STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0476	A. BUILDING: _____ B. WING _____	C 11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE RIDGE	500 LENOIR ROAD MORGANTON, NC 28655

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L 000	INITIAL COMMENTS A relicensure and complaint investigation survey was conducted from 11-7-2022 through 11-9-2022. Event ID#TQEB11. The following intake was investigated NC 000193966. 1 of 1 complaint allegations were substantiated resulting in a deficiency.	L 000		
L 049	.2210(A) REPORTING, INVESTIGATING ABUSE, NEGLECT 10A-13D.2210 (a) A facility shall take measures to prevent patient abuse, patient neglect, or misappropriation of patient property, including orientation and instruction of facility staff on patients' rights and the screening of and requesting of references for all prospective employees. This Rule is not met as evidenced by: Based on record review and staff interview the facility failed to protect a resident's right to be free from abuse for 2 of 2 residents (Resident #5 and Resident #6). The findings included: 1. Interview with the facility Secretary on 11/8/22 at 1:18 PM revealed she witnessed 2 different instances in which NA #1 was inappropriate with residents. She stated the 1st incident was observed when she was delivering newspapers on 9/24/22. The Secretary revealed she heard	L 049		

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L 049	Continued From page 1	L 049		

someone yelling and telling Resident #5 to get up. The facility secretary stated she peeked in the resident's room and saw Resident #5 on a mechanical stand-up lift that had wheels on it. She stated Resident #5 was observed hanging on tight as the mechanical lift was rolled quickly in a circle by NA #1. The way NA #1 quickly rolled the mechanical lift could have hurt Resident #5. The Secretary stated the 2nd instance was the next day (9/25/22). She observed Resident #5 sitting her wheelchair at the nursing station. Resident #5 was asking to go to the restroom. The Secretary stated Resident #5 would frequently asked about going to the toilet or to bed. NA #1 was observed to be standing at the nursing station. The Secretary stated she asked NA #1 to take Resident #5 to the bathroom. NA #1 responded by saying, "in a minute" and was short.

Interview with NA#2 on 11/8/22 at 1:45 PM stated she also recalled NA#1 telling Resident #5 that she wasn't in the mood on 9/24/22.
NA #2 described NA #1 as being irritated on 9/24/22.

2. Interview with Nurse #1 on 11/8/22 at 1:04 PM stated that on 9/17/22 she was in the medication room. She stated there were multiple residents at the nursing station. Nurse # 1 sated that she heard NA #1 getting loud with a resident. NA#1 was overheard saying things like, "because my nurse said so" and "you are not going back to bed." Nurse #1 stated when she arrived to the nursing station, NA #1 was talking to Resident #6.

Interview with NA #2 on 11/8/22 at 1:45 PM stated NA #1 was getting aggravated by a couple of residents on the unit to include Resident #6. The residents who were described as confused by NA

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L 049	Continued From page 2 #2 were saying they wanted to go to bed. NA #2 stated NA #1 snapped at the residents and said, "other people may baby you but I'm not." She also described NA #1 as turning resident's wheelchair hatefully. NA #2 revealed she communicated to NA #1 that she didn't have to treat the residents that way.	L 049		
L 050	.2210(B) REPORTING, INVESTIGATING ABUSE, NEGLECT 10A-13D.2210 (b) A facility shall ensure that the Division of Health Service Regulation is notified within 24 hours of the facility's becoming aware of any allegation against health care personnel of any act listed in G.S. 131E-256(a)(1). This Rule is not met as evidenced by: Based on record review and staff interview the facility failed to report allegations of abuse within 24 hours for 2 of 2 sampled residents (Resident #5, Resident #6). The findings included: 1. An email dated 9/26/22 written by the Secretary with the subject "SEPTEMBER 25th concern" was sent to recipients to include the Administrator and the Director of Nursing (DON). The email revealed the Secretary was very concerned about the neglect and verbal abuse that she witnessed. The concern further revealed	L 050		

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L 050	Continued From page 3	L 050		

she understood that certain residents could be challenging at times, but this specific resident (identity not provided) was asking nicely over and over and was being completely ignored. In hindsight she should have reported the yelling and aggressive way that this resident (identity not provided) was spun across the room on her lift the day before by this same Nursing Assistant (NA) (identify not provided). She was clinging to the lift and looked scared to death. The email stated this was not an exaggeration, it was an observation. Her knuckles were white just trying to hold on to the lift. The Secretary wrote, "If I treated a resident the way that she continued to observe this specific NA (identify not provided) do, she would expect someone else to do the same and honestly, she would appreciate it if more people did". The email revealed, every bit of negligent treatment or verbal/emotional abuse that the Secretary had witnessed was always centered around one NA (identity not provided).

