STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		NH0476	B. WING		C <b>03/16/2018</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	NTE, ZIP CODE	
GRACE R	IDGE		OIR ROAD		
		MORGA	NTON, NC 2865	5	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS		L 000		
	•	nd complaint investigation. ncies as a result of the			
L 076	.2305(A) QUALITY O	F CARE	L 076		
	10A-13D.2305 (a) The provide necessary ca accordance with med patient's comprehens on-going plan of care	re and services in ical orders, the ive assessment and			
	interview, the facility forder to use a seat be resident to her wheel physician's orders prictherapy for 2 of 4 sam reviewed for oxygen t #5), and; develop carrand pressure ulcer deresidents whose care #4 and #5). Findings  1. Resident #6 was acunit on 8/9/17. There usage in the skilled not include an order to restrain Resident #6's	and staff ailed to: obtain a physician's self to restrain one sampled chair (#6); obtain or to administering oxygen apled residents who were therapy (Residents #2 and the plans for oxygen therapy evelopment for 3 of 8 plans were reviewed (#1, included:  Indicate the skilled nursing was no order for restraint the plans and order staff the plans were reviewed (#1, included:		1. Resident #6  *How corrective action accomplished for affected resident:  (1) Obtained MD order for restraint (vel for Resident #6  *Identify other residents with potential to be affected:  (1) DON reviewed 100% of other reside to identify any other residents with restraints. None identified  *Measures to be put into place to preven reoccurrence  (1) DON or designee will audit 100% of resident charts with restraints to ensure forder is present. Weekly review of charts starting the week of 3/26/18 and weekly then every two weeks x two; then monthl and randomly thereafter as appropriate to ongoing compliance with obtaining MD or (2) Audit/observation to be presented/discussed at monthly QAPI mex one year with revisions as necessary.	ents 3/19/18  t f the MD 4/2/18 x four; y x two co assure order.
	Resident #6 was observith a hook and loop	erved on 3/15/18 at 1:02 PM fastener strap applied			

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

(X6) DATE TITLE

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SUF COMPLET	
			A. BUILDING			
		NH0476	B. WING		03/1	; 6/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GRACE R	IDGE	500 LENOI				
	I	MORGANT	ON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
L 076	Continued From page	e 1	L 076			
	across her thighs.					
	3/15/18 revealed, "Th falling out of the chair At 3:56 PM on 3/15/1 had the hook and look she would lean and fall Resident #6 was obse	8, NA #2 stated Resident #6 p fastener strap because		1. Resident #6 (con't)  *How corrective action accomplished for affected resident  (1) Staff education completed for staff caring for Resident #6, clarifying that the belt is a restraint for resident.  (2) Staff education on restraints includi  (a) What is a restraint  (b) When should restraints be relevant to the affected. No other residents with restat this time	e velco ng: ased	3/19/18 4/2/18 3/19/18
	Nurse #1 was interviewed on 3/16/18 at 10:00  AM. She said the purpose of the hook and loop fastener strap was to remind Resident #6 she should not get up. She said she can take it off on her own. "It is not a restraint." Nurse #1 stated Resident #6 removed it more in the evenings and said she thought she had it in the assisted living unit.			*How will plan be monitored to ensure compliance  (1) DON or designee will monitor the nursing documentation to assure that it residents with restraints weekly starting 3/26/18 x four weeks; then every two we and then monthly x two and randomly thappropriate to assure ongoing complian.  (2) Audit/observation to be presented/out monthly QAPI meetings x one year was necessary.	the week of eeks x two ereafter as ce. discussed	4/2/10
	The Administrator and were interviewed on 3 Administrator said the when Resident #6 walliving and provided a dated 3/16/17 (prior to skilled nursing unit) for chair with seat belt. Tof the seat belt was to forward. The DON sawould be needed.  Physician #1 was interviewed.	applied across her thighs.  d Director of Nurses (DON) 8/16/18 at 10:30 AM. The e seat belt was implemented as a resident in assisted physician's telephone order o her admission to the or a reclining back wheel The DON said the purpose o remind her not to lean aid I would think an order  erview on March 16, 2018 at may have given a verbal				

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		
		NH0476	B. WING	<del></del>	C 03/16/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
GRACE R	IDGE	500 LENOII MORGANT	R ROAD ON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
