resident	: #3's 01/01/2021 revealed an				
	order for citalopram	n 20mg 1 tablet once a day.		THIC		
			THIS			
	Review of Resident					
		rd (MAR) for August 2021 and		PAGE		
		vealed an entry for citalopram				
		a day documented as given		INTENTIONALLY		
	from 08/27/21 throu	ign 09/02/21.				
	Observation of Res	ident #3's medications on		LEFT		
		evealed a cartridge containing				
		alopram 10mg 1 tablet every				
	day dispensed on 0			BLANK		
		on, record review and		****		
	· ·	termined Resident #3 was not		****		
	interviewable.			****		
	Telephone intonvious	v with a representative from		****		
	-	cted pharmacy on 09/02/21 at		****		
	10:38am revealed:	Aca pharmacy on 00/02/21 at		****		
		n Resident #3's hospice				
		red from the facility on		***	**	
		citalopram 20mg 1 tablet			****	
		pram 10mg 1 tablet every day.				
		nted MARs for the facility at the				
	end of the previous					
		between printing the facility				
		by the facility staff, therefore d not have changed the order				
		e new MAR in September				
	2021.	5 W. W. W. W. Coptolinool				

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Division of Health Service Regulation STATE FORM

P3VF12 If continuation sheet 21 of 36

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		COM		(X3) DATE SURVEY COMPLETED
	0. 00201.0		A. BUILDING:	·	
		HAL029010	B. WING		R <b>09/03/2021</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE	
GRAYSO	ON CREEK OF WELC	OME	US HWY 52 ON, NC 272		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 367	Continued From pa	age 21	D 367	****	
	-The order change	for Resident #3's citalopram		****	
	was missed somehow and was not changed on			****	
	the September 2021 MAR.			****	
	Interview with a me	edication aide (MA) on		****	
	09/02/21 at 11:45am revealed:			***	++
		medication cartridges			****
delivered by pharmacy before adding them to the medication cart.					
		or or Administrator were		THIC	
	responsible to add new orders or changes to the			THIS	
	MAR.			DACE	
		ncorrect and the Interim nistrator were unavailable, MAs		PAGE	
		der to verify orders.		INITENITIONIALLY	
		ed the needed medication		INTENTIONALLY	
	order, they then tra onto the MAR.	inscribed the order or change		LEFT	
	Onto the WAR.			LEFI	
		w with the hospice provider on		BLANK	
	09/02/21 at 12:05p	m revealed: ed to be weaned from the		BLAIN	
	citalopram dose of			****	
		medication aide (MA) on		****	
		t a verbal order to pharmacy to		****	
	once a day to 10m	:#3's citalopram from 20mg		****	
		took verbal/telephone orders		****	
	and faxed them to			****	
	Interview with a co	and modication aids (MA) on		***	**
	09/02/21 at 12:15p	cond medication aide (MA) on more more more more more more more more			****
	-She did not remer	nber taking a verbal order from			
		nt #3's citalopram 20mg to			
	change to 10mg.	ed verbal orders, they wrote			
		acility's order sheets and gave			
	them to the Interim	Director of Administrator to			
	check.	woulding the Interior Discretice			
	-When orders were	e verified, the Interim Director,			

Division of Health Service Regulation						
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	: <u></u>	COMP	LETED
				<del></del>	-	,
		1141 000040	B. WING		F	
		HAL029010	D. WINO		09/0	3/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		6781 OLD	US HWY 52	•		
GRAYSC	ON CREEK OF WELCO	OME TO THE REPORT OF THE PERSON OF THE PERSO	ON, NC 272			
	T		JN, NC 272	T		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROI		DATE
1710		,	17.0	DEFICIENCY)		
				****		
D 367	Continued From pa	ge 22	D 367	****		
	Administrator or MA	As added or changed orders				
	on the MAR.			****		
				****		
	Telephone interview with a third medication aide			****		
	(MA) on 09/02/21 at 3:42pm revealed:			****		
	-She performed the checks on medication					
	cartridges during the pharmacy medication			***	**	
		/21 around 9:30pm.			****	
	-She noticed Resident #3's citalopram was 10mg					
	instead of 20mg.			TUIO		
	-She thought she would not have been able to			THIS		
		provider that late at night, so				
		to verify the order change.		PAGE		
		actice for the MA who took the		17.02		
	order would add it t					
	-She did not change	e the MAR because she		INTENTIONALLY		
		took the verbal order would				
	change the MAR th			LEFT		
		eave from work and was not				
		th the MA who took the order.				
	•			BLANK		
	Interview with Interi	m Director on 09/02/21 at				
	10:40am revealed:			****		
	-She did not know t	hat Resident #3's citalopram		****		
	order changed on 0			****		
		ff had a new order or order				
	0 , , 0	the orders to the Interim		****		
	Director or the Adm			****		
	_	ough medication refills from		****		
	pharmacy.			***	**	
		a dose did not match the			****	
	1	otified the Interim Director or			****	
	the Administrator.					
		or or Administrator verified				
	orders and added/o	changed them on the MAR.				
		dministrator on 09/02/21 at				
	10:50am revealed:	- · · · · · · · · · · · · · · · · · · ·				
		Resident #3's citalopram order				
	changed on 08/26/2	21.				