Review of 24-hour report dated 9/28/22 revealed an allegation of abuse occurred on 9/24/22. The allegation stated NA #1 was overheard speaking to Resident #5 in a disrespectful way. NA #1 had a harsh tone and had gotten resident on a mechanical lift to take Resident #5 to the toilet. NA#1 had jerked the lift around and Resident #5 had white knuckles. The report further revealed the facility became aware of the allegation on 9/25/22 at 2:00PM. The 24-hour report was not submitted until 9/28/22.

Interview with the facility Secretary on 11/8/22 at 1:18 PM revealed she witnessed 2 different instances in which she witnessed NA #1 was inappropriate with residents. She stated the 1st incident was observed when she was delivering newspapers on 9/24/22. The Secretary revealed

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L 050	Continued From page 4	L 050		

she heard someone yelling and telling Resident #5 to get up. The facility secretary stated she peeked in the resident's room and saw Resident #5 on a mechanical stand-up lift that had wheels on it. She stated Resident #5 was observed hanging on tight as the mechanical lift was rolled quickly in a circle by NA #1. The way NA #1 quickly rolled the mechanical lift could have hurt Resident #5. The Secretary stated the 2nd instance was the next day (9/25/22). She observed Resident #5 sitting her wheelchair at the nursing station. Resident #5 was asking to go to the restroom. The Secretary stated Resident #5 would frequently asked about going to the toilet or to bed. NA #1 was observed to be standing at the nursing station. The Secretary stated she asked NA #1 to take Resident #5 to the bathroom. NA #1 responded by saying, "in a Minute" and was short. The Secretary stated that she had received abuse training from the facility, and she should have reported it immediately.

Interview with NA #2 on 11/8/22 at 1:45 PM stated NA #1 described NA #1 as irritated the day of the incident (9/24/22). She was getting aggravated by a couple of residents on the unit to include Resident #6. The residents who were described as confused by NA #2 were saying they wanted to go to bed. NA #2 stated NA #1 snapped at the residents and said, "other people may baby you but I'm not". She also described NA #1 as turning resident's wheelchair hatefully. NA #2 revealed she communicated to NA #1 that she didn't have to treat the residents that way. She also told Resident #5 that she wasn't in the mood today. NA #2 revealed she was supposed to report incidents of abuse to the nurse who would communicate the incident to the DON or the Administrator. She indicated that she had not reported the incident, but Nurse #1 was aware

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L 050	Continued From page 5	L 050		

and that's who she would have told. She further recalled the Administrator contacting the facility to discuss how to treat residents on 9/25/22.

Interview with the DON on 11/8/22 at 2:21 PM revealed staff were to report instances of abuse to the nursing supervisor in the instance she or the Administrator was not in the building. She stated it would be the Administrator and herself that conducted investigations. In the instance it was blatant abuse the facility would suspend the accused staff. She stated she became aware of the incident involving Resident #5 on Monday (9/26/22) when she came into work. She stated she expected the incident to be reported the day in which it occurred. The Secretary should have reported the incident on Saturday (9/24/22). She revealed that due to not getting emails on her phone, it would be the Administrator that would have been aware of the email dated 9/26/22 from the Secretary. Allegations were to be reported to the appropriate state agency within 24 hours of the facility knowledge of the allegation.