L 076	order for the use of a to the chart. Resident skilled unit on 3/14/18  2. Review of the med Resident #2 was read 03/14/18 with diagnos femur and pubis, hypodisease, arteriosclero hypothyroidism, atrial non-celiac gluten sen malignant neoplasm to pacemaker, vitamin Exercise of a Long Terdated 3/13/18 revealed need for oxygen adm.  A physician's order for not found on the med. According to the vital oxygen saturation during through 16, 2018 with the company of the oxygen yester. Observations of Resident AM revealed she was cannula (NC) with the per minute (LPM). Regot the oxygen yester.	Velcro strap and it never got #2 was readmitted to the 8.  dical record revealed dimitted to the skilled unit on ses including fracture of the ertension, chronic kidney tic heart disease, fibrillation, insomnia, sitivity, hypokalemia, pronchus or lung, anxiety, o deficiency and allergies.  Im Care Transfer Instruction ed it did not indicate the inistration.  In oxygen administration was ical record.  sign record, Resident #2's ring the period from March was in the range of 96 -  dent #2 on 3/15/18 at 8:35 a using oxygen via nasal at flow meter set at 1.0 liters esident #2 stated she just	L 076	2. Resident #2 *How corrective action was accomplished affected resident Received order from MD for oxygen for Resident #2 *Identify other residents with potential to affected (1) DON reviewed 100% of other resididentify any other residents with oxygen Six of seventeen residents were found to oxygen and presently all have orders. *Measures to be put into place to prevent reoccurrence (1) DON or designee will audit 100% or resident charts that have oxygen to ensoorder is present. Weekly review starting week of 3/26/18 x four; then every two with x two; then monthly x two and randomly thereafter as appropriate to assure ongoing compliance with obtaining MD of (2) Audit/observation will be presented/discussed at monthly QAPI mix one year with revisions as necessary.	3/16/18 be ents to 3/20/18 be have at the greeks arder.
	and said she could no administration. She s orders for oxygen usa	ewed on 3/16/18 at 11:45 AM of find an order for oxygen said there were standing age when a resident's s 88 to 92% and she said			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		
		NH0476	B. WING		C 03/16/2018
NAME OF PROV	VIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE	
GRACE RIDG	3E		OIR ROAD		
		MORGAI	NTON, NC 2865	5	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
L 076 C	ontinued From page	e 3	L 076		
	desident #2 was usin ne hospital.	g oxygen prior to going to			
(Est dia lit rost) (I) (I) (I) (I) (I) (I) (I) (I) (I) (I	DON) said she recall ummary that was no ated 3/13/18 with a said her oxygen sat som air at rest. It no 2 on room air, her ox ropped to 81%. At taxygen at 2 LPM via soncentration rate was fithe DON at this time at 1.0 LPM.  Thysician #2 was interested to the hospital. She incommunication also much hospital. She (no physician's order to the mought it got missed. a. Review of the material and the desident #5 was admitted.	edical record revealed hitted 1/12/16 with diagnoses otic heart disease, shortness		3a. Resident 5 *How corrective action was accomplished affected resident Received order from MD for oxygen for F#5.  * Identify other reisdents with potential to be affected (1) DON reviewed 100% of other resident identify any other residents with oxygen. Six out of seventeen residents have oxygen.	28 3/16/18 sesident are a 3/20/18 sesident are a 3/20/18
D A he	Review of Resident #5's Physician's orders revealed there was no order for continuous oxygen via nasal cannula (NC).  During an initial observation on 03/15/18 at 9:00 AM Resident #5 was sitting in her wheelchair in her room with oxygen via NC attached to an oxygen concentrator. The oxygen flow meter was set between 1.0 and 1.5 liters per minute (LPM). Subsequent observations on 03/15/18 at 4:02 PM, 03/16/18 at 8:21 AM, and 03/16/18 at 2:00			*Measures to be put into place to prevent reoccurrence  (1) DON or designee will audit 100% of the resident charts that have oxygen to ensure order is present. Weekly review starting the week of 3/26/18 x four; then every two week x two; then monthly x two and randomly the as appropriate to assure ongoing compliar with obtaining MD order.  (2) Audit/observations will be presented/discussed at monthly QAPI mea x one year with revisions as necessary.	e MD ne 4/2/18 neks ereafter nce

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		NH0476	B. WING		03/16/2018	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
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	OLUMBA DV OT		ON, NC 28655			
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L 076	Continued From page	e 4	L 076			
	between 1.0 and 1.5	LPM.				
