

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL029010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/06/2024
NAME OF PROVIDER OR SUPPLIER GRAYSON CREEK OF WELCOME		STREET ADDRESS, CITY, STATE, ZIP CODE 6781 OLD US HWY 52 LEXINGTON, NC 27295		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 06/04/24 through 06/06/24.	D 000		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Hot foods shall be served hot and cold foods shall be served cold as set forth in Rule 15A NCAC 18A .1620(a) for facilities with a licensed capacity of 7 to 12 residents and as set forth in Rule 15A NCAC 18A .1323 Food Protection in Activity Kitchens, Rehabilitation Kitchens, and Nourishment Stations for facilities with a licensed capacity of 13 or more residents, which are hereby incorporated by reference, including subsequent amendments. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to offer table service with a place setting consisting of a napkin and a non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers for each meal. The findings are: Observation of the lunch meal service in the Special Care Unit (SCU) on 06/04/24 at 12:30pm revealed: -The lunch menu served was a baked chicken breast, potatoes, salad, roll, muffins, tea, milk and	D 287		

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

TITLE

(X6) DATE

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D 287	Continued From page 1 water. -There were 13 residents in the dining room. -There were 13 place settings prepared for residents and none of the prepared place settings included a knife. -There were 3 residents who were given spoons. -There were 10 residents who were given forks. -Three residents with spoons were served chopped chicken. -The 10 residents with forks were served a whole boneless chicken breast. -There were 7 residents who picked up the chicken breast and ate it with their hands. -There were two residents who attempted to cut the chicken with their fork. -One resident requested a fork to cut his chicken. -One resident struggled eating the salad with a spoon. -One personal care aide (PCA) assisted one resident who requested a knife to cut up his chicken. Interview with one resident on 06/04/24 at 12:40p revealed: -He asked the PCA for a knife to cut his chicken. -The PCA used the resident's fork and spoon to cut the chicken breast into bite size pieces. Observation of the breakfast meal service in the SCU on 06/05/24 at 7:30am revealed: -The breakfast menu served was cereal, oatmeal, hashbrowns, yogurt, boiled egg, coffee, water and juice. -There were 12 residents in the dining room. -There were 12 place settings prepared for residents and none of the prepared place settings included a knife. -There were 3 residents who were given spoons. -There were 9 residents who were given forks. -The 3 residents with spoons were served	D 287			

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D 287	Continued From page 2 chopped sausage. -There were 9 residents who were able to cut the sausage with their fork. Review of the resident's records revealed no documentation signed by the PCP that residents were not to be provided a knife at meal times. Interview with the PCA in the SCU on 06/04/24 at 8:00am revealed: -She did not know each place setting had to have a knife. -The kitchen usually sent one knife for staff to cut food for the residents if they needed assistance. -She was not aware of any reports of resident injuries inflicted by knives in the SCU. -The PCA should be present in the dining room to assist any resident who needed assistance with cutting up their food. Interview with the medication aide (MA) in the SCU on 06/04/24 at 8:10am revealed: -She did not know each place setting had to have a knife. -The kitchen never sent knives with the meals. -She did not know SCU residents had to have a knife. -She was not aware of any reports of resident injuries inflicted by knives in the SCU. -The PCAs and MAs were responsible for assisting residents who needed assistance cutting their food up. Interview with the cook on 06/04/2024 at 8:30am revealed: -The kitchen only sent a fork and spoon to the SCU because of safety concerns. -She was not aware of any reports of resident injuries inflicted by knives in the SCU. -She sent one knife with each meal for staff to cut	D 287		

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D 287	Continued From page 3 up food for residents in the SCU. Interview with the Resident Care Coordinator (RCC) on 06/06/24 at 11:35am revealed: -She was aware the kitchen staff only sent spoons and forks to the SCU at each meal service. -She was not aware residents were not being assisted with cutting up their food. -She was not aware of an incident where a resident hurt someone with a knife. -The staff in the SCU could request knives to assist residents with cutting their food up. - Her expectation was that a resident who was competent enough to use a knife should have access to it, but residents were to be supervised while using it. Interview with the Director on 06/06/24 at 12:20pm revealed: -She was aware residents in the SCU did not have access to knives to cut their food up with. -Residents were not permitted to have knives because they could use them to harm other residents. -She was not aware of an incident where a resident harmed someone with a knife. -She was not aware residents were not being assisted with cutting up their food. -Her expectations were for PCAs and MAs to assist all residents with eating and cutting up food if they were not able to. -It was the responsibility of the SCU staff to request knives from the kitchen to use for cutting food for residents. Telephone interview with the Administrator on 06/06/24 at 1:30pm revealed: -There should be a fork, knife and spoon available to all residents at each meal in the SCU.	D 287		

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D 287	Continued From page 4 -She did not anticipate residents having to pick up food and eat with their hands because they did not have a knife to cut up their food. -Her expectation was for staff to always be present to offer any feeding assistance or to cut food up for residents. -The kitchen staff could also cut the meat up before they send it to the SCU.	D 287		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure 1 of 1 sampled resident (#1) who required feeding assistance was assisted upon receipt of her meal. The findings are: Review of Resident #1's current FL2 dated 02/29/24 revealed: -Diagnoses included dementia, arthritis, and major depressive disorder. -Resident #1 required assistance with feeding. Review of Resident #1's care plan dated 02/29/24 revealed Resident #1 required extensive assistance with eating and she must be fed.	D 312		

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D 312	Continued From page 5 Observation of the lunch meal service on 06/04/24 between 12:05pm and 12:45pm revealed: -Resident #1's plate was sat in front of her at 12:06pm and staff continued to pass out plates to other residents. -Resident #1 sat in her wheelchair looking at her food and did not attempt to eat. -Staff sat down to provide feeding assistance to Resident #1 at 12:14pm after all residents had been served their meals. -Resident #1 consumed 90% of her meal. Observation of the breakfast meal service on 06/05/24 between 7:36am and 8:00am revealed: -Resident #1 was brought into the dining hall for breakfast at 7:36am. -There was a bowl of cold cereal at her place setting. -At 7:44am, staff placed Resident #1's breakfast meal on the table in front of her. -Resident #1's meal consisted of toast, hash browns, oatmeal, sliced hard boiled eggs, sausage, and yogurt. -Resident #1 sat in her wheelchair looking at her food and did not attempt to eat. -At 7:55am, staff sat down with Resident #1 and began providing feeding assistance. -Resident #1 consumed 100% of her meal. Interview with the cook on 06/05/24 at 8:15am revealed: -She told staff not to set a place in front of Resident #1 until they were ready to feed her. -One of the personal care aides (PCA), who was assisting in the dining room during the lunch meal on 06/04/24 and breakfast meal on 06/05/24, should have passed plates while the other staff provided feeding assistance.	D 312			