2. Review of the facilities 5-day working report (investigation) dated 10/3/22 revealed an attached witness statement dated 9/27/22 written by Nurse # 1 who stated on 9/17/22 at approximately 1:30pm, as she was in the medication room, she overheard NA #1 get very loud and stern and what seamed harsh in tone with someone. The witness statement further stated NA# 1 said comments such as, because my nurse said so and I am doing my job, no we are not putting you back in bed, that is enough you need to stop, and we are not putting you back to bed. The witness statement continued that as Nurse #1 rounded the corner, she noted both NA #2 and NA #1 were sitting at their desk with several residents sitting in wheelchairs in the

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L 050	Continued From page 6	L 050		

sitting area. It was only then Nurse # 1 realized NA #1 had been speaking to Resident # 6. Nurse #1 revealed Resident #6 said, "I just don't understand I can't go to bed". The witness statement further revealed Nurse #1 told NA #1, "we will be very lucky if we both don't get called into the office over that episode, you have either got to learn some patients or walk away, that speaking to her in that way was not right, not respectful and not acceptable". NA #1 stated in return to Nurse #1 that Nurse #1 had not heard how the residents were calling her Expletives.

Review of NA #1's Termination dated 10/3/22 revealed "problem identification" that stated it was reported by a teammate that they were concerned with NA #1's interaction with a resident (identification not provided) on 9/24/22. They observed you speaking harshly to the resident while the resident was in the lift. They were also concerned regarding the way you were handling the resident in the lift. The resident appeared scared, with hands that were clenched and white. This reported incident led to an investigation. During the investigation they received other reports expressing the same concerns regarding tone of voice; interactions; your expressed frustration and rude and disrespectful statements to residents. On 9/17/22, the charge nurse brought you into the office after overhearing your conversation with Resident #6. The charge nurse overheard you speaking to the resident in a loud, stern, and somewhat harsh tone. These reported observed interactions do not support our behavior or our resident's rights policy.

Interview with Nurse #1 on 11/8/22 at 1:04 PM stated that on 9/17/22 she was in the medication room. She stated there were multiple residents at the nursing station. Nurse # 1 sated that she

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L 050	Continued From page 7 heard NA #1 getting loud with a resident. NA#1 was overheard saying things like, because my nurse said so", and "you are not going back to bed". Nurse #1 stated when she arrived to the nursing station, NA #1 was talking to Resident #6. Nurse #1 stated she had reported the incident to the oncoming nurse during report. She had not reported the incident to management. She stated she should have reported the incident prior to writing her witness statement on 9/27/22. Interview with the DON on 11/8/22 at 2:21 PM revealed allegations were to be reported to the appropriate state agency within 24 hours of the facility knowledge of the allegation. She stated the facility was not made aware of the incident that occurred dated 9/17/22 until the facility began the investigation into the incident reported for 9/25/22 in which a witness statement was provided. The incident should have been reported immediately and was not reported within 24 hours of the facilities knowledge. Interview with the Administrator on 11/9/22 at 9:08 AM revealed allegations of abuse were to report to the appropriate state agency within 24 hours of the facilities knowledge. The Administrator stated the staff were responsible for communicating instance of abuse immediately.	L 050		
L 051	.2210(C) REPORTING, INVESTIGATING ABUSE, NEGLECT 10A-13D.2210 (c) A facility shall investigate allegations of any act listed in G.S. 131E-256(a)(1), shall document all information pertaining to such investigation, and shall take the necessary steps to prevent further incidents while the investigation is in progress.	L 051		

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L 051	Continued From page 8	L 051		

This Rule is not met as evidenced by:
Based on record review and staff interview the facility failed to safeguard residents following an allegation of abuse for 1 of 2 residents (Resident #5).

The findings included:

An email dated 9/26/22 written by the Secretary with the subject "SEPTEMBER 25th concern" was sent to recipients to include the Administrator and the Director of Nursing (DON). The email began stating the Secretary apologized for bothering administration on Sunday morning (9/25/22). The email revealed the Secretary was very concerned about the neglect and verbal abuse that she witnessed. The concern further revealed she understood that certain residents could be challenging at times, but this specific resident (identity not provided) was asking nicely over and over and was being completely ignored. In hindsight she should have reported the yelling and aggressive way that this resident (identity not provided) was spun across the room on her lift the day before by this same Nursing Assistant (NA) (identify not provided). She was clinging to the lift and looked scared to death. The email stated this was not an exaggeration, it was an observation. Her knuckles were white just trying to hold on to the lift. The Secretary wrote, "If I treated a resident the way that she continued to observe this specific NA (identify not provided) do, she would expect someone else to do the same and honestly, she would appreciate it if more people did".The email revealed, every bit of

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L 051	Continued From page 9	L 051		

neglectful treatment or verbal/emotional abuse that the Secretary had witnessed was always centered around one NA (identity not provided).