	Nurse #1 stated she is start on oxygen due to saturation but was not a start on 03/1 Administrator confirm continuous oxygen but initiated. The Administrator and a start of the saturation o	6/18 at 2:45 PM. The led Resident #5 was on ut was not sure when it was strator reviewed Resident and noted there was no the use of continuous strator stated oxygen was d there should be a it to be administered.  erview on 03/16/18 at 3:15 provided a copy of an email een a nurse and the 8. The nurse informed the 5 had a bad cough with es noted in the base of her oxygen via NC 2 LPM to saturation between 93% to attor stated she thought this alous oxygen had been d there was no written				
	b. Review of the medical record revealed Resident #5 was admitted 1/12/16 with diagnoses including atherosclerotic heart disease, shortness of breath, and recurrent pneumonia.					
	Review of Resident # there was no plan of continuous oxygen.	5's care plans revealed care for the use of				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE S COMPLE	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	LDING:		ETED
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		NH0476	B. WING		03/1	6/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ITE, ZIP CODE		
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		MORGANT	ON, NC 2865	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
L 076	During an initial obser AM Resident #5 was her room with oxygen oxygen concentrator. set between 1.0 and Subsequent observat PM, 03/16/18 at 8:21 PM revealed Resident oxygen via NC with the between 1.0 and 1.5 An interview with Phy 1:55 PM revealed he and thought a plan of staff would know how manage residents who During an interview of Director of Nursing (Dishould be care planned why Resident #5 did not the use of continual further revealed care quarterly during care  4. Review of the mediagnoses including the revealed and th	rvation on 03/15/18 at 9:00 sitting in her wheelchair in a via NC attached to an The oxygen flow meter was 1.5 liters per minute (LPM). ions on 03/15/18 at 4:02 AM, and 03/16/18 at 2:00 at #5 was on continuous he oxygen flow meter set LPM.  rsician #1 on 03/16/18 at considered oxygen a drug care was important so the to assess, monitor, and to used continuous oxygen.  n 03/16/18 at 2:33 PM the DON) stated oxygen use ed and she could not explain not have a care plan in place ous oxygen. The interview plans were typically updated plan meetings.  dical record revealed hitted on 02/25/12 with chronic airway obstruction, umatic mitral valve disease.  4's March 2018 Physician's der for continuous oxygen minute (LPM) to keep eater than or equal to 92%.	L 076	3b. Resident #5 *How corrective action was accomplished affected resident Care plan was updated to include use of content of the affected (1) DON reviewed 100% of other residency oxygen and verified that oxygen use was applan. Six out of seventeen residents have oxygen presently they all have care plans that reflusage.  *Measures to be put into place to prevent reoccurrence (1) DON or designee will audit 100% of the resident charts that have oxygen to ensuring oxygen usage is on care plan. Weekly restarting the week of 3/26/18 x four; then entwo weeks x two; then monthly x two and randomly thereafter as appropriate to assiongoing compliance with care planning oxyusage. (2) DON or designee will update care planesident condition changes (3) Audit/observations will be presented/discussed at monthly QAPI mex one year with revisions as necessary.	ents with on care en and ect oxygen the ethat view very ure en sas	3/19/18 3/20/18 4/2/18
		rvation on 03/15/18 at 8:47				

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		( -,	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE		
OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	UILDING: COMPLE		ETED
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	NH0476	B. WING		03/1	6/2018
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SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX TAG	,		COMPLETE DATE
Continued From page	e 6	L 076			
