	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION ::	(X3) DATE COMP	SURVEY LETED
					R	
		HAL029010	B. WING		02/1	7/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GRAYSO	N CREEK OF WELCO	ME .	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 APPROPOLICIENCY)	D BE	(X5) COMPLETE DATE
D 000	Initial Comments		D 000			
		ensure Section conducted an up survey on 02/15/23 through				
D 273	10A NCAC 13F .09 (b) The facility shall to meet the routine of residents. This Rule is not me Based on observati interviews, the facili with the primary can healthcare needs for (#1) who had difficut. The findings are: Review of Resident 06/01/22 revealed: -Diagnoses include swallowing) and estable was intermitted. The diet order was soft. Review of Resident revealed she was a 06/01/22. Review of Resident summary dated 06/-Resident #1 was be hospital to the assistant procession of the summary dated of t	02 Health Care Il assure referral and follow-up and acute health care needs et as evidenced by: ons, record reviews and ity failed to ensure follow-up re provider (PCP) to meet the or 1 of 5 sampled residents ilty eating. #1's current FL2 dated d dysphagia (difficulty ophageal stricture. ntly disoriented. documented as mechanical #1's Resident Register dmitted to the facility on #1's hospital discharge 01/22 revealed: eing discharged from the sted living facility that day.	D 273	The Administrator/Director shall enhealthcare referral and follow up is completed to meet the routine and health care needs of all residents a stated in rule 10A NCAC 13F .0902 New policy was developed and implemented 8-1-19. Policy states orders are to be brought directly to facility director for review. Director designee will fax orders to appropr agency to ensure follow up and refare completed as ordered. Docume of requests will be keep with origin order. Director will follow up to enseach order is completed by appropagency, all appointments will be mareferrals and documentation will be of appointments at the facility for referral and follow ups to ensure country and accurate using a Healthcare for and referral monitoring form. The Administrator/Director will mor weekly X 3, biweekly X 3, monthly then quarterly thereafter.	acute as 2. all new the or her iate errals entation al ure ade for e kept eview. hitor omplete ollow up	03/30/23
	ealth Service Regulation	•		1		
		ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

Keisha Banks 04/03/2023

6QKV11

ADMINISTATOR

03/30/2023

If continuation sheet 1 of 33

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	A (X2) MULTIPLE CONSTRUCTION (X3) DATE SU		CLIDVEV	
	OF CORRECTION	IDENTIFICATION NUMBER:	()		COMP	
			, t. DOILDING.		_	
		HAL029010	B. WING		R 02/17/2023	
NAME OF I	PROVIDER OR SUPPLIER		ODECC CITY O	STATE, ZIP CODE		
NAME OF I	-ROVIDER OR SUPPLIER		US HWY 52			
GRAYSO	N CREEK OF WELCO	OMF The state of t	OS HWY 52 DN, 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 APPROVIDENCY)	D BE	(X5) COMPLETE DATE
D 273	Continued From pa	ae 1	D 273	***		
	·					
		s, stomach and duodenum)		***		
	8mm balloon.	ated her esophagus to an		***		
	-	I stay the dietician found		***		
		-calorie malnutrition and		***		
		ure Plus dietary supplements		***		
	three times daily.			***		
		omplained of difficulty		***		
		evaluated by speech therapy concern for oropharyngeal		***		
		ommended no further ST		***		
	intervention.			***		

		#1's diet order dated			***	
		an order for a mechanical soft nts three times daily with			***	
	meals.	its tillee tillles dally with		THIS		
				PAGE		
		#1's diet order dated 11/30/22		INTENTIONALLY		
		or a regular texture diet with		LEFT		
	supplements three	times daily with meals.		BLANK		
	Review of Resident	:#1's licensed health		***		
		rt (LHPS) assessment dated		***		
		documentation that Resident		***		
		nodified diet with staff		***		
	•	monitored for reminders due		***		
	to dementia but wa	s able to feed herself.		***		
	Review of the thera	peutic diet list dated 02/15/23		***		
		n revealed Resident #1 was		***		
	documented as bei	ng ordered a regular diet with		***		
	supplements three	times daily.		***		
	Review of Resident	:#1's monthly weights from		***		
	June 2022 to Febru	, ,		***		
		dmission in June 2022 was			***	
	documented as 93	pounds.			***	
	-Her weight in Febr as 89 pounds.	uary 2023 was documented				

6899

DIVISION	of Health Service Re	guiation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE S	
		HAL029010	B. WING		R 02/17/2023	
NAME OF F	PROVIDER OR SUPPLIER		DESS CITY	STATE, ZIP CODE	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
NAME OF F	ROVIDER OR SUPPLIER		US HWY 52			
GRAYSO	N CREEK OF WELCO)ME	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 APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 273	Continued From pa	ge 2	D 273	***		
	-Her weight from July 2022 to January 2023			***		
	ranged from 90 pounds to 94 pounds.			***		
		·		***		
		lunch meal served on		***		
	02/15/23 at 11:45ar			***		
	her supplement to d	erved ice water, iced tea, and		***		
		erved meatloaf that was cut		***		
	•	th ketchup drizzled over top of		***		
		s, cooked carrot slices, a		***		
	dinner roll, and a sli	ice of cake. ent #1 picked up her knife and		***		
		into smaller pieces.			***	
		the mashed potatoes,			***	
		t, and she ate a couple bites		TUIC		
	of meatloaf.	t count duving the good and		THIS		
	took time between t	t cough during the meal and		PAGE		
	took time between	taking cach bite.		INTENTIONALLY		
	Interview with Resid	dent #1 on 02/15/23 at		LEFT		
	11:47am revealed:			BLANK		
	 Her meat loaf was hard time eating it v 	broken up, but she still had a				
		eat to be ground up more so		***		
	she could swallow i			***		
		elped her cut her food, but it		***		
	-	up enough for her to eat it.		***		
		rare of her trouble with eating of just take small bites and eat		***		
	slowly.	Just take sirial bites and eat		***		
	•			***		
		ith Resident #1 on 02/15/23 at		***		
	2:45pm revealed:	d to receive a soft diet because		***		
		by teeth and had a history of		***		
		r esophagus stretched.			***	
	-She had dentures,	but her mouth structure had			***	
		entures no longer fit.				
	-She was able to ea	at most foods except for some				

6899

meats.

Division of Health Service Regulation
STATE FORM

6QKV11 If continuation sheet 3 of 33

	or realth Service IN				1000 - 1	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE	
, , , , , , , , , , , , , , , , , , , ,	J. JOHNEOHOW		A. BUILDING			
		HAL029010	B. WING		R 02/17/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS CITY	STATE, ZIP CODE		
			US HWY 52			
GRAYSO	GRAYSON CREEK OF WELCOME					
			ON, NC 272			
(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 APPRO		DATE
				DEFICIENCY)		
D 273	Continued From pa	ne 3	D 273	***		
22.0	·		22.0	***		
		ement with all her meals and		***		
	got enough to eat.			***		
	Interview with a me	dication aids (MA) on				
	02/15/23 at 3:07pm	dication aide (MA) on		***		
	•	ly was aware of her		***		
		ot being able to chew some of		***		
	the meats that were			***		
	-Resident #1's fami	ly visited often and usually		***		
	brought her foods, I			***		
		ent #1 would refuse her meal				
		en when staff assisted her with		***		
	cutting up her meat				***	
		s gave Resident #1 an			***	
		ich as a peanut butter and jelly		THIS		
		ich, if she requested it. ponsible to report resident		PAGE		
		he Resident Care Coordinator		INTENTIONALLY		
	(RCC) or the Direct					
		revious Director of the facility		LEFT		
		rior about Resident #1's		BLANK		
	complaints about he	er meals.		***		
		f the previous Director had		***		
		1's primary care provider		***		
		ent #1's complaints about not		***		
	being able to chew			***		
		ted to anyone else about concerns because she had		***		
		to the previous Director.				
		er of attorney (POA) was		***		
		#1's meal concerns.		***		