Review of 24-hour report dated 9/28/22 revealed an allegation of abuse occurred on 9/24/22. The allegation stated NA #1 was overheard speaking to Resident #5 in a disrespectful way. NA #1 had a harsh tone and had gotten resident on a mechanical lift to take Resident #5 to the toilet. NA#1 had jerked the lift around and Resident #5 had white knuckles. The report further revealed the facility became aware of the allegation on 9/25/22 at 2:00PM.

Review of the facilities 5-day working report (investigation) dated 10/3/22 revealed an attached witness statement by NA # 2 dated 9/28/22 that stated she witnessed verbal abuse, resident neglect from NA #1 on Saturday (9/24/22). NA #1 had come into work with a negative attitude and poor body language. NA #1 was kind of rude speaking with residents. A couple of residents were asking what was wrong with her, if she was ok, or telling her to stop talking to them rude. The witness statement continued that at 12:30 PM NA #1 yelled at another resident and told her to stop. NA#2 could tell all day that NA #1 was aggravated and brought her outside issues and feelings to work while letting it interfere with taking care of residents.

Interview with the facility Secretary on 11/8/22 at 1:18 PM revealed she witnessed 2 different instances in which she witnessed NA #1 was inappropriate with residents. She stated the 1st incident was observed when she was delivering newspapers on 9/24/22. The Secretary revealed she heard someone yelling and telling Resident

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L 051	Continued From page 10 #5 to get up. The facility secretary stated she peeked in the resident's room and saw Resident #5 on a mechanical stand-up lift that had wheels on it. She stated Resident #5 was observed hanging on tight as the mechanical lift was rolled quickly in a circle by NA #1. The way NA #1 quickly rolled the mechanical lift could have hurt Resident #5. The Secretary stated the 2nd instance was the next day (9/25/22). She observed Resident #5 sitting her wheelchair at the nursing station. Resident #5 was asking to go to the restroom. The Secretary stated Resident #5 would frequently asked about going to the toilet or to bed. NA #1 was observed to be standing at the nursing station. The Secretary stated she asked NA #1 to take Resident #5 to the bathroom. NA #1 responded by saying, "in a Minute" and was short. The Secretary stated that she had received abuse training from the facility, and she should have reported it immediately. Interview with NA #2 on 11/8/22 at 1:45 PM stated NA #1 described NA #1 as irritated the day of the incident (9/24/22). She was getting aggravated by a couple of residents on the unit to include Resident #6. The residents who were described as confused by NA #2 were saying they wanted to go to bed. NA #2 stated NA #1 snapped at the residents and said, "other people may baby you but I'm not." She also described NA #1 as turning resident's wheelchair hatefully. NA #2 revealed she communicated to NA #1 that she didn't have to treat the residents that way. She also told Resident #5 that she wasn't in the mood today. NA #2 revealed she was supposed to report incidents of abuse to the nurse who would communicate the incident to the DON or the Administrator.	L 051		

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L 051	Continued From page 11 Review of the facilities staffing schedule revealed NA #1 worked 3 days following the allegation of abuse on 9/25/22, 9/26/22 and 9/27/22. Interview with the Director of Nursing (DON) on 11/8/22 at 2:21 PM revealed the facility had not removed NA #1 from her duties following the allegation of abuse. She stated until the investigation revealed there was a concern; she was allowed to continue to work. As a result of the investigation dated 9/28/22 she was removed from the schedule on 9/28/22. Interview with the Administrator on 11/9/22 at 9:08 AM revealed NA#1 was not removed from shift following the allegation of Abuse. She was allowed to work during part of the investigation.	L 051		