AM Resident #4 was via NC attached to an oxygen flow meter wa (LPM). Subsequent of 11:55 AM, 03/16/18 a 3:00 PM revealed Resoxygen via NC with the 2.0 LPM.  An interview with Phy 1:55 PM revealed he and thought a plan of staff would know how manage residents who During an interview of Director of Nursing (Dishould be care planned why Resident #4 did in for the use of continue further revealed care	resting in bed with oxygen a oxygen concentrator. The as set at 2.0 liters per minute observations on 03/15/18 at at 10:00 AM, and 03/16/18 at sident #4 was on continuous ne oxygen flow meter set at resician #1 on 03/16/18 at considered oxygen a drug care was important so the at to assess, monitor, and no used continuous oxygen.  In 03/16/18 at 2:33 PM the DON) stated oxygen use ed and she could not explain not have a care plan in place ous oxygen. The interview plans were typically updated		affected resident Care plan was updated to include use of of affected  (1) DON reviewed 100% of other resident oxygen and verified that oxygen use was care plan. Six out of seventeen residents have oxyg presently they all care plans that reflect or usage.  *Measures to be put into place to prevent reoccurrence  (1) DON or designee will audit 100% of the resident charts that have oxygen to ensur oxygen usage is on the care plan. Weekl starting the week of 2/26/18 x four; then exweeks x two; then monthly x two and rand thereafter as appropriate to assure ongoin compliance with care planning oxygen us (2) DON or designee will update care planted tondition changes.  (3) Audit/observations will be	oxygen  oe  Ints with on the  en and xygen  the the te that y review every two domly ng age. ans as	3/20/18 3/19/18 4/2/18
Resident #1 was adm diagnoses including a dementia, and athero Review of the medical Physician's order writeliquid film-forming dreday and to keeps hee written on 01/28/18 to area on Resident #1's to follow the protocol Review of a nurse's in the wound on Resident	nitted on 04/27/17 with adult failure to thrive, sclerotic heart disease.  If record revealed a ten on 01/22/18 to apply a essing to both heels twice a els floated. An order was a make Hospice aware of the sright heel on Monday and for pressure injury.				
	Continued From page AM Resident #4 was via NC attached to an oxygen flow meter wa (LPM). Subsequent of 11:55 AM, 03/16/18 as 3:00 PM revealed Re oxygen via NC with the 2.0 LPM.  An interview with Phy 1:55 PM revealed he and thought a plan of staff would know how manage residents who buring an interview of Director of Nursing (Eshould be care plannownly Resident #4 did for the use of continuing further revealed care quarterly during care  5. Review of the med Resident #1 was admidiagnoses including a dementia, and atherored Review of the medical Physician's order write liquid film-forming dred day and to keeps hee written on 01/28/18 to area on Resident #1's to follow the protocol Review of a nurse's in the wound on Reside opened up and was a series of the medical physician's order write and the protocol Review of a nurse's in the wound on Reside opened up and was a series of the medical physician's order writen on 01/28/18 to a protocol Review of a nurse's in the wound on Reside opened up and was a series of the medical physician's order writen on 01/28/18 to a protocol medical physician's order writen on 01/28/18 to a protocol medical physician's order writen on 01/28/18 to a protocol medical physician's order writen on 01/28/18 to a protocol medical physician's order writen on 01/28/18 to a protocol physician's order writen order w	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 6  AM Resident #4 was resting in bed with oxygen via NC attached to an oxygen concentrator. The oxygen flow meter was set at 2.0 liters per minute (LPM). Subsequent observations on 03/15/18 at 11:55 AM, 03/16/18 at 10:00 AM, and 03/16/18 at 3:00 PM revealed Resident #4 was on continuous oxygen via NC with the oxygen flow meter set at	ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 6  AM Resident #4 was resting in bed with oxygen via NC attached to an oxygen concentrator. The oxygen flow meter was set at 2.0 liters per minute (LPM). Subsequent observations on 03/15/18 at 11:55 AM, 03/16/18 at 10:00 AM, and 03/16/18 at 3:00 PM revealed Resident #4 was on continuous oxygen via NC with the oxygen flow meter set at 2.0 LPM.  