	•	v with a representative at		***		
		oenterologist's office on		***		
	02/16/23 at 11:30ar				***	
		GD procedures completed on				
		/22 to stretch her esophagus.			***	
		cheduled for EGD procedures igust 2022, but both were				
		ent #1 or her representative.				
	carrocica by reside	nit in a controproduction of				

Division of Health Service Regulation

STATE FORM 6899 6QKV11 If continuation sheet 4 of 33

ווטופועום	of Health Service Re	guiation	r		,	
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R	,
		HAL029010	B. WING			7/2023
		HAL029010			02/1	112023
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)ME	ON, NC 272			
040.15	CUMMADY CTA		1		ON	0.5
(X4) ID PREFIX		TEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
D 273	Continued From pa	go 4	D 273	***		
D 210	Continued i Tom pa	ge 4	D 273	***		
	-Resident #1's POA	messaged their office on				
	06/29/22 with a con	cern that Resident #1 had		***		
	ongoing issues with	swallowing, but then		***		
	cancelled her appo	intments without giving a		***		
	reason.			***		
		called their office on 09/21/22				
		GD, but when she was told		***		
		ould need an office visit prior to		***		
), she did not schedule the		***		
	appointment.			***		
		a diet recommendation for		***		
		ally they recommended their				
	patients eat whatev	er they could tolerate.			***	
	Interview with a MA	on 02/16/23 at 12:10pm			***	
	revealed:	1011 02/10/23 at 12.10pm		THIS		
		times asked to eat her meals		PAGE		
		oom with the MA because she				
	coughed and hacke			INTENTIONALLY		
		sation with Resident #1's POA		LEFT		
		sussing Resident #1's trouble		BLANK		
		s and suggested she		***		
		O to have Resident #1's		***		
	esophagus stretche	ed again.		***		
	-Whoever was work	king in the dining room always				
		s meats really small.		***		
	_	s received a mechanical soft		***		
	diet.			***		
		Resident #1's diet concerns to		***		
	•	or which was about a month		***		
	ago.					
		er full meals, including the		***		
	meat, sometimes.	ont #1 coughed while she was		***		
		ent #1 coughed while she was ays had a lot of phlegm to		***		
		she was eating or not.			***	
	Cough up whether s	one was eating of not.			***	
	Telephone interview	wwith Resident #1's POA on			0.4.4	
	02/16/23 at 12:40pr					
		Resident #1's complaints				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP		
		1141 020040		/ING		R 02/17/2023	
		HAL029010	B. WIIIO		02/1	//2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	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 APPROF DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
D 273	-She had scheduled EGDs as recomme gastroenterologist, cancel them and sa those anymoreResident #1 compliswallowing to her a to schedule an approact of the schedule and approach of the schedule and schedule an	e to eat some meats. d Resident #1 for subsequent inded by the but Resident #1 asked her to aid she did not want to do lained about difficulty lot, but whenever she offered cointment to address her need. Doordinate and schedule intments and the facility had Resident #1 to appointments stility had discussed their sident #1's swallowing with een gagging and coughing on the facility's previous PCP or for a regular diet in the facility brought in food for so she was unsure what the ring her. The facility and she did not know by brought her in a lot of food hungry. The facility appointments and decause she was responsible dent #1's appointments and decause she was responsible dent #1's appointments and	D 273	*** *** *** *** *** *** *** THIS PAGE INTENTIONALLY LEFT BLANK *** *** *** *** *** *** ***	***		
	for scheduling Resi				***		

6899

Division of Health Service Regulation STATE FORM

6QKV11 If continuation sheet 6 of 33

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE S COMPL	
			A. BUILDING.			
		HAL029010	B. WING		R 02/17	7/2023
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
GRAYSO	ON CREEK OF WELCO	OME	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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	1:00pm revealed: -Resident #1's diet but she could not e she served her med requestIn the past, she ha meats, but Residen up and refused to e			***		
	 -She cut up everything on Resident #1's plate. -She had talked to the MAs and the Director before about Resident #1's complaints about her diet and was told to serve her a mechanical soft 			***	***	
	diet.	Serve her a mechanical soft			***	
	sandwich or a chee	ed a peanut butter and jelly se sandwich upon request for se those were her favorites hem easily.		THIS PAGE INTENTIONALLY LEFT		
	02/16/23 at 1:17pm -Since she was adr #1 had always com to eat the meat on I -Resident #1 talked about her swallowir about it.	nitted to the facility, Resident plained about not being able		*** *** *** *** *** ***		
	soft dietShe had reported to Resident #1 not be meatThe MA had told howas ordered a mecowhat she was server-She did not know in Resident #1's conci-She had talked with the she was talked with the soft with the soft with the soft was server as the	o one of the MAs about ng able to chew or swallow er to let Resident #1 know she hanical soft diet and that was		*** *** *** *** ***	* *** ***	

Division of Health Service Regulation STATE FORM

E FORM 6899 6QKV11 If continuation sheet 7 of 33

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	HAL029010	B. WING		R 02/17/2023	
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE	02/1/	172023
	6781 OLD	US HWY 52			
GRAYSON CREEK OF WELCON	ΛF	ON, NC 2729			
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
do anything differently meals to Resident #1 -Sometimes she cut of smaller pieces and signaller pieces and signale	nad not asked the facility to ly regarding how they served l. up Resident #1's meat into he would eat it. rd Resident #1 clear her ut she never coughed or of phlegm in her chest so a lot whether she was eating tor were both aware of incerns. with a MA on 02/17/23 at occdures done to stretch her ught the procedures were every 6 months. For Resident #1's last EGD, do her diet order to regular en she had returned to work, allowing all of her food weeks Resident #1 had bout what food she was regarding Resident #1's me. nad also discussed with her ne thought the complaints at tion-seeking behaviors to get taide meals brought in, so a medication for anxiety and the facility every Monday, and dated on Resident #1's	D 273	*** *** *** *** *** *** *** THIS PAGE INTENTIONALLY LEFT BLANK *** *** *** *** *** *** ***	***	

Division of Health Service Regulation

STATE FORM 6899 6QKV11 If continuation sheet 8 of 33

DIVIDION	Of Fleatill Service IN	guiation					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE S COMPL		
		HAL029010	B. WING		1	R 02/17/2023	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS CITY S	STATE, ZIP CODE			
		6781 OLD	US HWY 52				
GRAYSC	ON CREEK OF WELCO)MF	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 APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
D 273	Continued From pa	ge 8	D 273	***			
	-She updated the P	CP verbally during her visits at lid not have documentation of		*** *** ***			
	9:45am revealed: -Resident #1's curre a regular textureThe kitchen served but cut all of her foot to herResident #1 had re concerns to herShe had discussed concerns with her F to pursue any furthe evaluation, swallow -They updated Res concerns and eatin was visitingResident #1's PCF verbally during her	with the RCC on 02/17/23 at ent diet order was regular with direct Resident #1 a regular diet, od up for her before serving it eported her swallowing direct Resident #1's swallowing POA, but the POA did not want er intervention such as a ST study or EGD procedures. Ident #1's POA on her diet ginabits every week when she was also made aware time at the facility, but had not lers because the POA had in.		*** *** *** *** *** THIS PAGE INTENTIONALLY LEFT BLANK *** ***	*** ***		
	-The facility staff me enough to eat eithe	ade sure that Resident #1 had r by cutting up the meals they rering alternatives and making		*** *** ***			
	at 12:15pm reveale -She thought when Resident #1's diet of error, but she had r -The kitchen served soft dietSince Resident #1 she had complaine swallowing certain	the previous PCP changed order to regular it had been in not caught the error. It Resident #1 a mechanical was admitted to the facility, It about having trouble		*** *** *** ***	***		