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D 312	Continued From page 6 Interview with a PCA on 06/05/24 at 8:30am revealed: -She assisted in the dining hall during her shift by passing out plates to residents. -Once all plates were passed out, she sat down to assist residents who needed feeding assistance. -Resident #1 and another resident, who sat at the dining table with her, were the only 2 residents who required feeding assistance. -Staff were supposed to serve the residents needing feeding assistance last because they had to sit down and feed them. -She did not know why Resident #1's plate was placed in front of her during lunch meal on 06/04/24 and the breakfast meal on 06/05/24 and served to her after all residents had been served. Interview with a second PCA on 06/05/24 at 8:36am revealed: -There were 2 residents who required feeding assistance during all meals. -She usually sat down to serve 1 of the 2 residents during meals. -She and the other PCA should have waited until all the residents were served to serve the residents who needed feeding assistance. -Usually she asked for plates for the residents who needed feeding assistance when she was ready to sit down with them. -On 06/05/24, the cook gave her and the other PCA all the plates for residents who had orders for a mechanical soft diet, including Resident #1. -After being given the plate for Resident #1, she just placed it on the table in front of her. -If there were 3 staff working in the dining hall, 2 of the staff would feed the 2 residents requiring feeding assistance while the other staff passed out plates to the other residents.	D 312		

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D 312	Continued From page 7 Interview with the Dietary Manager (DM) on 06/05/24 at 2:02pm revealed: -She prepared the plates for residents who needed feeding assistance first and set them under the heating lamp until staff were ready to provide feeding assistance. -She was not present for the breakfast meal on 06/05/24 and she did not know why residents had to wait to receive feeding assistance with the lunch meal on 06/04/24. Interview with the Resident Care Coordinator (RCC) on 06/06/24 at 11:55am revealed: -All resident should have been served before the residents who needed feeding assistance so that those residents could be served immediately after they received their food. -She did not watch any of the meals, so she had not seen if staff fed Resident #1 immediately after being served her meal. Interview with the Director on 06/06/24 at 1:41pm revealed: -There were 2 residents in the facility who required feeding assistance, including Resident #1. -The 2 residents' plates should have been held warm until staff were able to get to them. -Staff were to sit with the residents and feed them as soon as they were served their plates. Telephone interview with the Administrator on 06/06/24 at 2:29pm revealed: -Resident #1 required feeding assistance. -Staff should have served the other residents' plates first and then took Resident #1's plate to her and sat down to provide feeding assistance.	D 312			

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D 317	Continued From page 8	D 317			
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be 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. 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. The findings are: Observation of the facility on 06/04/24 at 9:00am revealed there was an activity calendar for May 2024 posted outside the activity room. Observation of the facility on 06/04/24 between 9:01am and 4:30pm revealed an activity calendar for June 2024 had been posted outside the activity room. Review of the June 2024 activity calendar revealed: -There were 14 hours of activities listed for each week between 06/01/24 and 06/30/24. -Activities listed included church service, card games, puzzles, music therapy, crosswords, word search, poetry, coloring, bingo, gardening, sitting in the sun, bird watching, buddy walks, learn history facts, puzzles, chair exercise, and scrapbooking. -On 06/04/24, poetry was scheduled from 9:00am to 10:00am and coloring was scheduled from 1:00pm to 2:00pm.	D 317			

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D 317	Continued From page 9 -On 06/05/24, music therapy was schedued from 9:00am to 10:00am and bingo was scheduled from 3:00pm to 4:00pm. -On 06/06/24, bird watching was scheduled from 10:00am to 11:00am and word search was scheduled from 1:00pm to 2:00pm. Observations of the facility on 06/04/24, 06/05/24, and 06/06/24 at various times throughout the day revealed there were no group activities being conducted for residents. Observation of the activity room on 06/05/24 at 11:35am revealed: -There were puzzles, books, magazines, a toss game, a stacking tower game, a chess game, and a scrabble game available. -There were two completed puzzles on a table. Interview with a resident on 06/05/24 at 10:15am revealed: -The only group activities offered by were birthday Bingo facilitated by a local church once a month and church on Sundays. -He would like to do more activities. -He spent his day listening to the radio and looking outside. Interview with a second resident on 06/05/24 at 10:17am revealed: -The only activities offered by the facility were birthday Bingo and Sunday church services that were provided by a church. -She would like to play bridge but there were no playing cards available. -The staff at the facility did not offer any other activities. Interview with 3 residents on 06/05/24 between 11:03am and 12:24pm revealed:	D 317			

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D 317	Continued From page 10 -One resident said there were no activities offered in the facility except for bingo once a month. - "They don't do nothing." -All 3 residents said there was not an Activity Director that residents were aware of. -All 3 residents said a local church group came in to play Birthday Bingo with residents once a month. -Two residents said a church service was held at the facility every other Sunday. -All 3 residents said there were no daily activities. -One resident looked at the activities calendar daily and activities were not being done. Interview with a medication aide (MA) on 06/06/24 at 8:45am revealed: -She did not know who was responsible for conducting activities with residents. -The only activity she was aware of was bingo once a month provided by a local church and there was church service every Sunday. -She heard a couple residents say it was boring around the facility. -Most residents stayed in their rooms, some watched television in the common room, and other residents sat outside in the rocking chairs or went outside to the smoking area to occupy their time. Interview with a personal care aide (PCA) on 06/06/24 at 10:30am revealed: -She thought the Assistant Director was responsible for activities. -She had not seen any activities offered to residents. -No one had ever asked her to do activities with residents. -The only activity she was aware of occurred weeks ago when someone from a hospice provider came to the facility to sing to one of the	D 317		