An interview with Physician #1 on 03/16/18 at 1:55 PM revealed he considered oxygen a drug and thought a plan of care was important so the staff would know how to assess, monitor, and manage residents who used continuous oxygen.  During an interview on 03/16/18 at 2:33 PM the Director of Nursing (DON) stated oxygen use should be care planned and she could not explain why Resident #4 did not have a care plan in place for the use of continuous oxygen. The interview further revealed care plans were typically updated quarterly during care plan meetings.  5. Review of the medical record revealed Resident #1 was admitted on 04/27/17 with diagnoses including adult failure to thrive, dementia, and atherosclerotic heart disease.  Review of the medical record revealed a Physician's order written on 01/22/18 to apply a liquid film-forming dressing to both heels twice a day and to keeps heels floated. An order was written on 01/28/18 to make Hospice aware of the area on Resident #1's right heel on Monday and to follow the protocol for pressure injury.  Review of a nurse's note dated 03/01/18 revealed the wound on Resident #1's right heel had opened up and was approximately 2.0 cm	IDGE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 6  AM Resident #4 was resting in bed with oxygen via NC attached to an oxygen concentrator. The oxygen flow meter was set at 2.0 liters per minute (LPM). Subsequent observations on 03/15/18 at 11:55 AM, 03/16/18 at 10:00 AM, and 03/16/18 at 13:00 PM revealed Resident #4 was on continuous oxygen via NC with the oxygen flow meter set at 2.0 LPM.  An interview with Physician #1 on 03/16/18 at 1:55 PM revealed he considered oxygen a drug and thought a plan of care was important so the staff would know how to assess, monitor, and manage residents who used continuous oxygen.  During an interview on 03/16/18 at 2:33 PM the Director of Nursing (DON) stated oxygen use should be care planned and she could not explain why Resident #4 did not have a care plan in place for the use of continuous oxygen. The interview further revealed care plans were typically updated quarterly during care plan meetings.  5. Review of the medical record revealed Resident #1 was admitted on 04/2717 with diagnoses including adult failure to thrive, dementia, and atherosclerotic heart disease.  Review of the medical record revealed a Physician's order written on 01/22/18 to apply a liquid film-forming dressing to both heels twice a day and to keeps heels floated. An order was written on 01/28/18 to make Hospice aware of the area on Resident #1's right heel on Monday and to follow the protocol for pressure injury.  Review of a nurse's note dated 03/01/18 revealed the wound on Resident #1's right heel nod opened up and was approximately 2.0 cm	SIDE SOLENOIR RAD MORGANTON, NC 28655  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION).  Continued From page 6  AM Resident #4 was resting in bed with oxygen via NO attached to an oxygen concentrator. The oxygen flow meter was set al. 2.0 liters per minute (LPM). Subsequent observations on 03/15/18 at 1:35 AM, 03/16/18 at 10:00 AM, and 03/16/18 at 1:35.00 PM revealed Resident #4 was on continuous oxygen via NC with the oxygen flow meter set at 2.0 LPM.  An interview with Physician #1 on 03/16/18 at 1:55 PM revealed he considered oxygen and thought a plan of care was important so the staff would know how to assess, monitor, and manage residents who used continuous oxygen.  During an interview on 03/16/18 at 2:33 PM the Director of Nursing (DON) stated oxygen use should be care planned and she could not explain why Resident #4 did not have a care plan in place for the use of continuous oxygen. The interview further revealed care plans were typically updated quarterly during care plan meetings.  5. Review of the medical record revealed Resident #1 was admitted on 04/27/17 with diagnoses including adult failure to thrive, dementia, and atherosclerotic heart disease.  Review of the medical record revealed a Physician's order written on 01/22/18 to apply a liquid film-forming dressing to both heels twice a day and to keeps heels floated. An order was written on 01/28/18 to make Hospice aware of the area on Resident #1* sight heel and opened up and was approximately 2.0 cm