Division of Health Service Regulation STATE FORM

6899 6QKV11 If continuation sheet 9 of 33

	or realtribervice re				1000		
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE		
AND ELAN	OF CORRECTION	IDLIVIII IOATION NOWDER.	A. BUILDING:	BUILDING:		COMPLETED	
					F	,	
		HAL029010	B. WING		1	7/2023	
		IIALVAVVIV			1 02/1	112023	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
		6781 OLD	US HWY 52	2			
GRAYSO	N CREEK OF WELCO	DME LEXINGTO	ON, NC 272	95			
	OLIMAN DV OTA		•		ON.	4.5	
(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 APPRO		DATE	
				DEFICIENCY)			
D 070	0 " 15		D 070	***			
D 273	Continued From pa	ge 9	D 273	***			
	a hard time swallow	ving meat even when cut up.					
		Resident #1's current PCP		***			
		lent #1 having trouble with		***			
	swallowing.	The state of the s		***			
		spected the MAs to notify her if					
		aving ongoing issues or		***			
		time regarding not being able		***			
		t she could notify the PCP.		***			
		residents at mealtimes		***			
		ne previous couple of weeks.					
		bserved Resident #1 during		***			
		she ate without complaint and		***			
	did not cough or ha				***		
		ocial anxiety and sometimes			***		
		could eat in the medication					
	room.			THIS			
				PAGE			
	Telephone interview	wwith Resident #1's PCP on		INTENTIONALLY			
	02/17/23 at 12:25pr						
		orking at the facility on		LEFT			
		Resident #1 for the first time		BLANK			
	on 02/13/23.			***			
		ot mentioned any swallowing		***			
	concerns or trouble			***			
		iagnoses of dysphagia,					
		e, and dementia so it was		***			
		d not think to mention it.		***			
		lert and oriented only to		***			
		uring her assessment on		***			
		I not feel she was an accurate					
	historian.			***			
		id not contacted her at all		***			
		#1's diet and had not		***			
	0	ary concerns to her when she		***			
	was at the facility.	,		***			
		tified about Resident #1's			***		
		s she would have referred her			***		
	_	logy and the dentist.					
		to be notified if a resident had					

Division of Health Service Regulation

an ongoing concern about swallowing.

STATE FORM 6899 6QKV11 If continuation sheet 10 of 33

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL029010	B. WING		R 02/17/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GRAYSO	ON 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 APPROPRICIENCY)	D BE COMPLETE	
D 273	Continued From pa	ge 10	D 273	***		
	be obstruction vers served a regular ters swallow it. -She agreed with the Resident #1 a mechanized a regular double ordered at 1:00 pm. -She was aware of concerns. -Resident #1's preveregular texture becarequested it. -Resident #1's diet to mechanical soft preveregular double ordered it. -Resident #1's current swallowing concerns the new PCP had more proporting dietary cound she thought the she talked with the them to serve Resident #1's current of the serve Resident #1's current of the swallowing without the diet and swallowing swallowing server	w with the Administrator on revealed: Resident #1's swallowing ious PCP changed her diet to ause Resident #1 had had since been changed back per Resident #1's request. ent PCP was not aware of her is because she was unsure if net Resident #1 yet. would be responsible for ncerns to the RCC or Director,		*** *** *** *** *** *** *** THIS PAGE INTENTIONALLY LEFT BLANK *** *** *** *** *** *** ***	*** ***	
D 317	10A NCAC 13F .09	05 (d) Activities Program	D 317	***		
	10A NCAC 13F .09 (d) There shall be a of planned group activities that promo	05 Activities Program at least 14 hours of a variety ctivities per week that include ote socialization, physical ccomplishment, creative		***RESPONSE ON PAGE 12	2	

DIVISIO	n of Health Service Re	egulation				
	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		HAL029010	B. WING		R 02/17/2023	
NAME C	F PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAY	ON CREEK OF WELCO	OME	US HWY 52 DN, NC 272			
(X4) IC PREFIX TAG	(EACH DEFICIENCY	NTEMENT 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 APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 31	expression, increase new skills. This Rule is not meased on observation reviews, the facility 14 hours per week the residents. The findings are: Review of the Febricalendar revealed: -Sunday football on Sunday on 02/12/2-Movie and popcorriduration of time for -Puzzles at 3:00pm duration of time for -Heart making at 10 from 1:00pm to 2:0 02/27/23Happy Valentines listedThere were no act for 02/15/23 and 02 00 00 00 00 00 00 00 00 00 00 00 00	sed knowledge, and learning of set as evidenced by: ions, interviews, and record failed to ensure a minimum of of planned group activities for uary 2023 facility activity 202/05/23 and Superbowl with no times listed. In at 3:00pm on 02/11/23 (no the activity listed). Ion 02/06/23 and 02/20/23 (no the activity listed). Ion 02/06/23 and 02/20/23 (no the activity listed). Ion 02/13/23 and Ion on 02/13/23 and Ion on 02/13/23 and Ion of 2/16/23. In at 2/16/23 and 02/16/23 at Ion of 2/16/23 at Ion of 2/16/23 at Ion of 2/16/23 and Ion of 2/16/23 and Ion of 2/16/23 and Ion of 2/16/23 at Ion of 2/16/23 and Ion of 2/16/23 and Ion of 2/16/23 at Ion of 2/16/23 at Ion of 2/16/23 and Ion of 2/16/23 at	D 317	The Administrator/Director shall end the activity program shall have at 14 hours of a variety of planned gractivities per week that include activities expression, increased knowledge, and learning of new stated in rule 10A NCAC 13F .090 A new staff member was appointed head the activity program. A calent was updated and posted with 14hr planned activities per week. Facility had Residents rights training 3/28/Facility Staff met with Ombudsmant facility on 3/28/23, discussing activity and improvement in activity program. The Administrator/Director will most the activity program to ensure compliance using an Activity Program onitoring form. The Administrator/Director will most weekly X 3, biweekly X 3, monthly then quarterly thereafter.	east roup tivities all t, sills as 5 (d). d to dar rs of y Staff 23. en at vity ents am. nitor	03/30/23

