Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	1 ' '	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		C		
		NH0476	B. WING		1	9/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
GRACE R	IDGE	500 LENOI	R ROAD ON, NC 28655	•			
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)	
PREFIX TAG	,	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 000	INITIAL COMMENTS		L 000				
	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 049	.2210(A) REPORTING ABUSE, NEGLECT	G, INVESTIGATING	L 049				
	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.						
	facility failed to protect from abuse for 2 of 2 Resident #6).	ew and staff interview the ct a resident's right to be free residents (Resident #5 and					
	at 1:18 PM revealed sinstances in which NA residents. She stated observed when she won 9/24/22. The Section 1:18 PM revealed sinstances in which is a section of the sectio	acility Secretary on 11/8/22 she witnessed 2 different A #1 was inappropriate with					

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			, i. Bolebiito.		c	
		NH0476	B. WING		11/09/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GRACE R	IDGF	500 LENC	DIR ROAD			
		MORGAN	ITON, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
L 049	Continued From page	e 1	L 049			
	The facility secretary resident's room and somechanical stand-up. She stated Resident tight as the mechanic circle by NA #1. The mechanical lift could. Secretary stated the day (9/25/22). She on her wheelchair at the #5 was asking to go to the Secretary stated Reseasked about going to was observed to be some station. The Secretary take Resident #5 to the secretary stated Research was research	stated she peeked in the saw Resident #5 on a lift that had wheels on it. #5 was observed hanging on all lift was rolled quickly in a way NA #1 quickly rolled the have hurt Resident #5. The 2nd instance was the next bserved Resident #5 sitting nursing station. Resident o the restroom. The ident #5 would frequently the toilet or to bed. NA #1 standing at the nursing y stated she asked NA #1 to				
	she also recalled NAs	on 11/8/22 at 1:45 PM stated #1 telling Resident #5 that od on 9/24/22. #1 as being irritated on				
	stated that on 9/17/22 room. She stated the the nursing station. In heard NA #1 getting I was overheard saying nurse said so" and "y bed." Nurse #1 state nursing station, NA #1 Interview with NA #2 NA #1 was getting agresidents on the unit residents who were defined the state of the state o	se #1 on 11/8/22 at 1:04 PM 2 she was in the medication ere were multiple residents at Nurse # 1 sated that she oud with a resident. NA#1 g things like, "because my ou are not going back to d when she arrived to the 1 was talking to Resident #6. on 11/8/22 at 1:45 PM stated gravated by a couple of to include Resident #6. The lescribed as confused by NA wanted to go to bed. NA #2				

Division of Health Service Regulation

STATE FORM 6899 TQEB11 If continuation sheet 2 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					С
		NH0476	B. WING		11/09/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		500 LENOII	R ROAD		
GRACE R	IDGE	MORGANT	ON, NC 28655	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 APPROPR DEFICIENCY)	BE COMPLETE
L 049	Continued From page	2	L 049		
	stated NA #1 snapped "other people may ba described NA #1 as to hatefully. NA #2 reve	d at the residents and said, by you but I'm not." She also urning resident's wheelchair valed she communicated to have to treat the residents			
L 050	.2210(B) REPORTING ABUSE, NEGLECT	G, INVESTIGATING	L 050		
	Division of Health Ser within 24 hours of the	acility shall ensure that the rvice Regulation is notified facility's becoming aware of thealth care personnel of 131E-256(a)(1).			
	facility failed to report	as evidenced by: ew and staff interview the allegations of abuse within mpled residents (Resident			
	The findings included	:			
	concern" was sent to Administrator and the The email revealed the concerned about the that she witnessed.	6/22 written by the bject "SEPTEMBER 25th recipients to include the Director of Nursing (DON). The Secretary was very neglect and verbal abuse The concern further revealed certain residents could be			

Division of Health Service Regulation

STATE FORM 6899 TQEB11 If continuation sheet 3 of 12

Division of Health Service Regulation

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		NH0476	B. WING		11/09/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GRACE R	IDGE	500 LENOI				
			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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
L 050	Continued From page	e 3	L 050			
	(identity not provided over and was being of hindsight she should and aggressive way to provided) was spun at the day before by this (NA) (identify not provided) was not are observation. Her knut to hold on to the lift. It treated a resident the observe this specific do, she would expect same and honestly, so more people did". The of negligent treatment hat the Secretary has centered around one	but this specific resident) was asking nicely over and completely ignored. In have reported the yelling hat this resident (identity not percent of the same Nursing Assistant wided). She was clinging to pere death. The email of the exaggeration, it was an peckles were white just trying. The Secretary wrote, "If I have way that she continued to the would appreciate it if the email revealed, every bit to roverbal/emotional abuse do witnessed was always NA (identity not provided). The same Nursing Assistant wided) and the same of the email of the email of the email revealed, every bit to roverbal/emotional abuse do witnessed was always NA (identity not provided).				
	an allegation of abuse allegation stated NA is to Resident #5 in a di a harsh tone and had mechanical lift to take NA#1 had jerked the had white knuckles. The facility became as	e occurred on 9/24/22. The #1 was overheard speaking srespectful way. NA #1 had gotten resident on a e Resident #5 to the toilet. lift around and Resident #5 The report further revealed ware of the allegation on The 24-hour report was not				
	1:18 PM revealed she instances in which sh inappropriate with resincident was observe newspapers on 9/24/	ility Secretary on 11/8/22 at e witnessed 2 different e witnessed NA #1 was sidents. She stated the 1st d when she was delivering 22. The Secretary revealed welling and telling Resident				