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:					
			A. BOILDING			
		NH0476	B. WING		03/16	6/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
CDACE D	IDCE	500 LENG	OIR ROAD			
GRACE R	IDGE	MORGAN	ITON, NC 28655	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
L 076	protective foam dress 03/09/18 the nurse no	e 7 sing had been applied. On oted a black area on the 2nd right foot and had informed	L 076	5. Resident #1  *How corrective action was accomplishe affected resident Care plan was updated to include care of the corrections are considered.	of pressure	3/19/18
	Continued review of F on 03/09/18 a culture an oral antibiotic was	Physician's orders revealed of right heel drainage and ordered. In addition, an was written for the pressure		*Identify other residents with potential to affected  (1) DON reviewed 100% of other resid pressure ulcers to ensure care plan including pressure ulcer. No others residents in the assures to be put in place to prevent	lents with uded care	3/19/18
	ulcers on Resident #1 on his right foot.  Review of Resident # there was no care plathe pressure ulcers of An interview with the on 03/15/18 at 11:10. Resident #1's right here.	1's right heel and the 2nd toe  1's care plans revealed in in place that addressed rany interventions.  Director of Nursing (DON)  AM revealed the area on the later area and the area on the 2nd toe		reoccurrence  (1) DON or designee will audit 100% of resident charts that have pressure ulcers that care of pressure ulcer is on the care Weekly review starting the week of 3/26, then every two weeks x two; then month and randomly thereafter as appropriate tongoing compliance with care planning pulcers.  (2) DON or designee will update care president condition changes.  (3) Audit/observations will be presented/discussed at monthly QAPI may no eyear with revisions as necessary.	s to ensure e plan. /18 x four; ily x two to assure pressure plans as	4/2/18
	DON stated the press be care planned and	vere typically updated				
L 078	.2305(C) QUALITY O  10A-13D.2305 (c) The utilize any chemical o restraints for the purp discipline or convenie are not required to tre patient's medical cond evaluation shall be do	e facility shall not r physical ose of ence, and that eat the dition. An	L 078			

Division of Health Service Regulation

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	=1ED
					_ c	
		NH0476	B. WING		03/1	6/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	ITE, ZIP CODE		
GRACE R	IDGE	500 LENOI	R ROAD			
ONAGE IX		MORGANT	ON, NC 2865	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
L 078	that the least restrictive restraint have been in patients requiring restraints. This Rule is not met Based on observation interview, the facility of the least restrictive mander implementation restrain the thighs of wheel chair. Resident the skilled unit who use Findings included:  A physician's telephone to her admission to the indicated, Order reclinated belt.  Resident #6 was adminition 8/9/17. There usage in the skilled not a care plan for falls deproblem for "potential related to lack of safe weakness, unsteady spinocerebellar degendation. Anti-tippers to work on 9/4/17, a physical assessment form was was determined to be restraint elimination, it restraint reduction or was no documentation unrestrained observations.	as evidenced by:  as evidenced as evident in whether the evidence of the evidenc	L 078	Resident #6 *How corrective action accomplished for affected resident (1) Staff education completed for staff of Resident #6 that the velco belt is a reservaint (a) What is a restraint (b) When should restraints be released. (3) MD order obtained for restraint (velocity) (velocity) Education completed for Administrated DON on correctly completing the quarter "Physical Restraint Elimination Assessment" *Identify other residents with potential to affected. No other residents with restraint time  *How will plan be monitored to ensure continued to ensure continued to the resident of the plant in the	straint.  g  sed co belt) tor and y ent"  be ts at this  mpliance rsing ollection on correct for  when it	3/19/18 4/2/18 3/16/18 3/28/18