6899

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7 201221110.	·	R	
		HAL029010	B. WING			//2023
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRAYSO	N CREEK OF WELCO)ME	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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 317	Continued From pa	ge 12	D 317	***		
	-There were trivia, dice and board games			***		
	available on shelves.			***		
	-Coloring sheets and colored pencils and crayons were available on a table.			***		
	word available on a table.			***		
		male resident on 02/15/23 at		***		
	10:15am revealed the resident entered the activities room and took a copy of a crossword			***		
puzzle from a shelf.			***			
	Interview with a res	ident on 02/15/23 at 10:15 am		***		
	revealed:			***	***	
		up activities offered in the casional party and church			***	
	service.	, ,		THIS		
		saw and word puzzles on her organize any group		PAGE		
	activities.	or organize any group		INTENTIONALLY		
	latamia, contitta a a a a	and resident on 00/45/00 at		LEFT		
	3:35pm revealed:	cond resident on 02/15/23 at		BLANK		
	-There was usually	not anything written on the		***		
	activities calendar. The staff at the factors	ility did not conduct any		***		
	activities with the re	esidents.		***		
	-The only activity th	at had been provided was a church group, and that was		***		
	not every day.	a criureri group, and mat was		***		
	-She would particip	ate if the facility had		***		
	scheduled group ad	CTIVITIES IIKE CRATTS.		***		
		d resident on 02/15/23 at		***		
	3:47pm revealed: -There were not an	y scheduled activities for		***		
	residents to go to.			***	***	
		h that had services on			***	
	sometimes on Mon	one who played music day.				
		any activities with the				

6899

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	_ETED
			D WING		F	
		HAL029010	B. WING		02/1	7/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAYSO	N CREEK OF WELCO)MF	US HWY 52			
		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 APPROF	D BE	(X5) COMPLETE DATE
D 317	Continued From pa	ge 13	D 317	***		
	-They had bingo sometimes, but her vision			***		
	prevented her from participatingShe liked to play piano and sing.			***		
	-Sile liked to play pi	and and sing.		***		
		ff on 02/15/23 at 3:50pm		***		
	revealed: -The Director was o	conducting activities		***		
	occasionally, once			***		
		ector would have her do crafts		***		
	with residents.	and did bingo 1 time a week		***		
	and played music.	and did bingo i time a week		***		
	-There was not a d	esignated person to conduct			***	
	activities for resider trying to hire some	nts, but that the facility was			***	
	trying to thre some	one.		THIS		
		rth resident on 02/16/23 at		PAGE		
	3:30pm revealed:	vho was supposed to do		INTENTIONALLY		
	activities for the res			LEFT		
		ne activity room for books,		BLANK		
	puzzles or games b books and sudoku.	ecause she had her own		***		
		ed to participate in daily		***		
	activities if the facili			***		
	Interview with a fifth	resident on 02/16/23 at		***		
	3:36pm revealed:			***		
		e had seen was bingo provided		***		
	by a church group. -He did not go to the	e activity room for books,		***		
	puzzles or games.	o activity room for books,		***		
	-He liked gardening			***		
	 He would participa facility offered them 	te in daily activities if the		***		
	issuity choice them	•			***	
		cond staff on 02/16/23 at			***	
	1:30pm revealed:	who was responsible to				

Division of Health Service Regulation

maintain the activities calendar.

STATE FORM 6899 6QKV11 If continuation sheet 14 of 33

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	
		HAL029010	B. WING		02/17/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAYSO	ON CREEK OF WELCO	OMF	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 APPROPERTION OF T	D BE COMPLÉ	TE
D 317	Continued From page 14		D 317	***		
	were responsible to residents, but that I -She had not seen activities with the reany group activities -Churches came to the residents once came to play music roomThe last activity shabout a month ago. Interview with a visit revealed he visited were no activities c services. Interview with a see 9:30am revealed sh	provide bingo and music for a week, and a gentleman cocasionally in the dining e remembered was bingo		*** *** *** *** *** *** *** THIS PAGE INTENTIONALLY LEFT BLANK	***	
	Interview with the R (RCC) on 02/16/23 -The Activities Direct facility for about 2 v -The Director would the activities calend not returnShe was the RCC, secretary, MA/SIC schedule, even if it dayThe facility hosted Day party for reside -Other activities incibirthday bingo and	d be responsible for making up dar since the previous AD had but also acted as the and Assistant Director. to conduct activities on the was something small every a Super Bowl and Valentine's ents in the past week. luded fingernail painting,		*** *** *** *** *** *** *** *** *** ***	***	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL029010	B. WING		R 02/17/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
CDAVCC	N ODEEK OF WELCO	6781 OLD	US HWY 52	2		
GRAYSC	ON 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 317	17 Continued From page 15		D 317	***		
	every other Wednesday evening, and a gentleman came to play music for residents once a week. Interview with the Director on 02/16/23 at 3:45pm revealed: -She was certified as an Activity Director (AD) and was responsible to maintain the activities calendar and conduct resident group activities since the previous AD was no longer with the facility as of a couple weeks agoShe had a staff write the activities that were on			***		

				**:	L	
				***	***	
	the calendar now.	no'o Day party this wook for			***	
	the residents.	ne's Day party this week for		T. 110	^^^	
	-Other activities we	re buddy walks around the		THIS		
		Thursdays, current events,		PAGE		
		d puzzles in the activity room. aff conduct current events in		INTENTIONALLY		
		ring their breaks which usually		LEFT		
	last about 15 minut	es each time.		BLANK		
		conduct bible study for about 2		***		
		orning around 7:00am and ne at 10:00am for church		***		
	service.	io at 10.00am for orial or		***		
		nad not conducted any		***		
		because it got busy.		***		
		the secretary/SIC as AD to certification within the next		***		
	few weeks.			***		
	Int	-li-i-tt 00/47/00 t		***		
	Interview with the A 12:55pm revealed:	dministrator on 02/17/23 at		***		
	•	ivities because some residents		**:	*	
	had COVID-19 in m	nid-January 2023 until early			***	
	February 2023.	nt to some in when the facility			***	
	posted a notice of (nt to come in when the facility				
	residents/staff in the					
		esponsible to maintain the				

Division of Health Service Regulation

STATE FORM 6899 6QKV11 If continuation sheet 16 of 33

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			7/2023
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAYSC	ON CREEK OF WELCO)ME	US HWY 52 DN, NC 272			
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 317	Continued From pa	ge 16	D 317			
	provided group acti	and to ensure residents were vities scheduled each week. nours of activities to be d out by staff.				
D 358	(a) An adult care hereparation and adprescription and not by staff are in acco (1) orders by a lice which are maintain (2) rules in this Seand procedures. This Rule is not medications as orderesidents (Resident medications as orderesidents (Resident medication patch.) The findings are: Review of Resident 07/01/22 revealed: -Diagnoses include vision loss of the rightypertension, and interviews an orderesident and inistration Recrevealed:	04 Medication Administration ome shall assure that the ministration of medications, n-prescription, and treatments rdance with: ensed prescribing practitioner ed in the resident's record; and ction and the facility's policies et as evidenced by: ens, record reviews, and ity failed to administer ered for 1 of 5 sampled its #4) regarding a pain	D 358	The Administrator/Director shall as that the preparation and administrate medications, prescription and non-prescription, and treatments by stain accordance with: orders by a lice prescribing practitioner which are maintained in the resident's record DHSR rules and the facility's police. Training with Medication Aides/Supervisors on 3-28-23 including of facility medication ordering police procedures. Documentation of trainwill be kept at the facility for review Administrator/Director will monitor medication pass periodically to en medications are being administered according to rule 10A NCAC 13F .1004(a). Monitoring will be dousing a monitoring tool designed by Administrator. Administrator/Direct monitor for compliance weekly X 3 biweekly X 3, monthly X 3, then que thereafter. Documentation will be left the facility for review.	ation of aff are ensed d; ies. review cy and ning v. The sure ed one by the tor will d, uarterly	03-30-23

