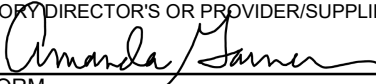


Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL029010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>02/17/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GRAYSON CREEK OF WELCOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6781 OLD US HWY 52</b> <b>LEXINGTON, NC 27295</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments  The Adult Care Licensure Section conducted an annual and follow-up survey on 02/15/23 through 02/17/23.	D 000		
D 273	<p>10A NCAC 13F .0902(b) Health Care</p> <p>10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure follow-up with the primary care provider (PCP) to meet the healthcare needs for 1 of 5 sampled residents (#1) who had difficulty eating.</p> <p>The findings are:</p> <p>Review of Resident #1's current FL2 dated 06/01/22 revealed: -Diagnoses included dysphagia (difficulty swallowing) and esophageal stricture. -She was intermittently disoriented. -The diet order was documented as mechanical soft.</p> <p>Review of Resident #1's Resident Register revealed she was admitted to the facility on 06/01/22.</p> <p>Review of Resident #1's hospital discharge summary dated 06/01/22 revealed: -Resident #1 was being discharged from the hospital to the assisted living facility that day. -During her hospitalization she had an esophagogastroduodenoscopy (EGD) (a procedure using a scope to view the inside of a</p>	D 273	<p>The Administrator/Director shall ensure healthcare referral and follow up is completed to meet the routine and acute health care needs of all residents as stated in rule 10A NCAC 13F .0902. New policy was developed and implemented 8-1-19. Policy states all new orders are to be brought directly to the facility director for review. Director or her designee will fax orders to appropriate agency to ensure follow up and referrals are completed as ordered. Documentation of requests will be keep with original order. Director will follow up to ensure each order is completed by appropriate agency, all appointments will be made for referrals and documentation will be kept of appointments at the facility for review. The Administrator/Director will monitor referral and follow ups to ensure complete and accurate using a Healthcare follow up and referral monitoring form. The Administrator/Director will monitor weekly X 3, biweekly X 3, monthly X 3, then quarterly thereafter.</p>	03/30/23

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTATOR	(X6) DATE 03/30/2023
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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL029010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>02/17/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GRAYSON CREEK OF WELCOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6781 OLD US HWY 52</b> <b>LEXINGTON, NC 27295</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 317	<p>Continued From page 11</p> <p>expression, increased knowledge, and learning of new skills.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a minimum of 14 hours per week of planned group activities for the residents.</p> <p>The findings are:</p> <p>Review of the February 2023 facility activity calendar revealed: -Sunday football on 02/05/23 and Superbowl Sunday on 02/12/23 with no times listed. -Movie and popcorn at 3:00pm on 02/11/23 (no duration of time for the activity listed). -Puzzles at 3:00pm on 02/06/23 and 02/20/23 (no duration of time for the activity listed). -Heart making at 10:00am, coloring handouts from 1:00pm to 2:00pm on 02/13/23 and 02/27/23. -Happy Valentines Day on 02/14/23 with no times listed. -There were no activities listed on the calendar for 02/15/23 and 02/16/23.</p> <p>Observations on 02/15/23 and 02/16/23 at various times throughout the day revealed there were no group activities being conducted for residents.</p> <p>Observation of the activities room at 10:10am on 02/15/23 revealed: -There were jigsaw and crossword puzzles available on tables and shelves. -There were adventure, autobiographical, romance and travel books available on a shelf.</p>	D 317	<p>The Administrator/Director shall ensure the activity program shall have at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills as stated in rule 10A NCAC 13F .0905 (d). A new staff member was appointed to head the activity program. A calendar was updated and posted with 14hrs of planned activities per week. Facility Staff had Residents rights training 3/28/23. Facility Staff met with Ombudsman at facility on 3/28/23, discussing activity calendar and upcoming activity events and improvement in activity program. The Administrator/Director will monitor the activity program to ensure compliance using an Activity Program monitoring form. The Administrator/Director will monitor weekly X 3, biweekly X 3, monthly X 3, then quarterly thereafter.</p>	03/30/23











Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL029010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>02/17/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GRAYSON CREEK OF WELCOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6781 OLD US HWY 52</b> <b>LEXINGTON, NC 27295</b>
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D 317	Continued From page 16  activities calendar and to ensure residents were provided group activities scheduled each week. -She expected 14 hours of activities to be planned and carried out by staff.	D 317		
D 358	<p>10A NCAC 13F .1004(a) Medication Administration</p> <p>10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:</p> <p>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and</p> <p>(2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (Residents #4) regarding a pain medication patch.</p> <p>The findings are:</p> <p>Review of Resident #4's current FL2 dated 07/01/22 revealed: -Diagnoses included dementia without behaviors, vision loss of the right eye, anemia, essential hypertension, and hyponatremia. -There was an order for lidocaine 5% patch apply up to 2 patches and wear up to 12 hours.</p> <p>Review of Resident #4's Medication Administration Record (MAR) for December 2022 revealed: -There was an entry for lidocaine 5% patch apply</p>	D 358	<p>The Administrator/Director shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: orders by a licensed prescribing practitioner which are maintained in the resident's record; DHSR rules and the facility's policies. Training with Medication Aides/ Supervisors on 3-28-23 including review of facility medication ordering policy and procedures. Documentation of training will be kept at the facility for review. The Administrator/Director will monitor medication pass periodically to ensure medications are being administered according to rule 10A NCAC 13F .1004(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 quarterly thereafter. Documentation will be kept at the facility for review.</p>	03-30-23











Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL029010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>02/17/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GRAYSON CREEK OF WELCOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6781 OLD US HWY 52</b> <b>LEXINGTON, NC 27295</b>
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D 367	<p>Continued From page 22</p> <p>10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following:</p> <ol style="list-style-type: none"> <li>(1) resident's name;</li> <li>(2) name of the medication or treatment order;</li> <li>(3) strength and dosage or quantity of medication administered;</li> <li>(4) instructions for administering the medication or treatment;</li> <li>(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;</li> <li>(6) date and time of administration;</li> <li>(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,</li> <li>(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).</li> </ol> <p>This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to ensure the medication administration records were accurate for 1 of 5 sampled residents (#5) including inaccurate documentation of a short-term expectorant medication, a short-term anti-inflammatory medication, and an anti-anxiety medication.</p> <p>The findings are:</p> <p>Review of Resident #5's current FL2 dated 01/14/22 revealed diagnoses included physical deconditioning, cognitive decline, macrocytic</p>	D 367	<p>The Administrator/Director shall ensure The resident's medication administration record (MAR) shall be accurate and include the following: resident's name; name of the medication or treatment order; strength and dosage or quantity of medication administered; instructions for administering the medication or treatment; reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; date and time of administration; documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, name or initials of the person administering the medication or treatment. All MARs for every resident were reviewed for accuracy by facility Director/Lead Med Aide on 03-29-23. Training with Medication Aides/Supervisors on 3-28-23 including review of facility medication policy and procedures. Documentation of training will be kept at the facility for review. The Administrator/Director will monitor medication pass periodically to ensure medications are being administered according to rule 10A NCAC 13F .1004(j). 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 quarterly thereafter. Documentation will be kept at the facility for review.</p>	03-30-23

























## STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER HAL029010	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 2/17/2023
NAME OF FACILITY GRAYSON CREEK OF WELCOME	STREET ADDRESS, CITY, STATE, ZIP CODE 6781 OLD US HWY 52 LEXINGTON, NC 27295	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix D0363	Correction	ID Prefix D0392	Correction	ID Prefix	Correction
Reg. # 10A NCAC 13F .1004(f)	Completed	Reg. # 10A NCAC 13F .1008(a)	Completed	Reg. #	Completed
LSC	10/06/2021	LSC	10/06/2021	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR <i>Keisha Banks</i>	DATE 03/03/2023
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 6/4/2021		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		