Division of Health Service Regulation

STATE FORM P3VF12 If continuation sheet 23 of 36

	of Fleatiff Service IN				1	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE	-
AND FLAIN	OF SOURCE FION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED	
					R	1
		HAL029010	B. WING			3/2021
NAME OF I		CTDEET ADI		CTATE ZID CODE	•	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRAYSO	N CREEK OF WELCO	)MF	US HWY 52			
		LEXINGI	ON, NC 272	95		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION SHOULD		(X5) COMPLETE
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		DATE
		,		DEFICIENCY)		
D 367	Continued From no	go 22	D 367	****		
D 301	Continued From page 23		D 307	****		
	-The MA on duty ch	ecked medication delivered				
	on medication exch	ange day on 08/27/21 from		****		
	the pharmacy.			****		
	<ul> <li>-If MAs saw a dose or frequency was incorrect, they notified the Interim Director or Administrator.</li> <li>-The Interim Director or Administrator verified the order in question and added or changed the MAR</li> </ul>			****		
				****		
				***	**	
	to match.				****	
		ited MARs for each month, but				
		ges between printing were				
	added by herself or the Interim Director.			THIS		
added by hersell of the intentil bilector.		the interim Birector.				
D 303	D 392 10A NCAC 13F .1008(a) Controlled Substances		D 392	PAGE		
D 392	TUA NUAU TSF . TU	oo(a) Controlled Substances	D 392	TAGE		
	10A NCAC 13F 10	08 Controlled Substances		INITENITIONIALLY		
		ome shall assure a readily		INTENTIONALLY		
		f controlled substances by				
		ceipt, administration and		LEFT		
		olled substances. These				
	records shall be ma	aintained with the resident's		BLANK		
		an order that there can be		BLANK		
	accurate reconciliat	ion.		****		
				****		
	This Rule is not me	et as evidenced by:		****		
		ons, interviews, and record		****		
		failed to ensure a readily		****		
		nat accurately reconciled the		****		
		ion, and disposition of		***	**	<u> </u>
		es for 1 of 5 residents		^^^		<u> </u>
	sampled (#1) with o	orders for a narcotic sleep aid,			****	<u> </u>
	and anti-anxiety me	edication.				
	The findings are:					
	Deview of Desident	#41a august El O datad				
		#1's current FL2 dated				
		diagnoses included vascular		SEE PAGE 25 FOR RESPO	NISE	
	demenda with bena	viors, chronic obstructive		OLL I AGE 23 I ON NESPO		

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Division of Health Service Regulation STATE FORM