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL029010	B. WING		02/17	7/2023
	PROVIDER OR SUPPLIER	OMF 6781 OLD	DRESS, CITY, 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
D 358	up to 2 patches top to 12 hours) schedular revealed revealed: There was an entrup to 2 patches top to 12 hours) schedular revealed: There was an entrup to 2 patches top to 12 hours) schedular revealed for 31. There was documed were applied for 31. There was no entrup atches and no documed were removed. Review of Resident through 02/15/23 relatives and no documed through 02/15/23 relatives and through 02/15/23 relatives and no documed were applied for 14. There was an entrup to 2 patches top to 12 hours) schedular removed. Review of Resident through 02/15/23 relatives and no documed were applied for 14. There was no entrup to 2 patches and no documed applied for 14. There was no entrup to 2 patches and no documed applied for 14. There was no entrup to 2 patches and no documed applied for 14. There was no entrup to 2 patches and no documed applied for 14. There was no entrup to 2 patches and no documed applied for 14. There was no entrup to 2 patches top to 12 hours) schedular through 02/15/23 relatives and no documed applied for 14. There was no entrup to 2 patches top to 12 hours) schedular through 02/15/23 relatives and no documed applied for 14. There was no entrup to 2 patches top to 12 hours) schedular through 02/15/23 relatives and no documed applied for 14.	ically every day (may wear upuled for application at 8:00am. entation lidocaine patches of 31 opportunities. If of the removal of the cumentation when the patches of 31 opportunities. If a sumentation when the patches of 31 opportunities. If a sumentation lidocaine patches of 31 opportunities. If a sumentation when patches of 31 opportunities. If a sumentation lidocaine patches of 31 opportunities. If a sumentation lidocaine patches of 31 opportunities. If a sumentation lidocaine patches of 31 opportunities. If a sumentation when patches of 31 opportunities. If	D 358	*** *** *** *** *** *** *** THIS PAGE INTENTIONALLY LEFT BLANK *** *** *** *** *** *** ***	***	

Division of Health Service Regulation

DIVISION	of Health Service Re	guiation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL029010	B. WING		02/1	? 7/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		6781 OLD	US HWY 52	·		
GRAYSO	N CREEK OF WELCO	DME 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 APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 358	Continued From pa	ge 18	D 358	***		
	•	t the facility's contracted		***		
		er Resident #4's lidocaine		***		
	patches.			***		
		ed she applied lidocaine		***		
		3 and 02/14/23, but the		***		
	patches were not a	patches on 02/15/23, but they		***		
		the medications delivered		***		
	from the pharmacy			***		
		hes should have been		***		
	reordered 4 to 5 day out.	ys prior to Resident #4 running		***		
		why Resident #4's lidocaine			***	
		eordered prior to her running			***	
	out.			THIS		
	-"It gets nectic arou	nd here sometimes."		PAGE		
	Interview with a sec	cond MA on 02/16/23 at		INTENTIONALLY		
	3:37pm revealed:			LEFT		
		had to be reordered from the		BLANK		
	pharmacy.	eeded to be reordered should		***		
		ed 5 days prior to running out.		***		
		cond shift when the lidocaine		***		
	patches should be			***		
		ot had lidocaine patches on to tarted working at the facility in		***		
	July 2022.	taited working at the facility in		***		
		one Resident #4 did not have		***		
		es applied and there was no		***		
	where to document			***		
	have lidocaine patc	one knew Resident #4 did not hes.		***		
	•	e pharmacy to inquire about		***		
	the order for lidocai	ne patches and she did not		^^^	***	
	know why she did n				***	
		who was responsible for macy about medications that			***	
	were not available i					

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL029010	B. WING		R 02/17/2023	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 02/1	112020
		6781 OLD	US HWY 52	,		
GRAYSO	N CREEK OF WELCO)MF	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 APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
D 358	Continued From pa	ge 19	D 358	***		
	contracted pharmace revealed: -Resident #4 had a patches 5% apply us 12 hoursThe order for lidoce they had to be reorgededLidocaine patches on 07/14/22 with a certain the transfer of t	dent #4 on 02/16/23 at 4:28pm ar back every once in a while, he could not tolerate. Apply a pain patch to her back, plied the pain patch in a long ot remember when MAs last n.		*** *** *** *** *** *** THIS PAGE INTENTIONALLY LEFT BLANK ***	*** ***	
	9:19am revealed: -Resident #4 had lice prior to 02/17/23, but them appliedShe last applied a on Thursday, 02/09 3 patches remainingShe did not reorde patches and she was out of patchesMAs usually reorde when there were ab-lt usually only took delivered to the face	wwith a MA on 02/17/23 at docaine patches the week at she often refused to have didocaine patch to Resident #4/23 at 8:00am and there were g. r Resident #4's lidocaine as not sure if Resident #4 ran ered the lidocaine patches bout 5 patches remaining. 1 day for the patches to be		*** *** *** *** *** *** *** *** ***	*** ***	

Division of Health Service Regulation

STATE FORM 6899 6QKV11 If continuation sheet 20 of 33

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SU COMPLE	
			A. BUILDING.	·	R	
		HAL029010	B. WING		02/17/	2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
GRAYSO	ON CREEK OF WELCO)MF	US HWY 52 DN, 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 358	Continued From pa	ge 20	D 358	***		
	January 2023Resident #4 comp was first admitted to	harmacy around the end of lained of pain often when she to the facility (July 2022), but in much about having pain		*** *** *** ***		
	now.	•		***		
	Telephone interview with the Resident Care Coordinator (RCC) on 02/17/23 at 9:45am			***		
	revealed: -She did not know l	Resident #4 did not have		***		
		vailable in the facility for		***	***	
	administrationMAs were respons	sible for reordering Resident			***	
	#4's lidocaine patch supply remaining. -If Resident #4 nee lidocaine patches of getting the patches have informed her -The MAs should her	ded a new prescription for the or if there was a problem with reordered, the MAs should		THIS PAGE INTENTIONALLY LEFT BLANK ***		
	Telephone interview with Resident #4's Primary Care Provider (PCP) on 02/17/23 at 12:23pm revealed: -She began working at the facility on 01/11/23She last saw Resident #4 on 02/13/23 and Resident #4 reported to her that she "was doing"			*** *** *** ***		
	just fine." -Resident #4 had a apply up to 2 patch -The order for lidoc prior to her seeing	n order for lidocaine 5% patch es and ware up to 12 hours. aine patches was in place Resident #4 as a patient; she he order for lidocaine patches		*** *** ***	***	
	to be more specific -She did not know s any patches to Res -She reviewed the l	staff had not been applying			***	

Division of Health Service Regulation STATE FORM

PRM 6899 6QKV11 If continuation sheet 21 of 33

	Division of Health Service Regulation							
STATEMENT OF DEI AND PLAN OF CORF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		HAL029010	B. WING		R 02/1	7/2023		
NAME OF PROVIDE		CTDEET ADI		STATE, ZIP CODE				
NAME OF FROVIDE	N ON SUFFLIEN		US HWY 52					
GRAYSON CREE	EK OF WELCO)ME	ON, NC 272					
	ACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE		
D 358 Contin	nued From pa	ge 21	D 358	***				
-She expatches -She expatches -She expatches -She expansion of the last section of the	expected the ses daily as ordexpected the sexpected the sexpected the sexpected the sexpected in the patches are lidocaine lid	facility to reach out to her if ing the lidocaine patch or had patches from the pharmacy. with the Director on 02/17/23 d: Resident #4 did not have vailable for administration and atches had not been pharmacy since July 2022. ible for reordering medication medication running out. Is to reach out to the pharmacy hes were not in the facility to ad not been delivered. Is to contact Resident #4's PCP ocaine patches had not been with the facility to ad not been delivered. It to administered medication of the pharmacy had not been delivered. The property of the pharmacy had not been delivered with the facility to administered medication of the pharmacy had not been with the facility to administered medication of the pharmacy had not been delivered with the facility to administered medication of the pharmacy had not been delivered with the facility to administered medication of the pharmacy had not been delivered medication of the phar		*** *** *** *** *** *** *** THIS PAGE INTENTIONALLY LEFT BLANK *** *** *** *** *** *** ***	***			
reach and to	out to the phate the Director.	armacy, Resident #4's PCP	D 367	*** ***RESPONSE ON PAGE 23	***			