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D 317	Continued From page 11 residents who received hospice services. Interview with a second PCA on 06/06/24 at 10:39am revealed: -There was a church group that came in to do bingo with the residents, but she did not know how often. -A church group also came in on Sundays to have service with residents, and there was a man who came in to sing to the residents, but she did not know how often. -If any other activities were completed, they were completed when she was assisting residents with showers because she did not see any other activities. -She nor any of the other floor staff assisted with conducting activities for residents. Interview with the Resident Care Coordinator (RCC) on 06/06/24 at 11:55am revealed: -She was responsible for creating the activity calendar and conducting most activities with the residents. -If there were any outside groups that came in, she announced the activity over the load speaker so residents would know. -Some activities she conducted included coloring and coordinating a jewelry consultant to visit the facility every other week to sell jewelry to the residents. -She ensured that 14 hours of activities were completed every week. -If she was busy, then she had another staff member to do activities with the residents. Interview with the Assistant Director/MA Supervisor on 06/06/24 at 12:31pm revealed: -The RCC was responsible for completing the activities calendars. -All staff were responsible for ensuring activities	D 317		

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D 317	Continued From page 12 were conducted in the facility for residents. -She knew there should be 14 hours of activities conducted weekly but there was not enough staff. -She tried to print coloring sheets for residents occasionally. Interview with the Director on 06/06/24 at 1:41pm revealed: -The Assistant Director/MA Supervisor and the RCC were responsible for conducting activities with residents daily. -The RCC was responsible for completing the monthly calendar and the Assistant Director/MA Supervisor was responsible for ensuring activities were completed. -She had her Activity Director certification and she showed the RCC and the Assistant Director/MA Supervisor how the activities were to be conducted. -Fourteen hours of activities were being conducted weekly and included bingo, coloring, puzzles, current events with coffee, ice cream socials, and local vendors. Telephone interview with the Administrator on 06/06/24 at 2:29pm revealed: -She did not know who the Director had conducting activities now. -Residents had cookouts, and outside groups came to the facility to sing and play the piano. -She was aware there needed to be at least 14 hours of activities weekly. -The activities were scheduled but sometimes staff did not follow through with them.	D 317			
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 358			

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D 358	Continued From page 13 (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#4) related to a sleep aid and a pain medication. The findings are: Review of Resident #4's current FL2 dated 06/12/23 revealed diagnoses included post-traumatic stress syndrome, primary insomnia, and type 2 diabetes mellitus with diabetic polyneuropathy. a. Review of Resident #4's current FL2 dated 06/12/23 revealed an order for clonazepam (used to treat insomnia) 1mg 1 tablet at bedtime. Review of Resident #4's electronic medication administration record (eMAR) for May 2024 revealed: -There was an entry for clonazepam 1mg 1 tablet at bedtime scheduled for administration at 8:00pm. -There was documentation clonazepam was administered for 29 of 30 opportunities. -There was documentation clonazepam was not administered on 05/19/24 due to medication not	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL029010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/06/2024
NAME OF PROVIDER OR SUPPLIER GRAYSON CREEK OF WELCOME		STREET ADDRESS, CITY, STATE, ZIP CODE 6781 OLD US HWY 52 LEXINGTON, NC 27295		
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D 358	Continued From page 14 available. Review of Resident #4's controlled substance count sheet (CSCS) for May 2024 revealed: -The CSCSs were for clonazepam 1mg 1 tablet at bedtime for insomnia. -There was no documentation clonazepam was administered for 6 days from 05/19/24 through 05/24/24. Observation of medications available for administration for Resident #4 on 06/05/24 at 9:02am revealed: -Clonazepam 1mg 1 tablet at bedtime was available and was dispensed by the pharmacy on 05/21/24 with a quantity of 30 tablets. -The clonazepam tablets were in a bottle and it could not be determined how many tablets were remaining. Telephone interview with Resident #4's pharmacy on 06/05/24 at 9:48am revealed: -Resident #4 had an order for clonazepam 1mg 1 tablet at bedtime for insomnia. -Once the facility requested medications for Resident #4, the medication was released by the pharmacy, and it took 7 to 10 days for the facility to receive the medication via mail. -The facility requested Resident #4's clonazepam on 01/17/24 and it was released by the pharmacy on 01/20/24 with a quantity of 30 tablets for a 30-day supply. -There was an order for clonazepam written on 02/12/24 and clonazepam was dispensed to the facility on 02/15/24 with a quantity of 30 tablets for 30 days. -There were no requests for clonazepam in March 2024. -The facility requested clonazepam on 04/08/24 and it was released on 04/11/24 with a quantity of	D 358		

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D 358	Continued From page 15 30 tablets for a 30-day supply. -The facility requested clonazepam on 05/20/24 and clonazepam was released on 05/21/24 with a quantity of 30 tablets for a 30-day supply. Interview with Resident #4 during the tour of the facility on 06/04/24 at 9:39am revealed: -He had been without his clonazepam between 9 and 12 days last month, but the facility had it available now. -He needed his clonazepam to help him to sleep and he was not able to sleep when the facility ran out of it. -His family member brought him some melatonin 10mg gummies for sleep when he was out of his clonazepam and he took 6 or 7 melatonin gummies nightly when he was out of his clonazepam. Interview with a medication aide (MA) on 06/05/24 at 9:00am revealed: -Usually, the Resident Care Coordinator (RCC) or the Assistant Director/MA Supervisor called Resident #4's pharmacy for refills because his medication was not provided by the facility's contracted pharmacy. -Clonazepam was not dispensed to the facility each month and had to be reordered. -It could take up to 10 days for medications to get to the facility via mail after they had been ordered and it had taken longer than 10 days before. -She remembered Resident #4 was out of clonazepam, but she did not remember when. Interview with a MA on 06/06/24 at 10:03am revealed: -Resident #4 was out of clonazepam about a month ago. -She only worked on Saturdays and Sundays and she did not reorder medications including	D 358		