P3VF12 If continuation sheet 24 of 36

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				B) DATE SURVEY COMPLETED	
		7 t. BOILBING.		R		
	HAL029010	B. WING		09/03/2021		
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
GRAYSON CREEK OF WELCO	IME	US HWY 52				
	LEXINGTO	ON, NC 272	T			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE	
1. Review of Reside 01/01/21 revealed the temazepam (used to take 2 capsules every observation of Resion 09/01/21 at 4:00 per There were no temavailable.  There was one cass with 11 of 16 capsules. The directions on the administer 1 capsules. Review of the facility Count Sheet (CSCS capsules of temaze administration labele for a quantity of 16 of Telephone interview facility's contracted 3:34pm revealed: Resident #1 had an take 2 capsules ever for 8:00pm.  The scheduled tem on 05/12/21 for a quantity of 16 of 8:00pm.  The scheduled tem on 05/12/21 for a quantity of 16 of 8:00pm.  The scheduled tem on 05/12/21 for a quantity of 16 of 8:00pm.  The scheduled tem on 05/12/21 for a quantity of 16 of 8:00pm.	(COPD), trigeminal neuralgia, ent #1's current FL2 dated here was an order for to treat sleep disorders) 15mg ery night at bedtime. Ident #1's medication on hand pm revealed: lazepam 15mg capsules lisette of temazepam 30mg les remaining. he temazepam label read to le at bedtime as needed.  ly's Controlled Substances ly's Controlled Substances ly's revealed Resident #1 had 9 logam 30mg left for led as dispensed on 08/12/21 logapsules.  I with a representative at the lipharmacy on 09/01/21 at lipharmacy on 09/01/21 at lipharmacy on one was last filled lipharmacy had received an	D 392	The Administrator/Director shall ensur readily retrievable record of controlled substances by documenting the receip administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. All MA and control count sheet for every resident were reviewed for accuracy be facility Director on 10-01-21. Training Medication Aides/Supervisors on 9-17 including review of facility medication controlled substances count policy and procedures. Documentation of training will be kept at the facility for review. The Administrator/Director will monitor control count records periodically to ensure accurate documentation of controlled substance accordance to rule 10A NCAC 13F .1008(a). Monitoring will be done using a monitoring tool designed by the Administrator. Administrator/Director will monitor for compliance weekly X 3, biweekly X 3, monthly X 3, then quarte thereafter. Documentation will be kept the facility for review.	ot,  Rs  y with 7-21 and d	0/6/21	

Division	Division of Health Service Regulation						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI		
		HAL029010	B. WING		N9/0	3/2021	
		11AE029010			09/0	3/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
GRAYSO	ON CREEK OF WELCO	OMF The state of t	US HWY 52 ON, NC 272				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
D 392	Continued From pa	ge 25	D 392	****			
	-			****			
		sed on 08/12/21 for a quantity		****			
	of 16 capsules.	t a CSCS to the facility with		****			
		te for the temazepam.		****			
				****			
		with Resident #1's hospice		***	**		
		2/21 at 12:03pm revealed:			****		
		nacy dispensed a 16-day Im 30mg on 07/15/21 and			****		
		harmacy and it should have					
		1 through 07/30/21.		THIS			
		ave been any temazepam					
	from 07/31/21 throu			PAGE			
		armacy dispensed a 16-day Im 30mg on 08/12/21 and					
		harmacy and it should have		INTENTIONALLY			
		1 through 08/27/21 if they had					
	been administered	nightly.		LEFT			
		ot administered her					
		every night at bedtime as		BLANK			
	dispensed to the re	he supply of temazepam		<i>52</i> , 1111			
		old of it.		****			
	Review of Resident			****			
		rd (MAR) for July 2021		****			
	revealed:	y for tomazonam 15 mg tako 2		****			
		y for temazepam 15mg take 2 at at bedtime scheduled for		****			
	8:00pm.	it at boatime concaded for		****			
	-There was docume	entation all doses had been		***	.++		
		07/01/21 to 07/31/21.		***			
		y for temazepam 30mg			****		
		at bedtime and there were no as administered from					
	07/01/21 to 07/31/2						
		ry's CSCS for Resident #1's					
		dispensed on 05/07/21 labeled pedtime as needed compared					

to the July 2021 MAR revealed:

A BULLIDAG:    A BULLIDAG:   COMPILETED		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMPI	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  6781 OLD US HWY 52  LEXINGTON, NC 27295  CRAYSON CREEK OF WELCOME  SUMMARY STATEMENT OF DEFICIENCES  (RACH DEFICIENCY MUST SEE PRECEDED BY SHULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  D PRETX TAG  CONTINUED From page 26  On 07/101/21 at 9:00pm, temazepam 30mg was documented as signed out on the CSCS, On 07/102/21 at 9:00pm, temazepam 30mg was documented as signed out on the CSCS, but there were no initials of the staff signing out the medication (slank), -There was no CSCS sheet available for review for temazepam 30mg dispensed on 07/15/21 compared to the July 2021 MAR revealed: -Temazepam 30mg dispensed on 07/15/21 at 9:00pm, the medication aide's (MA) signature was not the same as the MA who had documented administration on the MAR.  Review of the facility's CSCS for Resident #1's temazepam 30mg was documented administration on the MAR.  Review of Resident #1's MAR for August 2021 revealed: -There was an entry for temazepam 15mg take 2 capsules every night at bedtime scheduled for 8:00pmThere was documentation temazepam was administered at bedtime from 08/01/21 to 08/31/21.  Review of the facility's CSCS for Resident #1's temazepam as needed at bedtime and there were no doses documented as administered from 08/01/21 to 08/31/21.  Review of the facility's CSCS for Resident #1's temazepam compared to the August 2021 MAR revealed: -There was no compared to the August 2021 MAR revealed: -There was no CSCS available for review for				A. BUILDING:		Б	
CRAYSON CREEK OF WELCOME   6781 OLD US HWY 52   EXINGTON, NO 27295			HAL029010	B. WING			
CALL   CALL	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG  D 392  Continued From page 26  On 07/01/21 at 9:00pm, temazepam 30mg was documented as signed out on the CSCS. On 07/02/21 at 9:00pm, temazepam 30mg was documented as signed out on the CSCS, but there were no initials of the staff signing out the medication (blank), -There was no CSCS sheet available for review for temazepam 30mg was documented as 30mg at bedtime documented administered on the residents MAR from 07/03/21 to 07/15/21.  Review of the facility's CSCS for Resident #1's temazepam 30mg was documented as signed out on the CSCS, and the MAR daily from 07/19/21 to 07/15/21On 07/19/21 at 8:00pm, the medication aide's (MA) signature was not the same as the MA who had documented administration on the MAR. Review of Resident #1's MAR for August 2021 revealed: -There was an entry for temazepam 15mg take 2 capsules every night at bedtime scheduled for 8:00pmThere was an entry for temazepam was administered at bedtime from 08/01/21 to 08/31/21There was an entry for temazepam 30mg capsule as needed at bedtime and there were no doses documented as administered from 08/01/21 to 08/31/21.  Review of the facility's CSCS for Resident #1's temazepam compared to the August 2021 MAR revealed: -There was no CSCS available for review for	GRAYSC	ON CREEK OF WELCO	DME				
-On 07/01/21 at 9:00pm, temazepam 30mg was documented as signed out on the CSCSOn 07/02/21 at 9:00pm, temazepam 30mg was documented as signed out on the CSCS, but there were no initials of the staff signing out the medication (blank), -There was no CSCS sheet available for review for temazepam 30mg at bedtime documented administered on the residents MAR from 07/03/21 to 07/15/21.  Review of the facility SCSCS for Resident #1's temazepam 30mg dispensed on 07/15/21 compared to the July 2021 MAR revealed: -Temazepam 30mg was documented as signed out on the CSCS and the MAR faily from 07/16/21 to 07/31/21On 07/19/21 at 8:00pm, the medication aide's (MA) signature was not the same as the MA who had documented administration on the MAR.  Review of Resident #1's MAR for August 2021 revealed: -There was an entry for temazepam was administered at bedtime from 08/01/21 to 08/31/21There was an entern of temazepam was administered at bedtime from 08/01/21 to 08/31/21.  Review of the facility's CSCS for Resident #1's temazepam compared to the August 2021 MAR revealed: -There was no CSCS available for review for	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	_D BE	COMPLETE
documentation as signed out for temazepam 15mg take 2 capsules at bedtime or temazepam	D 392	-On 07/01/21 at 9:0 documented as sig -On 07/02/21 at 9:0 documented as sig there were no initia medication (blank)There was no CSC for temazepam 30r administered on the 07/03/21 to 07/15/2  Review of the facilit temazepam 30mg compared to the Ju-Temazepam 30mg compared to the Ju-Temazepam 30mg out on the CSCS at 07/16/21 to 07/31/2 -On 07/19/21 at 8:0 (MA) signature was had documented as Review of Resident revealed: -There was an entricapsules every night 8:00pmThere was documented administered at bed 08/31/21There was an entricapsule as needed doses documented 08/01/21 to 08/31/2  Review of the facilit temazepam comparevealed: -There was no CSC documentation as signature was no CSC documentation as signature.	Dopm, temazepam 30mg was ned out on the CSCS. Dopm, temazepam 30mg was ned out on the CSCS, but its of the staff signing out the its	D 392	*****  ****  ****  ****  ****  THIS  PAGE  INTENTIONALLY  LEFT  BLANK  ****  ****  *****  *****  *****  *****	****	