Division of Health Service Regulation

STATE FORM 6899 TQEB11 If continuation sheet 4 of 12

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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					С
		NH0476	B. WING		11/09/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		500 LENOI	R ROAD		
GRACE R	IDGE	MORGANT	ON, NC 28655	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 COMPLETE
L 050	Continued From page	e 4	L 050		
L 050	peeked in the residen #5 on a mechanical son it. She stated Reshanging on tight as the quickly in a circle by Neurolled the medical son it. She stated Reshanging on tight as the quickly rolled the medical Resident #5. The Seinstance was the next observed Resident #5 the nursing station. For the restroom. The #5 would frequently a toilet or to bed. NA # standing at the nursing stated she asked NA the bathroom. NA #1 Minute" and was short she had received about and she should have Interview with NA #2 NA #1 described NA incident (9/24/22). She incident #6. The rest as confused by NA #2 go to bed. NA #2 states.	ility secretary stated she It's room and saw Resident tand-up lift that had wheels sident #5 was observed he mechanical lift was rolled NA #1. The way NA #1 chanical lift could have hurt cretary stated the 2nd t day (9/25/22). She 5 sitting her wheelchair at Resident #5 was asking to go e Secretary stated Resident lisked about going to the	L 050		
	but I'm not". She also	o described NA #1 as turning			
		hatefully. NA #2 revealed			
		NA #1 that she didn't have that way. She also told			
		wasn't in the mood today.			
		vas supposed to report			
	incidents of abuse to				
		dent to the DON or the			
		dicated that she had not			
		but Nurse #1 was aware			
		ould have told. She further			

Division of Health Service Regulation

STATE FORM 6899 TQEB11 If continuation sheet 5 of 12

Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	=TED
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		NH0476	B. WING		11/0	9/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		500 LENC	IR ROAD			
GRACE R	IDGE	MORGAN	TON, NC 28655	5		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	COMPLETE DATE
L 050	Continued From page	e 5	L 050			
	rocalled the Administr	rator contacting the facility to				
	discuss how to treat r					
	Intomious with the DO	N on 11/8/22 at 2:21 PM				
	_	report instances of abuse				
		isor in the instance she or				
		not in the building. She				
		Administrator and herself				
	that conducted invest	igations. In the instance it				
	was blatant abuse the	e facility would suspend the				
		tated she became aware of				
	_	Resident #5 on Monday				
	, ,	ame into work. She stated				
	T	dent to be reported the day				
		The Secretary should have				
	I	on Saturday (9/24/22). She not getting emails on her				
		e Administrator that would				
	•	he email dated 9/26/22 from				
		tions were to be reported to				
		agency within 24 hours of				
	the facility knowledge	of the allegation.				
	2. Review of the facili	ties 5-day working report				
	(investigation) dated					
	attached witness stat	ement dated 9/27/22 written				
	by Nurse # 1 who sta					
	approximately 1:30pm					
		e overheard NA #1 get very				
		hat seamed harsh in tone				
		vitness statement further				
		mments such as, because I I am doing my job, no we				
	_	ack in bed, that is enough				
		we are not putting you back				
	· ·	statement continued that as				
		e corner, she noted both NA				
		itting at their desk with				
		ng in wheelchairs in the				
		nly then Nurse # 1 realized				