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D 358	Continued From page 16 Resident #4's clonazepam when he was out. -She had not been told to reorder medications on the weekend. -She talked to another MA about the clonazepam needing to be refilled. -Resident #4 was administered clonazepam before going to bed and he was very upset about not being administered clonazepam. -Resident #4 told her that he was having trouble sleeping without clonazepam. Telephone interview with a second MA on 06/06/24 at 12:20pm revealed: -Resident #4 was out of clonazepam for a few days about a week or two ago. -MAs were responsible for reordering Resident #4's clonazepam when there was 10 to 14 days of medication remaining. -She did not reorder clonazepam because she thought another MA had already reordered it. Interview with the Assistant Director/MA Supervisor on 06/06/24 at 12:31pm revealed: -Resident #4 was out of clonazepam around the end of May for 3 to 4 days. -There was some confusion about who reordered the clonazepam; MAs were thinking other MAs reordered it. -Once clonazepam was delivered to the facility, MAs should have reordered Resident #4's clonazepam at least 2 weeks after receiving it via mail because it took 7 to 10 days for it to be delivered after it was ordered. Attempted telephone interview with Resident #4's primary care provider (PCP) and mental health provider (MHP) on 06/05/24 at 10:10am was unsuccessful. Attempted telephone interview with Resident #4's	D 358			

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D 358	Continued From page 17 family member on 06/06/24 at 10:35am was unsuccessful. Refer to the interview with the Resident Care Coordinator (RCC) on 06/06/24 at 11:55am. Refer to the interview with the facility's primary PCP on 06/05/24 at 4:29pm. Refer to the interview with the Director on 06/06/24 at 1:41pm. Refer to the telephone interview with the Administrator on 06/06/24 at 2:29pm. b. Review of Resident #4's current FL2 dated 06/12/23 revealed an order for pregabalin (used to treat neuropathy) 300mg 1 capsule twice daily. Review of Resident #4's electronic medication administration records (eMAR) for March 2024 revealed: -There was an entry for pregabalin 300mg 1 capsule twice daily scheduled for administration at 8:00am and 8:00pm. -There was documentation pregabalin was administered for 55 of 62 opportunities. -There was documentation pregabalin was not administered on 03/19/24 at 8:00am, 03/23/24 at 8:00am and 8:00pm, 03/24/24 at 8:00am and 8:00pm, 03/27/24 at 8:00pm, and on 03/31/24 at 8:00pm due to medication not available. Review of Resident #4's controlled substance count sheet (CSCS) for March 2024 revealed: -The CSCSs were for pregabalin 1 capsule twice daily for neuropathy. -There was no documentation pregabalin was administered 27 times on 03/18/24 at 8:00pm and from 03/19/24 through 03/31/24 at 8:00am and	D 358			

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D 358	Continued From page 18 8:00pm. Review of Resident #4's eMAR for April 2024 revealed: -There was an entry for pregabalin 300mg 1 capsule twice daily scheduled for administration at 8:00am and 8:00pm. -There was documentation pregabalin was administered for 60 of 60 opportunities. Review of Resident #4's CSCS for April 2024 revealed: -The CSCSs were for pregabalin 1 capsule twice daily for neuropathy. -There was no documentation pregabalin was administered 2 times on 04/01/24 at 8:00am and 8:00pm. Observation of medications available for administration for Resident #4 on 06/05/24 at 9:02am revealed: -Pregabalin 1 capsule twice daily was available and was dispensed from the pharmacy 05/21/24 with a quantity of 60 tablets. -The pregabalin capsules were in a bottle and it could not be determined how many capsules were remaining. Telephone interview with Resident #4's pharmacy on 06/05/24 at 9:48am revealed: -Resident #4 had an order for pregabalin 300mg 1 capsule twice daily for pain. -Once the facility requested medications for Resident #4, the medication was released by the pharmacy, and it took 7 to 10 days for the facility to receive the medication via mail. -There were no requests for refills in March 2024. -The facility requested Resident #4's pregabalin on 04/08/24 and it was released by the pharmacy	D 358		

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D 358	Continued From page 19 on 04/15/24 with a quantity of 60 tablets for a 30-day supply. -The facility requested Resident #4's pregabalin on 05/20/24 and it was released by the pharmacy on 05/21/24 with a quantity of 60 tablets for a 30-day supply. -The facility requested Resident #4's pregabalin on 05/22/24 and it was scheduled to be filled and released by the pharmacy on 06/15/24 with a quantity of 60 tablets for a 30-day supply. Interview with Resident #4 on 06/05/24 at 10:41pm revealed: -He thought he was out of pregabalin for about a month. -He experienced pain in the back of his neck when he was out of pregabalin. Interview with a medication aide (MA) on 06/05/24 at 9:00am revealed: -Usually the RCC or the Assistant Director/MA Supervisor called Resident #4's pharmacy for refills because his medication was not provided by the facility's contracted pharmacy. -Pregabalin was not dispensed to the facility each month and had to be reordered. -It could take up to 10 days for medications to get to the facility via mail after they had been ordered and it has taken longer than 10 days before. -She remembered Resident #4 was out of pregabalin, but she did not remember when. Interview with a MA on 06/06/24 at 10:03am revealed: -Resident #4 was out of pregabalin a few months ago. -She only worked on Saturdays and Sundays and she did not reorder medications including Resident #4's pregabalin when he was out. -She had not been told to reorder medications on	D 358		

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D 358	Continued From page 20 the weekend. -She contacted the MA Supervisor to let her know Resident #4 was out of pregabalin. -Resident #4 was very frustrated because he did not have pregabalin available. Telephone interview with a second MA on 06/06/24 at 12:20pm revealed: -Resident #4 was out of pregabalin for a day or two, but she did not remember when. -MAs were responsible for reordering Resident #4's pregabalin when there was 10 to 14 days of medication remaining. -She did not reorder pregabalin because she thought another MA had already reordered it. Interview with the Assistant Director/MA Supervisor on 06/06/24 at 12:31pm revealed: -She did not know when or why Resident #4 was out of pregabalin. -She thought there may have been some confusion about who reordered the pregabalin; MAs were thinking other MAs reordered it. -Once pregabalin was delivered to the facility, MAs should have reordered Resident #4's pregabalin at least 2 weeks after receiving it via mail because it took 7 to 10 days for it to be delivered after it was ordered. Attempted telephone interview with Resident #4's primary care provider (PCP) and mental health provider (MHP) on 06/05/24 at 10:10am was unsuccessful. Attempted telephone interview with Resident #4's family member on 06/06/24 at 10:35am was unsuccessful. Refer to the interview with the Resident Care Coordinator (RCC) on 06/06/24 at 11:55am.	D 358		