6899

Division of Health Service Regulation STATE FORM

If continuation sheet 22 of 33 6QKV11

STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING		R	
		HAL029010	B. WING		02/1	7/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAYSO	ON CREEK OF WELCO)ME	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 APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 367	Continued From pa	ge 22	D 367			
D 367	10A NCAC 13F .10 (j) The resident's narecord (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 justifice medications or treatmenting the redications or treatmenting the redications or treatment; (6) date and time of (7) documentation or medications or treatmenting (8) name or initials the medication or tresignature equivalent documented and madministration reconstruction of the same of	04 Medication Administration nedication administration be accurate and include the ; dication or treatment order; sage or quantity of medication administering the medication administering the medication of tments as needed (PRN) and sulting effect on the resident; fadministration; 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 aintained with the medication rd (MAR). Let as evidenced by: views, observations, and ity failed to ensure the stration records were accurate residents (#5) including ntation of a short-term	D 307	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; strength dosage 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 of any omission of medication administering the medication of treatment. All MARs for every resident reviewed for accuracy by facility Direct Med Aide on 03-29-23. Training with Medication Aides/Supervisors on 3-28 including review of facility medication and procedures. Documentation of trawill be kept at the facility for review. The Administrator/Director will monitor medication administered according to rule 1 NCAC 13F .1004(j). Monitoring will be using a monitoring tool designed by the Administrator. Administrator/Director will monitor for compliance weekly X 3, bit X 3, monthly X 3, then quarterly theread Documentation will be kept at the facility review.	ecord he e h and ering (PRN) on the on; dications mission, s of the or t were tor/Lead -23 policy ining he dication as are 0A done e e vill weekly after.	03-30-23
	01/14/22 revealed of	#5's current FL2 dated diagnoses included physical initive decline, macrocytic				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:	:		
		HAL029010	B. WING		R 02/17/2023	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, 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 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)	LD BE COMPLETE	
D 367	Continued From pa	ige 23	D 367	***		
	anemia, hypertensive urgency, stage 3 chronic kidney disease, and hyperlipidemia.			*** ***		
	dated 01/10/23 reveshort-term expecto	ent #5's physician's order ealed an order for Mucinex (a rant used to loosen and thin ys) 600mg 1 tablet twice a day		*** *** *** ***		
	Review of Resident #5's Medication Administration Record (MAR) for January 2023 revealed there was no entry for Mucinex 600mg 1 tablet twice a day for 10 days and no documentation Mucinex had been administered.			***	***	
	the facility's contract 2:47pm revealed M twice daily for 10 da	w with a representative from cted pharmacy on 02/15/23 at lucinex 600mg ER 1 tablet ays was dispensed to the with a quantity of 20 tablets.		THIS PAGE INTENTIONALLY LEFT BLANK		
	02/16/23 at 9:07am -The Resident Care responsible for revi sending the orders a copy of the new r duty to enter on the -She remembered Resident #5, and s administered Mucir -She did not know r	e Coordinator (RCC) was ewing new medication orders, to the pharmacy, and provided medication order to the MA on e MAR. the order for Mucinex for he documented she		*** *** *** *** *** *** *** *** *** ***	***	
	revealed: -The pharmacy ent -If there were new i	on 02/16/23 at 1:07pm ered medications on the MAR. medication orders after the y the pharmacy, the MAs were			***	

6899

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	(X3) DATE SURVEY COMPLETED			
				·	R		
		HAL029010	B. WING		02/17/2023		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE			
GRAYSO	N CREEK OF WELCO	OMF	US HWY 52				
	I	LEXINGIC	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 COMPLETE		
D 367	Continued From pa	ge 24	D 367	***			
	-	ing an entry for the new order		***			
		ument administration.		***			
		nber writing an entry for		***			
	Mucinex onto Resid	dent #5's MAR. seeing Mucinex on the MAR		***			
		hen she administered		***			
	Mucinex.			***			
	-She did not know was for Mucinex.	where the MAR documentation		***			
	was for Muchiex.			***			
		v with the Resident Care		***			
	,	on 02/17/23 at 9:45am			***		
	revealed: -MAs were respons	sible for reviewing entering new			***		
	medication orders			THIS			
		As, or the Director reviewed		THIS PAGE			
		ame day a new order was the order had been entered on		INTENTIONALLY			
	the MAR.	the order had been entered on		LEFT			
		he order for Mucinex was not		BLANK			
	entered on the MAI administered.	R or documented as		***			
	administered.			***			
		w with the Director on 02/17/23		***			
	at 12:42pm reveale	d: sible for adding new		***			
		to the paper MAR to document		***			
	administration.			***			
		Mucinex had not been entered		***			
	January 2023.	umented as administered in		***			
	-She expected MAs to document medication			***			
		ediately after the medication		***			
	was administered.			***	·		
		v with the Administrator on			***		
	02/17/23 at 12:57pi				***		
	 -MAs were respons medication orders t 	sible for adding new					
		or the RCC reviewed the MAR					

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			, 20.25 10.		R	
		HAL029010	B. WING		02/17	7/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAYSO	ON CREEK OF WELCO	OME TO THE REPORT OF THE PERSON OF THE PERSO	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 SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	.D BE	(X5) COMPLETE DATE
D 367	Continued From pa	ge 25	D 367	***		
		sure the new medication order		***		
	had been addedShe expected MAs	s to document administration		***		
	of all medications a	dministered.		***		
		Mucinex had not been entered administered on Resident 5's		***		
	MAR.	daministered on recoldent 0.5		***		
	h Review of Reside	ent #5's Primary Care		***		
	Physician's Care N	ote dated 01/11/23 revealed		***		
	an order for dexam	ethasone (an nedication used to treat or		***		
	prevent lung injury	from inflammation) 6mg 1			***	
	tablet daily for 5 day	ys.			***	
	Review of Resident	t #5's Medication		THIS		
		ord (MAR) for January 2023 no entry for dexamethasone		PAGE INTENTIONALLY		
	6mg 1 tablet daily for	or 5 days and no		LEFT		
	documentation dex administered.	amethasone had been		BLANK		

		wwith a representative from cted pharmacy on 02/15/23 at		***		
		examethasone 6mg 1 tablet		***		
	daily for 5 days was 01/12/23 with a qua	s dispensed to the facility on		***		
	01/12/23 With a qua	antity of 5 tablets.		***		
	Interview with a me 02/16/23 at 9:07am	dication aide (MA) on		***		
		e Coordinator (RCC) was		***		
		ewing new medication orders,		***		
		to the pharmacy, and provided nedication order to the MA on		***		
	duty to enter on the	MAR.			***	
		the order for dexamethasone d she documented she			***	
	administered dexar	methasone to Resident #5.				
		where the MAR documentation stration of dexamethasone for				