Division of Health Service Regulation

STATE FORM 6899 P3VF12 If continuation sheet 27 of 36

DIVISION	Of Fleatill Service IN	guiation			T	
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					F	,
		HAL029010	B. WING			
		TML023010			1 09/0	3/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		6781 OLD	US HWY 52	2		
GRAYSO	ON CREEK OF WELCO	DME LEXINGTO	ON, NC 272	95		
0/4) ID	CLIMMA DV CTA			T	NI	()(5)
(X4) ID PREFIX		TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
D 202	Cantinuad Francis	ma 07	D 392	****		
D 392	Continued From pa	ge 27	D 392			
	30mg at bedtime as	s needed from 08/01/21 to		****		
	08/17/21.			****		
	-The CSCS for temazepam 30mg labeled for on-			****		
	capsule at bedtime as needed dispensed on			****		
	08/12/21 for 16 capsules had documentation for					
	signed out at 8:00pm each night starting on			****		
	08/28/21 to 08/31/21.			***	**	
	-On 08/29/21 at 8:00pm, temazepam 30mg was				****	
		ned out on the CSCS, but the				
	documentation for the staff who signed out on the CSCS did not match the staff documenting					
				THIS		
	administration on th	ne MAR.				
				PAGE		
		:#1's MAR for September		17KGE		
	2021 revealed:					
		y for temazepam 15mg take 2		INTENTIONALLY		
		nt at bedtime scheduled for				
	8:00pm.			LEFT		
		entation all doses had been				
		09/01/21 to 09/02/21.		DI ANII		
		y for temazepam 30mg		BLANK		
		at bedtime and there were no as administered from				
	09/01/21 to 09/02/2			****		
	09/01/21 10 09/02/2	1.		****		
	Review of the facilit	y's CSCS for Resident #1's		****		
		red to the September 2021		****		
		CSCS for temazepam 30mg				
		sule at bedtime as needed		****		
		2/21 for 16 capsules had		****		
	documentation as signed out at 8:00pm on			***	**	
	09/01/21 to 09/02/2				****	
	20,0.,2. 10 00,02/2					
	Interview with the M	lemory Care Unit Coordinator				
		21 at 12:30 revealed:				
	` '	ome temazepam 30mg				
		that she had used to				
		cheduled dose on 09/01/21				
		ut of the scheduled dose of				

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temazepam 15mg 2 capsules at bedtime.

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING:	·	
		HAL029010	B. WING		R <b>09/03/2021</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE	
GRAYSO	N CREEK OF WELC	OME	US HWY 52		
ORATOC	NO ONE EN OF THE ES	LEXINGTO	ON, NC 272	95	
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 392	Continued From pa	age 28	D 392	****	
	-She did not know	why Resident #1 did not have		****	
	any scheduled tem			****	
		how long she had been out of		****	
	her scheduled dose of temazepam.			****	
	Interview with the Administrator on 09/02/21 at			****	
	1:05pm revealed the facility had some problems			***	**
with the hospice nurse practitioner refilling and signing medication orders, so the contracted				****	
		orders, so the contracted bte an order for Resident #1's			
	temazepam refill.			THIS	
	Refer to interview with the Memory Care Unit			DAGE	
		C) on 09/03/21 at 3:45pm.		PAGE	
		,		INITENITIONIALLY	
	Refer to interview v 09/02/21 at 12:55 p	with the Interim Director on om.		INTENTIONALLY	
	Defer to interview	with the Administrator on		LEFT	
	09/02/21 at 1:05pm				
				BLANK	
		ew with the Administrator on			
	09/03/21 at 5:05pm	1.		****	
	2. Review of Resid	dent #1's current FL2 dated		****	
	01/01/21 revealed:			****	
	to treat anxiety) twi	er for alprazolam 0.25mg (used		****	
		er for alprazolam 0.25mg every		****	
	4 hours as needed			***	4.4
	Tolonhana intensio	wwith Desident #1's centrast		^^^	****
		w with Resident #1's contract ation technician on 09/03/21 at			
	11:12pm revealed	alprazolam 0.25mg dispensing			
	dates as follows:				
	-Alprazolam 0.25m for 28 tablets.	g was dispensed on 06/04/21			
		g was dispensed on 06/18/21			
	for 28 tablets.				
	-Alprazolam 0.25m	g was dispensed on 07/02/21			