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D 358	Continued From page 21 Refer to the interview with the facility's primary PCP on 06/05/24 at 4:29pm. Refer to the interview with the Director on 06/06/24 at 1:41pm. Refer to the telephone interview with the Administrator on 06/06/24 at 2:29pm. Interview with the Resident Care Coordinator (RCC) on 06/06/24 at 11:55am revealed: -MAs should have reordered medications for Resident #4 10 days before running out of the medication. -She was not aware Resident #4 had been out of clonazepam or pregabalin. -If the MAs saw that the medication was not in the facility, they should have contacted Resident #4's primary care provider and pharmacy to have them send it faster. -The MAs should have let her or the Assistant Director/MA Supervisor know if the medication was not in the facility for an extended period of time. -Resident #4's medications could have been ordered from the facility's pharmacy. Interview with the facility's primary PCP on 06/05/24 at 4:29pm revealed: -Resident #4 had a PCP outside of the facility. -She expected staff to reorder Resident #4's medications prior to them running out of the medications. -She did not know of any missed doses of any of Resident #4's medications. -If the facility had issues with reordering Resident #4's medications or with getting an order from his pharmacy, she or the facility's mental health provider (MHP) could have written an order for	D 358		

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D 358	Continued From page 22 the medication. -According to her documentation, the facility staff had not requested any orders for pregabalin or clonazepam from her or the facility's MHP. Interview with the Director on 06/06/24 at 1:41pm revealed: -She did not know Resident #4 had been out of clonazepam or pregabalin. -MAs should have reordered Resident #4's medications at least 2 weeks prior to running out. -If Resident #4 ran out of medications, MAs should have let the RCC or the Assistant Director/MA Supervisor know and they could have contacted Resident #4's PCP or the facility's PCP. -Resident #4's medications could have reordered from the facility's contracted pharmacy or from the facility's back up pharmacy through the facility's PCP. -There was no reason why Resident #4 should have gone without medications. -She checked with the facility's contracted pharmacy and they had not dispensed clonazepam or pregabalin for Resident #4. Telephone interview with the Administrator on 06/06/24 at 2:29pm revealed she expected Resident #4's medications to be reordered before they ran out and to be administered as ordered. The facility failed to administer medications as ordered for a resident (#4) who had a diagnosis of primary insomnia and was not administered clonazepam for 6 consecutive days resulting in the resident not being able to sleep; and the resident was not administered pregabalin for 29 consecutive doses resulting in the resident having pain in the back of his neck. The failure of the facility to administer medications as ordered was	D 358		

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D 358	Continued From page 23 detrimental to the health, safety, and welfare of Resident #4 and constitutes a Type B Violation. <u>The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/05/24 for this violation.</u> THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED July 21, 2024.	D 358			
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a medication aide (MA) observed a resident (#4) take his medications related the resident's medications were left in a medication cup in the resident's room. The findings are: Review of the facility's undated medication administration policy revealed staff were to provide documentation on the electronic medication administration record (eMAR) after observing the residents taking the medications	D 366			

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D 366	Continued From page 24 and before administration to another resident. Review of Resident #4's current FL2 dated 06/12/23 revealed: -Diagnoses included post-traumatic stress syndrome, primary insomnia, and type 2 diabetes mellitus with diabetic polyneuropathy. -There was an order for atorvastatin (used to treat high cholesterol levels) 20mg 1 tablet every evening. -There was an order for carvedilol (used to treat hypertension) 6.25mg ½ tablet twice daily. -There was an order for clonazepam (used to treat panic disorder) 1mg 1 tablet at bedtime. -There was an order for donepezil (used to treat dementia) 10mg 1 tablet at bedtime. -There was an order for escitalopram (used to treat depression) 20mg 1 tablet at bedtime. -There was an order for famotidine (used to treat stomach ulcers) 20mg 1 tablet at bedtime. -There was an order for memantine (used to treat memory loss) 10mg 2 tablets at bedtime. -There was an order for metformin ER (used to treat diabetes) 1 tablet twice daily. -There was an order for pregabalin (used to treat nerve pain) 300mg 1 capsule twice daily. Review of Resident #4's electronic medication administration record (eMAR) for May 2024 and 06/01/24 through 06/05/24 revealed: -There was an entry for atorvastatin 20mg 1 tablet at bedtime scheduled for administration at 8:00pm. -There was an entry for carvedilol 6.25mg ½ tablet twice daily scheduled for administration at 8:00am and 8:00pm. -There was an entry for clonazepam 1mg 1 tablet at bedtime scheduled for administration at 8:00pm. -There was an entry for donepezil 10mg 1 tablet	D 366		

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D 366	Continued From page 25 at bedtime scheduled for administration at 8:00pm. -There was an entry for escitalopram 20mg 1 tablet at bedtime scheduled for administration at 8:00pm. -There was an entry for famotidine 20mg 1 tablet at bedtime scheduled for administration at 8:00pm. -There was an entry for memantine 10mg 2 tablets at bedtime scheduled for administration at 8:00pm. -There was an entry for metformin 500mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -There was an entry for pregabalin 300mg 1 capsule twice daily scheduled for administration at 8:00am and 8:00pm. Observation of Resident #4's room on 06/05/24 at 2:58pm revealed: -There was a cup of medications on Resident #4's dresser. -There were 7 tablets and 1 capsule including: 1 gray oblong tablet, 1 small white round tablet, 1 medium white round tablet, 1 blue medium round tablet with 2531 imprinted, 1/2 of a small white oblong tablet, 1 yellow medium round tablet, 1 white large oblong tablet, and 1 large red and white capsule. Interview with Resident #4 on 06/05/24 at 2:58pm revealed: -He noticed the cup of medication in his room last week, but he was not about to take them. -He knew the red and white capsule was pregabalin and the blue tablet was clonazepam which he took at bedtime, but he did not know what the rest of the medications in the cup were. -He did not tell anyone that the cup of medications was left in his room, because he	D 366			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL029010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 06/06/2024
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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 366	Continued From page 26 could not figure out who left them. Interview with the facility's primary care provider (PCP) on 06/05/24 at 4:29pm revealed the only medications left in a resident's room should have been medications the resident had a self-administration order for. Interview with a MA on 06/06/24 at 10:03am revealed: -She gathered medications and took them to residents' rooms to administer. -She watched the residents take their medications and checked the medications off as administered on the eMAR. -She had not left any medication in Resident #4's room. Telephone interview with a MA on 06/06/24 at 12:20pm revealed: -When she administered medication in a resident's room, she handed the resident the cup of medication and water, and she watched the resident take the medication. -She made sure the resident swallowed the medication and checked the medication off as administered on the eMAR. -She had not left any medication in Resident #4's room. Interview with the Resident Care Coordinator (RCC) on 06/06/24 at 11:55am revealed: -MAs should have observed Resident #4 take his medication instead of leaving medication in his room. -If Resident #4 was not in his room or was asleep, the MA should have woken him up and attempted to administer the medication. -If the medication was not administered, the MA should have taken the medication back to the	D 366			

