STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029010	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYSON CREEK OF WELCOME	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 completed an annual and follow-up survey from 09/16/25 to 09/17/25.	D 000		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (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: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#4) related to a medication used to relax airway muscles to improve breathing and a medication used to relieve allergy symptoms. The findings are: Review of Resident #4's current FL2 dated 07/10/25 revealed diagnoses included dementia and chronic obstructive pulmonary disease (COPD). a. Review of Resident #4's current FL2 dated 07/10/25 revealed there was an order for incruse ellipta (a medication used to treat COPD) 62.5mcg 1 puff daily. Review of Resident #4's electronic medication administration record (eMAR) for July 2025	D 358		

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D 358	Continued From page 1	D 358		

revealed:
-There was an entry for incruse ellipta 62.5mcg 1 puff daily with a scheduled administration time of 8:00am.
-Incruse ellipta was documented as administered from 07/01/25 to 07/31/25.

Review of Resident #4's eMAR for August 2025 revealed:
-There was an entry for incruse ellipta 62.5mcg 1 puff daily with a scheduled administration time of 8:00am.
-Incruse ellipta was documented as administered from 08/01/25 to 08/31/25.

Review of Resident #4's eMAR for September 2025 from 09/01/25 to 09/16/25 revealed:
-There was an entry for incruse ellipta 62.5mcg 1 puff daily with a scheduled administration time of 8:00am.
-Incruse ellipta was documented as administered from 09/01/25 to 09/16/25.

Observation of Resident #4's medications on hand on 09/17/25 revealed there was no incruse ellipta available for administration.

Interview with the medication aide (MA) on 09/17/25 revealed:
-She administered Resident #4's incruse ellipta inhaler when she worked.
-Resident #4 did not have the incruse ellipta available to administer that morning and she had to reorder it.
-Resident #4 did not refuse her inhaler.
-Resident #4 did not have any symptoms of shortness of breath.

Telephone interview with a representative from the facility's contracted pharmacy on 09/17/25 at

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D 358	Continued From page 2 10:50am revealed: -Resident #4 had an active order for incruse ellipta 62.5mcg 1 puff daily. -Incruse ellipta was dispensed from the pharmacy on 01/16/23. -There were no other dispense dates for the incruse ellipta. -There was a note that indicated the incruse ellipta required prior authorization but no reply was seen in the computer. Refer to interview with the Resident Care Director (RCD) on 1:09pm revealed: Refer to interview with the Administrator on 09/17/25 at 1:52pm. b. Review of Resident #4's current FL2 dated 07/10/25 revealed an order for fluticasone (a medication used to treat allergy symptoms) 50mcg nasal spray 1 spray in each nostril daily. Review of Resident #4's eMAR for July 2025 revealed: -There was an entry for fluticasone 50mcg nasal spray 1 spray in each nostril daily with a scheduled administration time of 8:00am. -There was documentation fluticasone nasal spray was administered daily from 07/01/25 to 07/31/25. Review of Resident #4's eMAR for August 2025 revealed: -There was an entry for fluticasone 50mcg nasal spray 1 spray in each nostril daily with a scheduled administration time of 8:00am. -There was documentation fluticasone nasal spray was administered daily from 08/01/25 to 08/31/25.	D 358		

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Review of Resident #4's eMAR for September 2025 from 09/01/25 through 09/16/25 revealed:
-There was an entry for fluticasone 50mcg nasal spray 1 spray in each nostril daily with a scheduled administration time of 8:00am.
-There was documentation fluticasone nasal spray was administered daily from 09/01/25 to 09/16/25.

Observation of Resident #4's medications on hand on 09/17/25 revealed there was no fluticasone nasal spray available for administration.

Interview with the MA on 09/17/25 revealed:
-She administered fluticasone nasal spray to Resident #4 when she worked the day shift.
-There was no fluticasone nasal spray available on the medication cart that morning for Resident #4 and she had to reorder it.
-Fluticasone was not part of the facility's cycle fill; someone would have to reorder it each time.
-If a resident did not have a medication, she reordered using the eMAR and it usually came in that night.
-Resident #4 did not refuse her fluticasone nasal spray.

Telephone interview with a representative from the facility's contracted pharmacy on 09/17/25 at 10:50am revealed:
-One bottle of fluticasone nasal spray was dispensed to the facility on 02/12/25 and 03/20/25.
-There were no other dispense dates available for Resident #4's fluticasone nasal spray.
-The fluticasone nasal spray was not part of the facility's cycle fill; someone from the facility would have to reorder it.

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D 358	Continued From page 4 Refer to interview with the Resident Care Director (RCD) on 09/17/25 at 1:09pm revealed: Refer to interview with the Administrator on 09/17/25 at 1:52pm. _____ Interview with the RCC on 09/17/25 at 1:09pm revealed: -She completed a monthly medication cart audit on every resident. -She compared each resident's medications to the orders and made sure all medications were on hand. -She also conducted random medication administration audits. -She did not know there were medications that were not on the medication cart. -The MAs were able to reorder medications using the eMAR system. Interview with the Administrator on 09/17/25 at 1:52pm revealed she expected medications to be administered as ordered.	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.	D 366		

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D 366	Continued From page 5 This Rule is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure the medication aide (MA) observed a resident take their medications that were on top of her dresser for 1 of 5 sampled residents (#1). The findings are: Review of the facility's policy titled, "Medication Policies & Procedures" on 09/17/25 at 9:35am revealed, in part, "staff will provide documentation on the medication administration record (MAR) after observing the resident taking the medication". Observation of Resident #1's room on 09/16/25 at 8:18am revealed: -There was a plastic medicine cup on the dresser that contained thirteen pills. -There was a cup of water beside the plastic medication cup. -Resident #1 was in her bed under the cover. -Resident #1 immediately got out of bed when the surveyor entered the room and took the medication in the plastic medication cup. Interview with Resident #1 on 09/16/25 at 8:20am revealed: -The medications in the plastic medication cup left on her dresser were her morning medications she took every day. -Some mornings she slept in and did not go to breakfast. -She was probably asleep when the MA came in with the medication, so she just left them. -The MAs frequently left her medication in her room for her to take when she got up.	D 366		

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D 366	Continued From page 6 Observation of the morning medication pass on 09/17/25 revealed Resident #1 was outside the medication room and took her medication from the MA. Interview with the MA on 09/17/25 at 9:50am revealed: -The process for medication administration was scan, pop, pass, and sign. -She did not leave Resident #1's medications in her room yesterday morning, Resident #1 came to the medication room and got them and took them to her room. -She was supposed to make sure residents took their medication before going to the next resident. -Sometimes Resident #1 became angry when she told her she could not take her medication back to her room. -This morning, she took her medication just fine. Interview with the lead MA on 09/17/25 at 9:55am revealed the MAs should observe each resident take their medication before going to the next resident. Interview with the Administrator on 09/17/25 at 1:52pm revealed: -MAs were expected to observe each resident take their medication. -The MAs should observe each resident take their medication to ensure compliance with medication administration. Attempted telephone interview with Resident #1's primary care provider (PCP) on 09/17/25 at 8:30am and on 09/17/25 at 2:45pm were unsuccessful.	D 366		