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
			71. 501251110.		R	,
		HAL029010	B. WING			3/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CDAVSC	ON CREEK OF WELCO	OME 6781 OLD	US HWY 52	!		
GRAISC	ON CREEK OF WELCO	LEXINGTO	ON, NC 272	95		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 392	Continued From pa	ige 29	D 392	****		
	, -			****		
	for 28 tabletsAlprazolam 0 25m	g was dispensed on 07/16/21		****		
	for 28 tablets.	g was disponed on or, 10,21		****		
	-Alprazolam 0.25mg was dispensed on 07/29/21			****		
	for 28 tablets.			****		
	Telephone interview	wwith Pasidant #1's hospica		***	**	
	Telephone interview with Resident #1's hospice pharmacist on 09/03/21 at 3:05pm revealed: -Alprazolam 0.25mg was dispensed on 08/16/21 for 15 tabletsAlprazolam 0.25mg was dispensed on 08/27/21				****	
				TLUC		
				THIS		
for 12 tablets.				54.65		
	Review of Resident	t #1's medication		PAGE		
		rd (MAR) for June 2021				
	revealed:	,		INTENTIONALLY		
		y for alprazolam 0.25mg twice				
		tation scheduled for		LEFT		
	administration at 8:	entation all doses had been				
		06/01/21 to 06/30/21.		BLANK		
		y for alprazolam 0.25mg every				
	4 hours as needed	with no documentation for as		****		
	needed administrat	ion.		****		
	Poviow of the facilit	ty's Controlled Substances		****		
		S) for Resident #1's		****		
		compared to the June 2021		****		
	MAR and July MAR			****		
		g dispensed on 06/04/21		***	**	
	labeled for one table	et twice a day was 06/05/21 to 06/18/21 matching			****	
		signed out on the CSCS.				
		g dispensed on 06/18/21				
	labeled for one tabl	•				
		06/19/21 to 06/30/21 matching				
		signed out on the CSCS.				
		at 8:00am when the staff nistration on the MAR did not				
		ning out alprazolam 0.25mg on				

Division of Health Service Regulation						
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	_ETED
					F	1
		HAL029010	B. WING			3/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
			US HWY 52	•		
GRAYSO	ON CREEK OF WELCO	)MF	ON, NC 272			
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	)N	(XE)
(X4) ID PREFIX	=	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
				DEI IOIENOT)		
D 392	Continued From pa	ge 30	D 392	****		
	the CSCS: and one	076/01/21 at 8:00pm the		****		
	CSCS was not documented for the staff signing			****		
	out the medication.			****		
				****		
		:#1's MAR for July 2021				
	revealed:	y for alprovalam 0.25mg twice		****		
		y for alprazolam 0.25mg twice		***	**	
	daily for anxiety/agitation scheduled for administration at 8:00am and 8:00pm.				****	
		entation all doses had been				
	administered from 07/01/21 to 07/31/21.			THIS		
	-There was an entr	y for alprazolam 0.25mg every		11110		
	4 hours as needed	with no documentation for as		DACE		
	needed administrat	ion.		PAGE		
	Davious of the facilit	w'a CSCS for Booldont #1'a		INITENITIONIALLY		
		y's CSCS for Resident #1's compared to the July 2021		INTENTIONALLY		
	MAR revealed:	compared to the duly 2021				
		5mg dispensed on 06/18/21;		LEFT		
		Dam the staff who signed out				
		on the CSCS did not match		BLANK		
		ng administration on the MAR;				
		8:00pm the CSCS was		****		
	1	imenting the staff who		****		
	MAR.	edication according to the		****		
		g dispensed on 07/02/21				
	labeled for one tabl			****		
		07/04/21 to 07/15/21 matching		****		
		signed out on the CSCS		****		
		at 8:00am, the CSCS was		***	**	
	· -	imenting the staff who			****	
		zolam compared to the MAR;				
		am and 8:00pm, the CSCS				
	alprazolam compar	the staff who administered				
		g dispensed on 07/16/21				
	labeled for one tabl	-				
		07/16/21 to 07/30/21 matching				
		signed out on the CSCS				