6899

ווטופועום	of Health Service Re	eguiation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	·	COMPI	LETED
					F	2
		HAL029010	B. WING		02/17/2023	
NAME OF F		OTDEET ADI		0747F 7ID 00DF		
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRAYSO	N CREEK OF WELCO)ME	US HWY 52			
			ON, NC 272			
(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	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
D 367	Continued From pa	ge 26	D 367	***		
2 00.	•	90 20		***		
	Resident #5.			***		
	Intonvious with a MA	on 02/16/22 at 1:07pm		***		
	revealed:	on 02/16/23 at 1:07pm		***		
		ered medications on the MAR.		***		
		nedication orders after the		***		
	MAR was printed by	y the pharmacy, the MAs were				
	responsible for writi	ng an entry for the new order		***		
		ıment administration.		***		
		ber writing an entry for		***		
		to Resident #5's MAR.		***		
		seeing dexamethasone on the ting when she administered			***	
	dexamethasone.	ting when she administered				
		where the MAR documentation		TUIC		
	was for dexametha	sone.		THIS		
				PAGE		
		with the Resident Care		INTENTIONALLY		
		on 02/17/23 at 9:45am		LEFT		
	revealed:	ible for reviewing entering parts		BLANK		
	medication orders of	ible for reviewing entering new		***		
		As, or the Director reviewed		***		
		ame day a new order was		***		
		the order had been enter on		***		
	the MAR.			***		
		he order for dexamethasone				
		the MAR or documented as		***		
	administered.			***		
	Telephone interview	with the Director on 02/17/23		***		
	at 12:42pm reveale			***		
	-MAs were respons			***		
		o the paper MAR to document		***		
	administration.				***	
		dexamethasone had not been			***	
	entered on the MAF					
	administered in Jan					
		s to document medication ediately after the medication				

Division of Health Service Regulation

STATE FORM 6899 6QKV11 If continuation sheet 27 of 33

DIVISION	Of Fleatill Service IN	squiation	1		1	
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	EIED
					R	•
		HAL029010	B. WING		1	7/2023
		11/12/20010	l) UZII	772023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
CDAVCO	N CDEEK OF WELCO	6781 OLD	US HWY 52	2		
GRATSU	N CREEK OF WELCO	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 APPRO DEFICIENCY)	PRIATE	DATE
				,		
D 367	Continued From pa	ge 27	D 367	***		
	-	g		***		
	was administered.			***		

		wwith the Administrator on		***		
	02/17/23 at 12:57pr					
	-MAs were respons	<u> </u>		***		
	medication orders t			***		
		or the RCC reviewed the MAR sure the new medication order		***		
	had been added.	sure the new medication order		***		
		s to document administration		***		
	of all medications a					
		dexamethasone had not been		***		
		nted as administered on			***	
	Resident 5's MAR.				***	
				THIS		
	c. Review of Reside	ent #5's current FL2 dated				
	12/02/22 revealed t	here was an order for		PAGE		
	lorazepam 0.5mg 1	tablet every 8 hours as		INTENTIONALLY		
	needed.			LEFT		
				BLANK		
	Review of Resident			***		
		ord (MAR) for December 2022		***		
	revealed:					
	every 8 hours as ne	y for lorazepam 0.5mg 1 tablet		***		
	,	eded. entation lorazepam was		***		
		nes on 12/02/22, once on		***		
		twice on 12/10/22, twice on		***		
	T	12/15/22, twice on 12/17/22,		***		
		once on 12/20/22, once on				
		12/24/22, once on 12/25/22,		***		
		once on 12/28/22, once on		***		
		12/30/22, and twice on		***		
	12/31/22.			***		

		:#5's Controlled Substance			***	
	•	CS) dated 11/15/22, 12/06/22,			***	
	and 12/27/22 revea					
		el on each sheet documented				
	an order for lorazep	oam 0.5mg 1 tablet every 8				

6899

DIVISION	<u>of Health Service Re</u>	egulation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				E CONSTRUCTION	(X3) DATE SUR	VEY
AND PLAN	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETE	ĒD
			201251110.			
					R	
		HAL029010	B. WING		02/17/2	023
					•	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CDAVCC	N CDEEK OF WELCO	6781 OLD	US HWY 52	!		
GRAISC	ON CREEK OF WELCO	LEXINGTO	ON, NC 272	95		
()(4) ID	CLIMMADV CTA	TEMENT OF DEFICIENCIES	•	PROVIDER'S PLAN OF CORRECTION	DNI .	(VE)
(X4) ID PREFIX	-	MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) OMPLETE
TAG				CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		

D 367	Continued From pa	ge 28	D 367	***		
	hours as needed.					
		entation lorazepam was signed		***		

		ember 2022 once on		***		
		12/03/22, once on 12/06/22,				
		wice on 12/10/22, twice on		***		
		12/15/22, twice on 12/17/22,		***		
		once on 12/19/22, once on		***		
		12/22/22, once on 12/24/22,				
	once on 12/25/27, o	once on 12/27/22, one on		***		
	12/28/22, once on '	12/29/22, twice on 12/30/22		***		
	and twice on 12/31/	/22.		***		

	There were docume	entation discrepancies			***	
		s and the MAR for December			***	
		12/02/22, 12/03/22, 12/19/22,				
		MAR did not match the		THIS		
		MAR did flot match the		PAGE		
	CSCS.)			INTENTIONALLY		
	Davidano af Davidand	#51- MAD for Lower 2000				
		#5's MAR for January 2023		LEFT		
	revealed:	6		BLANK		
		y for lorazepam 0.5mg 1 tablet		***		
	every 8 hours as ne			***		
		entation lorazepam was		***		
		nes twice on 01/01/23, twice		***		
		on 01/07/23, twice on		***		
		01/09/23, twice on 01/10/23,		***		
	twice on 01/13/23,	once on 01/17/23, once on				
	01/20/23, twice on 0	01/21/23, once on 01/24/23,		***		
	once on 01/25/23, d	once on 01/27/23, twice on		***		
	01/28/23, twice on (01/29/23, and once on		***		
	01/30/23.	·				

	Review of Resident	:#5's CSCSs dated 12/27/22,		***		
	01/10/3, and 01/19/	,		***		
		el on each sheet documented		^^^		
		pam 0.5mg 1 tablet every 8			***	
	hours as needed.	dani o.oniy i tablet every o			***	
		ontation large on an war size = -				
		entation lorazepam was signed				
		January 2023 twice on				
	01/01/23, twice on	01/02/23, once on 01/04/23,				J

6899

DIVISION	OF FIGARITY SETVICE IN	guiation			,	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			D WINC		F	
		HAL029010	B. WING		02/1	7/2023
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CDAVSC	N CREEK OF WELCO	OME 6781 OLD	US HWY 52	2		
OKATOC	N OKELK OF WELOC	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 APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 367	Continued From pa	ge 29	D 367	***		
D 367	twice on 01/07/23, to 01/09/23, once on 01/12/23, once on 01/14/23, once on 01/14/23, once on 01/21/23, twice on 01/25/23, once on 01/25/23, once on 01/25/23, once on 01/30/23, once on 01/30/23, once on 01/30/23, once on 01/30/23, once on 01/04/23, once on 01/22/23, once on 01/22/23, once on 01/22/23, once on 01/22/23, once on 02/14/23 once on 02/14/23, once on 02/14/23.	twice on 01/08/23, once on 01/10/23, once on 01/11/23, twice on 01/13/23, twice on 01/15/23, once on 01/16/23, twice on 01/20/23, twice on 01/22/23, once on 01/24/23, once on 01/26/23, once on 01/28/23, twice on 01/29/23, once on 01/29/23, once on 01/29/23, once on 01/20/23. The matrix of the m	D 367	*** *** *** *** *** *** *** THIS PAGE INTENTIONALLY LEFT BLANK *** *** *** *** *** *** ***	***	
	and 2/10/23 revealed			***		
		el on each sheet documented pam 0.5mg 1 tablet every 8		***		
	-There was docume out 9 times between on 02/01/23, once of	entation lorazepam was signed in 02/01/23 and 02/14/23 once on 02/02/23, twice on 02/11/23, once on 02/12/23, 23.			*** ***	