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D 366	Continued From page 27 medication room to dispose of. Interview with the facility's PCP on 06/05/24 at 4:29pm revealed she expected MAs to watch residents take their medications unless there was an order the medication could be self-administered. Interview with the Director on 06/06/24 at 1:41pm revealed: -She expected staff to watch residents take their medications before moving on to the next resident. -If a resident was asleep or not in their room, the MA should take the medication back to the medication room and attempt to administer the medication again later. -She did not know medications were left in Resident #4's room until she saw them in a cup on his dresser on 06/05/24. Telephone interview with the Administrator on 06/06/24 at 2:29pm revealed: -If the MA took medications to Resident #4 in his room, they should have watched him take the medications. -If Resident #4 did not take the medications at the time of administration, the MA should have taken the medications back to the medication room and tried again later. -Medications were not to be left in a resident's room.	D 366			
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents	D 375			

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D 375	Continued From page 28 who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 2 of 5 sampled residents (#4 and #5) had a physician's order to self-administer medications related to an expectorant, anti-acid, topical pain medication, mild pain reliever, and dry eye drops (#4), and a sleep-aid and a blood thinner medication (#5). The findings are: Review of the facility's undated medication administration policy revealed: -Self-administered medications that were kept in a resident's room were to be stored in a safe and secure manner and in a secured designated location. -Self-administered medications were to be easily accessible to appropriate residents in case of emergency situations. 1. Review of Resident #5's current FL2 dated 05/08/2024 revealed diagnoses included dysphagia, depression, esophageal obstruction, generalized anxiety disorder, peripheral vascular disease, age-related osteoporosis, type 2	D 375			

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D 375	Continued From page 29 diabetes mellitus and chronic obstructive pulmonary disease. Observation of Resident #5's room on 06/05/24 at 3:35pm revealed: -There was a box of over-the-counter (OTC) Mucus Relief (expectorant used to help loosen mucus in the lungs) on a nightstand. -There was a bottle of OTC Pepto Bismol (antacid used to treat heartburn, acid reflux indigestion and diarrhea) on a nightstand. -There was a tube of OTC Bio-freeze (topical cream used to treat minor ache and pains of muscles and or joints) on a nightstand. -There was OTC Tylenol 500mg (acetaminophen used to relieve pain and reduce fevers) on a nightstand. There was a bottle of OTC Systane eye drops (used to treat dry eyes) on a nightstand. Review of Resident #5's physician's order dated 02/08/24 revealed: -There was no order for Mucus Relief, Pepto Bismol, Bio-freeze, Tylenol 500mg or Systane eye drops. Review of Resident #5's electronic medical administration record (eMAR) for May 2024 and June 2024 revealed, Mucus Relief, Pepto Bismol, Bio-freeze, Tylenol 500mg or Systane eye drops were not listed on the (eMAR). Interview with Resident # 5 on 06/024 3:35pm revealed: -The resident used the nasal spray and inhaler as instructed when they were needed. -The resident's family member brought in Mucus Relief, Pepto Bismol, Bio-freeze, Tylenol 500mg and Systane eye drops	D 375			

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D 375	Continued From page 30 -The resident was not aware she needed an order from her primary care provider (PCP) to have the over the counter (OTC) medications in her room. -She believed the medication aides (MA) and personal care aids (PCA) knew she had the OTC medications in her room. Interview with the PCP on 06/05/24 at 4:50pm revealed: -She was not aware the resident had Mucus Relief, Pepto Bismol, Bio-freeze, Tylenol 500mg and Systane eye drops in her room without a self-administration order. -She would expect any staff member to remove the OTC medications from the room. -She would expect to be informed so she could evaluate the resident and write an order for self-administration if necessary. Interview with the MA on 06/06/24 at 10:05am revealed: -She was aware of the resident having self-administered medication in her room. -She was aware the resident had eye drops, Tylenol and Pepto Bismol on her side table. -She did not know the resident needed an order for self-administration of OTC medications in her room. Interview with the Resident Care Coordinator (RCC) on 06/06/24 at 11:35am revealed: -She was aware of the resident had self-administered medication in her room but was not sure of the names of the medications. -She was not aware the resident had OTC medications in her room that did not have an order. -The MA was responsible for verifying the medications in the room had an order on the	D 375			

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D 375	Continued From page 31 eMAR. -Her expectation would be for the MA to remove any OTC medications that were not listed on the eMAR from the resident's room and notify the RCC and Director so they could obtain an order from the PCP. Interview with the Director on 06/06/24 at 12:20am revealed: -She was not aware the resident had OTC medications in her room that did not have an order. -Her expectations would be for the MA to check to see if there was an order for the self-administered OTC medication when doing cart reviews. -The MA was responsible for verifying the medications in the room had an order on the eMAR. -The MA should remove all OTC medications without an order and notify the RCC or Director. Telephone interview with the Administrator on 06/06/24 at 1:30pm revealed: -She was not aware the resident had OTC medications in her room that did not have an order. -The PCA and MA are responsible for checking the rooms to make sure there are no medications without orders. -The families were aware they were not supposed to bring in OTC medications to the residents. -The expectation would be for family members to take OTC medication to the medication room so the MA could request an order for self-administration from the PCP. -The expectation would be that all resident rooms be checked for OTC medications weekly. 2. Review of Resident #4's current FL2 dated 06/12/23 revealed:	D 375			