	On 9/4/17, a physical assessment form was was determined to be restraint elimination, I restraint reduction or was no documentatio	restraint elimination s completed. Resident #6 e a "Good Candidate" for out was marked "No" for elimination program. There n of any attempted tion periods or explanation				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	NH0476	B. WING		03/1	; 6/2018
NAME OF PROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 03/1	0/2010
GRACE RIDGE	500 LENOIR MORGANTO	ROAD ON, NC 28655	;		
PREFIX (EACH DEFICIENCY MUS	IENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
L 078 Continued From page 9 reduction or elimination proportion of the decision not to go freeleased and she fell face intraorbital hematoma belocontused lip."  The Resident Status Collea 1/30/18 and 2/16/18 indicated on Resident #6.  Review of the March 2018 not include an order to use restraint reduction or elimination proportion in the decision in the decision of the decision not to go freduction or elimination of unrestrained observation of the decision not to go freduction or elimination of the decision not to go freduction or elimination or decision or elimination eliminatio	straint elimination mpleted. Resident #6 Good Candidate" for was marked "No" for ination program. There any attempted periods or explanation forward with the rogram.  ote dated 1/16/18 ortunately she fell out of forward. Velcro belt e forward; has a large low right eye with a  ection Tools dated cated restraints were not  8 physician orders did ea a Velcro strap to ghs.  traint elimination mpleted. Resident #6 Good Candidate" for was marked "No" for ination program. There any attempted periods or explanation forward with the rogram.  ed on 3/15/18 at 1:02 PM	L 078			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
			A. BUILDING:	A. BUILDING.		
		NH0476	B. WING		03	C / <b>16/2018</b>
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	= ZIP CODE		
			DIR ROAD	-, ZII		
GRACE R	IDGE	MORGAN	ITON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
L 078	Continued From page	± 10	L 078			
	Interview of NA #1 at					
		8, NA #2 stated Resident #6 p fastener strap because all over.				
	with a Velcro strap ap She was in the dining other residents and o	erved on 3/16/18 at 8:10 AM plied across her thighs. room at a table with three ne staff member who was dent with breakfast.				
	assisting another resident with breakfast.  Nurse #1 was interviewed on 3/16/18 at 10:00  AM. She said the purpose of the Velcro strap was to remind Resident #6 she should not get up. She said she can take it off on her own. "It is not a restraint." She said Resident #6 will remove it more in the evenings and said she thought she had it in the assisted living unit. She said if it is irritating to her, we take it off.					
	with the Velcro strap a the presence of Nurse asked what the belt w remove it, she could r Resident #6 by tappir take the seat belt off,	erved on 3/16/18 at 8:10 AM applied across her thighs. In e #1, Resident #6 was as and when asked to not. When Nurse #1 cued ag the belt and asked her to then Resident #6 was able She was also able to close it				
	were interviewed on 3 Administrator said the implemented when Reassisted living. She her nose. The Admin	d Director of Nurses (DON) 8/16/18 at 10:30 AM. The 9 Velcro belt was 9 esident #6 was a resident in 10 had fallen forward and hurt 10 istrator said we do think it is 10 N said the purpose was to				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			<u>.</u>
		NH0476	B. WING			6/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GRACE R	IDGE	500 LENOI	R ROAD ON, NC 28655	<b>.</b>		
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETE DATE
L 078	Collection Data Tool r	n forward. Both the N confirmed the Resident marking for no restraint was cal Restraint Elimination nolude any documented straint reduction or gh Resident #6 was	L 078	DEFICIENCE		

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