DIVISION	OF FIGARITY SETVICE INC	guiation				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					F	1
		HAL029010	B. WING			3/2021
NAME OF	PROVIDER OR SUPPLIER	STREET VIII	DESS CITY S	STATE, ZIP CODE		
NAIVIL OI	FROVIDER OR SUFFLIER		US HWY 52			
GRAYSC	N CREEK OF WELCO	)MF	OS HWY 52 ON, NC 272			
	OUR MAA DV OTA			T		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
D 392	Continued From pa	ge 31	D 392	****		
	except on 8 opportunities when the staff					
		istration on the MAR did not		****		
		cumented as signed out		****		
	alprazolam 0.25mg			****		
		0am and 8:00pm, staff who		****		
		am 0.25mg on the CSCS did		****		
		documented administration		***	**	
	on the MAR.	0			****	
	-On 07/26/21 at 8:00am and 8:00pm, staff who signed out alprazolam 0.25mg on the CSCS did					
		documented administration				
	on the MAR.	documented administration		THIS		
		0am and 8:00pm, staff who				
	signed out alprazola	am 0.25mg on the CSCS did		PAGE		
	not match staff who	documented administration				
	on the MAR.			INTENTIONALLY		
		0am and 8:00pm, staff who				
		am 0.25mg on the CSCS did odocumented administration		LEFT		
	on the MAR.	documented administration		LEFI		
	on the land to			DI ANII		
	Review of Resident	:#1's MAR for August 2021		BLANK		
	revealed:	_				
		y for alprazolam 0.25mg twice		****		
	, , ,	tation scheduled for		****		
	administration at 8:	ouam and 8:00pm.  entation all doses had been		****		
		08/01/21 to 08/30/21.		****		
		y for alprazolam 0.25mg every		****		
		with no documentation for as		****		
	needed administrat	ion.		***	**	
					****	
		ry's CSCS for Resident #1's				
	alprazolam 0.25mg MAR revealed:	compared to the August 2021				
		5mg dispensed on 07/30/21				
		was one tablet 08/02/21 at				
		no signed out alprazolam				
		S did not match the staff				
		nistration on the MAR.				

Division	Division of Health Service Regulation						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		HAL029010	B. WING		F 09/0	3/2021	
NAME OF I		CTDEET AD		STATE ZID CODE	•		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GRAYSO	N CREEK OF WELCO	)MF	US HWY 52 DN, NC 272				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
D 392	Continued From pa	ge 32	D 392	****			
	-There was a CSCS	S sheet for alprazolam 0.25mg		****			
	<ul> <li>There was a CSCS sheet for alprazolam 0.25mg one tablet twice a day with a start date of</li> </ul>			****			
		ets with 8 of 14 tablets signed		****			
		y a staff that did not match the		****			
		ted administration on the MAR		****			
	•	0pm on 08/13/21, 08/14/21,					
		0pm on 08/16/21 and		***			
	08/17/21There was a CSCS sheet for alprazolam 0.25mg				****		
		ay with a start date of					
		ets with 5 of 15 tablets signed		THIS			
		a staff that did not match the					
		ted administration on the MAR		PAGE			
		0pm on 08/21/21, 08/22/21,		.,,,,_			
	and at 8:00am on 0	umentation on a CSCS for		INTENTIONALLY			
		documented on the MAR for		INTERVIOR CET			
		1 and 8:00am on 08/28/21.		LEFT			
		S sheet for alprazolam 0.25mg		LEFI			
		ay with a start date of		DI ANIIZ			
		ets with 4 of 14 tablets signed a staff that did not match the		BLANK			
		ted administration on the MAR		****			
		9/21, 8:00am and and 8:00pm		****			
	on 08/29/21, and 8:	00pm on 08/31/21).					
	Design (Design			****			
		#1's alprazolam 0.25mg stration revealed there were 2		****			
		administration on 09/03/21 at		****			
		ne quantity indicated on the		****			
	current CSCS.	,		***	**		
					****		
		Memory Care Unit Coordinator					
		21 at 3:45pm revealed:					
		a CSCS for alprazolam for the 8/27/21 so she created one					
	on 09/02/21.	OLLITZ I 30 SHE GEALEU OHE					
		ident #1's alprazolam had					
		hut she wanted to be able to					

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account for them.