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D 375	Continued From page 32 -Diagnoses included post-traumatic stress syndrome, primary insomnia, and type 2 diabetes mellitus with diabetic polyneuropathy. -There was an order for aspirin (used to prevent blood clots) 81mg 1 tablet daily, but there were no orders to self-administer the aspirin. -There was not an order for melatonin (used to treat sleep problems) 10mg gummies. Review of Resident #4's physician's orders dated 02/08/24 revealed: -There was an order for aspirin 81mg 1 tablet daily, but there were no orders to self-administer the aspirin. -There was not an order for melatonin 10mg gummies. Review of Resident #4's record revealed there was no self-administration assessment completed. Review of Resident #4's care plan dated 12/19/23 revealed there was no documentation Resident #4 self-administered any of his medications. Review of Resident #4's electronic medication administration record (eMAR) for April and May 2024 and 06/01/24 through 06/04/24 revealed: -There was an entry for aspirin 81mg 1 tablet daily scheduled for administration at 8:00am. -There was documentation aspirin 81mg was administered daily. -There was no documentation there was a self-administration order for aspirin 81mg. -There was not an entry for melatonin 10mg gummies. Observation of Resident #4's room on 06/04/24 at 9:40am revealed: -There were medications in Resident #4's second	D 375		

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D 375	Continued From page 33 and third dresser drawers including a bottle of melatonin 10mg gummies and a bottle of aspirin 81mg. -There were instructions on the bottle of aspirin 81mg to take 1 tablet daily and the aspirin was dispensed by a pharmacy on 07/27/23. -It could not be determined how many tablets of aspirin were remaining in the bottle. -There were instructions on the bottle of melatonin 10mg gummies to take 2 gummies 30 minutes before bedtime. --There was not a pharmacy label on the melatonin gummies, and it could not be determined how many gummies were remaining in the bottle. Interview with Resident #4 during the tour of the facility on 06/04/24 at 9:39am revealed: -His family member brought him melatonin 10mg gummies for sleep when the facility ran out of another medication that he took for insomnia. -He took 6 or 7 melatonin gummies nightly when he was out of his medication used to treat insomnia and, now he took 3 to 4 gummies nightly. -He took could not remember the last time he took aspirin 81mg or what he took them for. Interview with a MA on 06/05/24 at 9:00am revealed: -Resident #4 had an order to self-administer some of his medications. -She had not looked at the medications in his room. -She did not know Resident #4 had medications in his room that he did not have self-administration orders for and were not on the eMAR. Telephone interview with a MA on 06/06/24 at	D 375			

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D 375	Continued From page 34 12:20pm revealed: -She did not know Resident #4 had aspirin 81mg and melatonin 10mg gummies in his room. -Resident #4 had aspirin 81mg on the medication cart and he did not have a self-administration order for aspirin. -Melatonin 10mg gummies was not on the eMAR and there was no self-administration order for the gummies. -Resident #4 sometimes called his PCP and the PCP's pharmacy to reorder medication. -She tried to "keep an eye on his medications" in his room. Interview with the Resident Care Coordinator (RCC) on 06/06/24 at 11:55am revealed: -A MA was supposed to check Resident #4's medications every night to ensure that he did not have more medications than he was supposed to and that he had enough of the medications that he needed to self-administer. -She did not know Resident #4 had melatonin 10mg gummies and aspirin 81mg in room without having an order for self-administration for the two medications. Interview with the Assistant Director/MA Supervisor on 06/06/24 at 12:31pm revealed: -She did not know Resident #4 had orders to self-administer any of his medications. -She did not know Resident #4 had aspirin and melatonin gummies in his room with no orders to self-administer those medications. -In order for Resident #4 to have medications in his room, he needed an order for self-administration for the medication. -She knew Resident #4 did not have a self-administration order for aspirin because she received Resident #4's aspirin through the mail and placed it in the medication room for the MAs	D 375		

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D 375	Continued From page 35 to administer. -She did not know if there was an order for melatonin gummies for Resident #4. Interview with the Director on 06/05/24 at 3:09pm revealed: -She did not know Resident #4 had medications in his room that he did not have a self-administration order for. -Medication aides (MA) were to check the medications in Resident #4's room every 2 weeks and compare the medications in his room to the medications listed on the eMAR. -If there was a medication in Resident #4's room that did not match or was not on the eMAR, MAs were to contact Resident #4's primary care provider (PCP) for clarification. Interview with the Director on 06/06/24 at 1:41pm revealed: -There had been a medication audit completed 2 months ago including Resident #4's self-administered medications in his room. -She did not know how MAs missed aspirin 81mg and melatonin 10mg gummies. Telephone interview with the Administrator on 06/06/24 at 2:29pm revealed: -Resident #4 needed self-administration orders for all medications that he had in his room. -She was not aware Resident #4 had medication in his room that did not have self-administration orders until 06/06/24. -Resident #4 would not let staff look at his medications. -Family members knew that medications brought into the facility were not to be left with the residents. Attempted telephone interview with Resident #4's	D 375			

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D 375	Continued From page 36 PCP on 06/05/24 at 10:10am was unsuccessful.	D 375		
D 377	10A NCAC 13F .1006(a) Medication Storage 10A NCAC 13F .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to ensure self-administered medications stored in a resident's room were stored in a safe and secure manner for 2 of 5 sampled residents (#4 and #5). The findings are: 1. Review of Resident #4's current FL2 dated 06/12/24 revealed there were no orders to self-administer any of Resident #4's medications. Review of Resident 4's physician's orders dated 02/08/24 revealed: -There was an order to self-administer balmex cream (used to treat minor skin irritations) 11.3% 85gm apply topically to affected area of groin every day after rash clears. -There was an order to self-administer fluticasone propionate (used to treat allergy symptoms) 50mcg nasal spray 2 sprays into each nostril daily. -There was an order to self-administer ketoconazole (used to treat seborrheic dermatitis) 2% cream 30 gm apply topically to affected area of groin twice daily until rash clears. -There was an order to self-administer	D 377		