6899

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	
		HAL029010	B. WING		02/17/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAYSO	N CREEK OF WELCO)MF	US HWY 52			
	T	LEXINGTO	ON, NC 272			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
D 367	Continued From pa	ge 30	D 367	***		

		entation discrepancies		***		
		s and the MAR for 02/01/23 on 02/03/23, and on 02/06/23.		***		
	(The MAR did not r			***		
	•	,		***		
		dication aide (MA) on		***		
	02/16/23 at 12:40p	on the CSCS and on the MAR		***		
		ered controlled substances.		***		
		d the medication available to		***		
	the CSCS to ensure	e tney matched. e Coordinator (RCC) was			***	
		ewing the CSCS and the			***	
	MARs to ensure the	ey matched.		THIS		
	-She had not notice the CSCS and the	ed any discrepancies between		PAGE		
	the CSCS and the	MANS.		INTENTIONALLY		
	Interview with the S	Special Care Unit Coordinator		LEFT		
		3 at 4:40pm revealed:		BLANK		
		stered lorazepam for Resident d on the MAR and on the		***		
	CSCS.	d on the WAR and on the		***		
		irector or RCC reviewed the		***		
	end of each month.	red them to the MAR at the		***		
		ed any discrepancies between		***		
	Resident #5's CSC			***		
		d not document on the MAR		***		
	because it got busy	ent back to document later		***		
		gotten to document on the		***		
	MAR when she adr	ministered Resident #5's		***		
	lorazepamShe he did not rev	iew the CSCSs and the MARs		***		
	for accuracy.	icw the Coops and the MANS			***	
	-				***	
		v with a MA on 02/17/23 at				
	9:19am revealed: -She thought the R	CC conducted MAR reviews,				

Division of Health Service Regulation

STATE FORM 6899 6QKV11 If continuation sheet 31 of 33

DIVISION	Of Fleatill Service 13	galation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						,
	HAL029010				02/1	7/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
0041/00	N OBEEK OF WELOG	6781 OLD	US HWY 52	!		
GRAYSC	N CREEK OF WELCO	DME 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 APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 367	Continued From pa	ge 31	D 367	***		
	but she did not kno	w how often				
		stered controlled substances,		***		
		n the MAR as well as the		***		
	CSCS.			***		
		outbreaks in the facility, there		***		
		the MAs signing the MAR in		***		
	addition to the CSC	ed the MAR did not match the		***		
		er 2022, January 2023, or		***		
	February 2023.	, , , , , , , , , , , , , , , , , , ,		***		

	Interview with the Revealed:	RCC on 02/17/23 at 9:45am			***	
		as responsible for reviewing			***	
		ursday for accuracy.		THIS		
		ved Resident #5's CSCS and		PAGE		
	MAR to ensure they	y matched and were accurate.				
	Tolophono intonviou	whith the Director on 02/17/22		INTENTIONALLY		
	at 12:42pm reveale	w with the Director on 02/17/23		LEFT		
	•	the documentation of Resident		BLANK ***		
		the CSCS did not match the				
	documentation on t			***		
		s to review the CSCS and the of each shift to ensure		***		
	accurate document			***		
	-She expected MAs	s to document on the CSCS		***		
		mediately after medication		***		
	administration.			***		
	Telephone interviev	v with the Administrator on		***		
	02/17/23 at 12:57pi			***		
	-Controlled substar	nces were to be documented		***		
		S, but she did not know if MAs		***		
		istration of controlled			***	
	substances on the	MAR. nedications administered to be			***	
	-	ninistered on the MAR.				
		ment signed out of controlled				
		CSCS and on the MAR when				

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7. BOILDING	·	F	•
		HAL029010	B. WING		1	7/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GRAYSO	N CREEK OF WELCO)ME	US HWY 52			
	I	LEXINGIO	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 367	Continued From pa	ge 32	D 367	***		
		ministration so they would not		***		
	forget.	or the RCC was responsible		***		
	for reviewing the Ma	ARs for accuracy.		***		
	-She did not know F	Resident #5's CSCS and MAR		***		
	did not match for hi	s lorazepam administration.		***		

				THIS		
				PAGE		
				INTENTIONALLY		
				LEFT		
				BLANK		

6899

Division of Health Service Regulation STATE FORM

6QKV11 If continuation sheet 33 of 33

				STAT	E FORM: RE	VISIT REP	PORT				
	R / SUP LIER /		MULTI LE ON	ISTRU TIO	N					DATE OF RE	VISIT
HAL0290			A. Building B. Wing						Y2	2/17/2023	Y3
NAME OF	FACILITY					l		CITY, STATE, Z	IP CODE		
GRAYSC	ON CREEK OF	WELCC	DME			6781 OLD U					
T I :		0					•				
corrective	e action was a	ccomplis	shed. Each def	iciency sho	se deficiencies pould be fully iden urvey Report (pr	tified using e	either the	regulation or	LSC provision	n number and	the
ITE	И		DATE	ITEM		D	ATE	ITEM		DAT	ΓE
Y4			Y5	Y4			Y5	Y4		Y	5
ID Prefix			Correction	ID Prefix			rection	ID Prefix		Corr	ection
Reg. #	10A NCAC 13F	.1004(f)	Completed	Reg. #	10A NCAC 13F .1	008(a) Cor	npleted	Reg. #		Com	pleted
LSC			10/06/2021	LSC		10/0	06/2021	LSC			
ID Prefix			Correction	ID Prefix		Cor	rection	ID Prefix		Corr	ection
Reg. #			Completed	Reg. #		Cor	npleted	Reg.#		Com	pleted
LSC			_	LSC				LSC			
								-			
ID Prefix			Correction	ID Prefix		Cor	rection	ID Prefix		Corr	ection
Reg. #			Completed	Reg. #		Cor	npleted	Reg.#		Com	pleted
LSC			-	LSC				LSC			
ID Prefix			Correction	ID Prefix		Cor	rection	ID Prefix		Corr	ection
Reg. #			Completed	Reg.#		Cor	npleted	Reg.#		Com	pleted
LSC			Completed	LSC			прістец	LSC			ipicted
			-								
ID Prefix			Correction	ID Prefix		Cor	rection	ID Prefix		Corr	ection
Reg.#			Completed	Reg. #		Cor	npleted	Reg. #		Com	pleted
LSC				LSC				LSC			
REVIEWE			VED BY	DATE	SIGNATU	RE OF SUR				DATE	
STATE AC		(INITIAL				Keist	ra Bo	inks		03/03/202	23
REVIEWE CMS RO	ED BY □	REVIEV (INITIAL	VED BY _S)	DATE	TITLE					DATE	

Page 1 of 1 EVENT ID: P3VF13

☐ YES ☐ NO

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

6/4/2021

FOLLOWUP TO SURVEY COMPLETED ON