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S	
			A. BUILDING:			
		HAL029010	B. WING		R 09/03	/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GRAYSO	ON CREEK OF WELCO	DME	US HWY 52			
	T		ON, NC 272	T		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 392	Continued From pa	ge 33	D 392	****		
				****		
		vith the Memory Care Unit		****		
	Coordinator (MCUC	C) on 09/03/21 at 3:45pm.		****		
	Refer to interview v	vith the Interim Director on		****		
	09/02/21 at 12:55 p			****		
				***	***	
	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.				****	
				THIS		
	Interview with the N	1CUC on 09/03/21 at 3:45pm		PAGE		
	-The MA who chan	ged out cycle fill medications nsure all medications were on		INTENTIONALLY		
		ete medication cart audits 2 ensure medications were		LEFT		
	available and CSC	Ss were accurate and signed. able to count controlled		BLANK		
	medications at the no one to count wit	end of her shift and there was h.		****		
		s supposed to count controlled		****		
		shift to ensure the count was		****		
	off.	CSs had been properly signed		****		
	-Due to staffing iss	ues she had been		****		
		cations on the assisted living		****		
	and the MCU.			***	***	
	12:55 pm revealed: -The MA on duty chensure all medication compared to the Marchest the compared to the Marchest the compared to the checked the compared to the checked the compared to the c	necked cycle fill medications to ons were available as AR. medication dosage, ensured			****	
		lications were available, and led substances that came with				

Division of Health Service Regulation

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Division	Division of Health Service Regulation						
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	-ETED	
					R	1	
		HAL029010	B. WING		09/0	3/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
		6781 OLD	US HWY 52				
GRAYSO	N CREEK OF WELCO	OME TO THE STATE OF THE STATE O	ON, NC 272				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)	
PRÉFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE	
D 392	Continued From pa	ge 34	D 392	****			
	cycle fill medications to ensure the count was			****			
	correct to ensure nothing happened during			****			
	transit.			****			
	-She expected MAs to follow up on any missing			****			
		Ill the provider for orders as		****			
	needed.			***:	L.L		
		vere audited on 08/27/21 for		***			
	expired medications and to ensure all medications were available and matched orders.				****		
		eted her own audit on her					
	medication cart.	otod no. omi ddan om no.		THIS			
	-She did not know o	documentation on the CSCS					
	had blanks where the	he MA was supposed to sign		PAGE			
	the medication out.	-		I AGE			
		he CSCS did not match the		INITENITIONIALLY			
	MAR.			INTENTIONALLY			
		staff were not signing off on e a controlled medication was					
	administered.	e a controlled medication was		LEFT			
		CSCS to be accurate and					
	correspond with the			BLANK			
		ed any CSCSs as she was new					
	in that position.			****			
				****			
		dministrator on 09/02/21 at		****			
	1:05pm revealed:	noted phormony purpo gudited					
		acted pharmacy nurse audited n 08/27/21 to ensure		****			
		vailable and did not find any		****			
	problems.	rranasie and did not mid any		****			
-She did not know documentation on the CSCS			***	**			
		he MA was supposed to sign			****		
	the medication out.						
		he CSCS did not match the					
	MAR.	4					
		staff were not signing off on e a controlled medication was					
	administered.	e a controlled medication was					
		CSCS to be accurate and					

correspond with the MARs.

	UT OF DEFICIENCIES		(VO) MUUTIDI	E CONOTRILOTION	(VO) DATE	OLIDVEN.
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	
			A. BUILDING:			
					F	
		HAL029010	B. WING		09/0	3/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		6781 OLD	US HWY 52			
GRAYSO	N CREEK OF WELCO	)MF	ON, NC 2729			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTION	)N	(X5)
PREFIX	_	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
				DEI IOIENOT)		
D 392	Continued From pa	ge 35	D 392	****		
				****		
	Interview with the A	dministrator on 09/03/21 at		****		
	5:05pm revealed: -The staff were trained to sign out controlled medications on the CSCS and document administration on the MAR when administering medicationsShe did not know Resident #1's CSCS were not			****		
				****		
				****		
				***	**	
		to the resident's MAR for			****	
	administration of controlled medications					
	(temazepam and al			THIS		
		sponsible to ensure tracking ations was accurate.				
		occasionally did random		PAGE		
		S being complete but expected				
		terim Director to do more		INTENTIONALLY		
	thorough auditing.			THE TOTAL CELL		
		perienced a lot of staff MCUC and Interim Director		LEFT		
		ne staffing shortages which				
		ir time for auditing the CSCS		DLANIZ		
	and MARs.	G		BLANK		
				****		
				****		
				****		
				****		
				****		
				****		
				***	**	
					****	

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