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D 377	Continued From page 37 latanoprost (used to treat glaucoma) 0.005% solution instill 1 drop to affected eye every evening. -There was an order to self-administer melatonin (used to treat sleep problems) 3mg 4 tablets at bedtime. -There was an order to self-administer prazosin (used to treat hypertension) 1mg 3 capsules at bedtime. -There was an order to self-administer refresh tears (used to treat dry eyes) 0.5% solution instill 1 drop into both eyes 4 times daily. Observation of Resident #4's room on 06/04/24 at 9:40am revealed: -There were medications in Resident #4's second and third dresser drawers. -There were medications in a plastic bag on Resident #4's bed. -There were medications in a cabinet in his bathroom. -There was no lock on his dresser drawers and no lock on the cabinet in the bathroom. Observation of the facility at various times on 06/04/24 and 06/05/24 revealed Resident #4's room door was open throughout the day at times when he was not present in the room. Interview with Resident #4 on 06/02/24 at 9:40am revealed: -He had orders to self-administer some of his medication and MAs administered the rest of his medications to him. -Staff did not tell him he needed to keep his medication in a certain place in his room or that it needed to be locked up. -There was no lock on his bedroom door, and he did not close his bedroom door when he left his room.	D 377		

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D 377	Continued From page 38 Interview with a medication aide (MA) on 06/06/24 at 8:45am revealed: -Resident #4 self-administered some of his medications and the medications were kept in his second and third dresser drawers. -She did not know that medications kept in a resident's room should have been kept in a secured place. -She did not think Resident #4's bedroom door locked. Interview with a second MA on 06/06/24 at 10:03am revealed: -Resident #4 had an order to self-administer his medication. -She had seen Resident #4's medications on his nightstand and underneath his television stand. -She knew Resident #4's medications should have been stored in a secure place, but he usually kept them in his dresser drawers. -She did not know if Resident #4 had a lockable space for medications. Interview with the Resident Care Coordinator (RCC) on 06/06/24 at 11:55am revealed: -Resident #4 kept the medications that he self-administered in the dresser drawers in his room. -She did not know residents who self-administered medications should have had a secured space to store their medications. -Resident #4's room door did not lock, but his closet door locked, and he was able to store his medications in his closet. Interview with the Director on 06/06/24 at 1:41pm revealed: -She knew residents who self-administered their medications needed a secured place to store	D 377		

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D 377	Continued From page 39 their medications. -Resident #4's medications were in his dresser drawers, so they were not visible to other residents. -Each resident including Resident #4, had a lockable closet and his medications could be stored there. Interview with the facility's primary care provider (PCP) on 06/05/24 at 4:29pm revealed she expected that residents who self-administered their medications had a secure space to store them. Telephone interview with the Administrator on 06/06/24 at 2:29pm revealed: -Residents who self-administered medications should have a secured place to store the medication. -Resident #4 had a closet with a lock on it and she did not mind providing a lock box for him. -Lock boxes were provided in a drawer for residents who had an order to self-administer medication. -She did not know why Resident #4 did not have a lock box for the medications that he self-administered. Attempted telephone interview with Resident #4's PCP on 06/05/24 at 10:10am was unsuccessful. 2. Review of Resident #5's current FL2 dated 05/08/2024 revealed diagnoses included dysphagia, depression, esophageal obstruction, generalized anxiety disorder, peripheral vascular disease, age-related osteoporosis, type 2 diabetes mellitus and chronic obstructive pulmonary disease. Review of Resident #5's physician's order dated	D 377		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL029010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/06/2024
NAME OF PROVIDER OR SUPPLIER GRAYSON CREEK OF WELCOME		STREET ADDRESS, CITY, STATE, ZIP CODE 6781 OLD US HWY 52 LEXINGTON, NC 27295		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 377	Continued From page 40 02/08/24 revealed: -Based on observations, record reviews a self-administer order for Fluticasone 50MCG/ACR SPR nasal spray use 1 spray into each nostril twice a day as needed for allergies. -There was a self-administer order for Ventolin 90MCG 18MG. inhaler and inhale 2 puffs every 4 hours as needed for wheezing or shortness of breath. Observation of Resident #5's room on 06/05/24 at 3:35pm revealed Fluticasone nasal spray and a Ventolin inhaler were sitting on a table beside the resident's bed. Interview with Resident #5 on 06/05/24 at 3:40pm revealed: -She kept her medication on her bedside table. -She never stored her medications in a drawer or secured locked space. -She did not have a lockable space to store medications. Interview with the primary care provider (PCP) on 06/05/24 at 4:50pm revealed: -Her expectations were for the resident to keep her medications in her bedside area. -She was not aware self-administered medications should be in a lockable space. -She was not concerned about the eye drops and inhaler, not being in a safe area because the resident never left her room. Telephone interview with a personal care aide (PCA) on 06/06/24 at 8:45am revealed: -She was aware Resident #5 had self-administered medication in her room. -She did not remember where the resident stored her medications. -She was not aware self-administered	D 377		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL029010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 06/06/2024
NAME OF PROVIDER OR SUPPLIER GRAYSON CREEK OF WELCOME			STREET ADDRESS, CITY, STATE, ZIP CODE 6781 OLD US HWY 52 LEXINGTON, NC 27295		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
D 377	Continued From page 41 medications should be stored in a safe lockable storage space. Telephone interview with a medication aide (MA) on 06/06/24 at 10:05am revealed: -She was aware of the resident having self-administered medication in her room. -She was aware the resident stored her medications at her bedside on a table. -She was not aware that self-administered medications should be stored in a safe, secure storage area. Interview with the Resident Care Coordinator (RCC) on 06/06/24 at 11:35am revealed: -She was aware the resident had self-administered medications in her room but not sure of the names of medications. -She was not sure where the resident stored her self-administered medications. -She was not aware self-administered medications should be stored in a safe lockable storage space. -She did not know if the facility had a policy on self-administered medications. Interview with the Director on 06/06/24 at 12:20am revealed: -She was not aware self-administered medications should be stored in a safe storage area or lockable storage space. -She was not sure where the resident stored her self-administered medications. -The facility did not have a policy regarding medication storage for self-administered medications in a resident's room. Telephone interview with the Administrator on 06/06/24 at 1:30pm revealed: -She was aware self-administered medications	D 377			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL029010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 06/06/2024
NAME OF PROVIDER OR SUPPLIER GRAYSON CREEK OF WELCOME			STREET ADDRESS, CITY, STATE, ZIP CODE 6781 OLD US HWY 52 LEXINGTON, NC 27295		
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D 377	Continued From page 42 should be in a safe and secure place. -She was not aware the self-administered medications were not secured in a drawer in the resident's room.	D 377			