Division of Health Service Regulation

STATE FORM 6899 TQEB11 If continuation sheet 6 of 12

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		NH0476	B. WING		C 11/09/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
ODAGE D	IDOE	500 LENOI	R ROAD		
GRACE R	IDGE	MORGANT	ON, NC 28655	i	
(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 050	Continued From page	e 6	L 050		
L 050	#1 revealed Resident understand I can't go statement further reve "we will be very lucky into the office over the got to learn some pat speaking to her in the respectful and not accreturn to Nurse #1 the how the residents we Review of NA #1's Te revealed "problem ide reported by a teamma concerned with NA # (identification not proposerved you speaking while the resident was concerned regarding the resident in the lift scared, with hands the This reported incident During the investigation reports expressing the tone of voice; interact frustration and rude at to residents. On 9/17 brought you into the conversation with Resoverheard you speak stern, and somewhat observed interactions or our resident's right	aking to Resident # 6. Nurse #6 said, "I just don't to bed". The witness ealed Nurse #1 told NA #1, if we both don't get called at episode, you have either ients or walk away, that it way was not right, not ceptable". NA #1 stated in at Nurse #1 had not heard re calling her Expletives. Traination dated 10/3/22 entification" that stated it was ate that they were 1's interaction with a resident wided) on 9/24/22. They had harshly to the resident is in the lift. They were also the way you were handling. The resident appeared at were clenched and white. It led to an investigation. On they received other esame concerns regarding itons; your expressed and disrespectful statements 1/22, the charge nurse office after overhearing your sident #6. The charge nurse ing to the resident in a loud, harsh tone. These reported to not support our behavior is policy.	L 050		
	stated that on 9/17/22 room. She stated the the nursing station.	#1 on 11/8/22 at 1:04 PM 2 she was in the medication are were multiple residents at 3 Jurse # 1 sated that she 3 Jury with a resident NA#1			

Division of Health Service Regulation

STATE FORM 6899 TQEB11 If continuation sheet 7 of 12

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			_	C	
		NH0476	B. WING		11/09/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
GRACE R	IDGE	500 LENOII			
			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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
L 050	Continued From page	e 7	L 050		
	was overheard saying nurse said so", and ") bed". Nurse #1 state nursing station, NA # Nurse #1 stated she If the oncoming nurse or reported the incident she should have reported the incident she should have reported the witness state age facility knowledge of the facility was not may that occurred dated 9 the investigation into 9/25/22 in which a with provided. The incident reported immediately 24 hours of the facility Interview with the Adra AM revealed allegation.	g things like, because my you are not going back to d when she arrived to the 1 was talking to Resident #6. had reported the incident to during report. She had not to management. She stated orted the incident prior to atement on 9/27/22. Who on 11/8/22 at 2:21 PM were to be reported to the ncy within 24 hours of the the allegation. She stated hade aware of the incident /17/22 until the facility began the incident reported for thess statement was nt should have been and was not reported within			
	the facilities knowledge the staff were respon-	ge. The Administrator stated sible for communicating			
L 051	ABUSE, NEGLECT 10A-13D.2210 (c) A f allegations of any act (1), shall document a	G, INVESTIGATING acility shall investigate listed in G.S. 131E-256(a) Il information pertaining to ad shall take the necessary er incidents while the	L 051		

Division of Health Service Regulation

STATE FORM 6899 TQEB11 If continuation sheet 8 of 12

Division of Health Service Regulation

AND PLAN OF CORRECTION) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING: COMP		SURVEY PLETED	
		A. BOILDING.			_
	NH0476	B. WING		11	C / 09/2022
ANALE OF PROMETE OF SUPPLIER			TE 7/2 0025		700/2022
NAME OF PROVIDER OR SUPPLIER		ODRESS, CITY, STA	TE, ZIP CODE		
GRACE RIDGE		DIR ROAD ITON, NC 28655	•		
0.0000000000000000000000000000000000000		.		PRESTIGNA	
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
L 051 Continued From page 8		L 051			
This Rule is not met as a Based on record review a facility failed to safeguard allegation of abuse for 1 #5). The findings included: An email dated 9/26/22 v with the subject "SEPTEI was sent to recipients to and the Director of Nursii began stating the Secrei bothering administration (9/25/22). The email revivery concerned about the abuse that she witnessed revealed she understood could be challenging at tiresident (identity not provover and over and was be in hindsight she should he and aggressive way that provided) was spun acrothe day before by this sa (NA) (identify not provided the lift and looked scared stated this was not an exobservation. Her knuckle to hold on to the lift. The treated a resident the was observe this specific NA do, she would expect sor same and honestly, she was not an exobserve this specific NA do, she would expect sor same and honestly, she was not an exobserve this specific NA do, she would expect sor same and honestly, she was not an exobserve this specific NA do, she would expect sor same and honestly, she was not an exobserve this specific NA do, she would expect sor same and honestly, she was not an exobserve this specific NA do, she would expect sor same and honestly, she was not an exobserve this specific NA do, she would expect sor same and honestly, she was not an exobserve this specific NA do, she would expect sor same and honestly, she was not an exobserve this specific NA do, she would expect sor same and honestly, she was not an exobserve this specific NA do.	and staff interview the diresidents following an of 2 residents (Resident of 2 residents) (Resident of 3 resident) (Resident of 3 resident) (Resident of 3 resident) (Resident of 3 resident) (Resident) (Resident of 3 resident) (Resident) (

Division of Health Service Regulation

STATE FORM 6899 TQEB11 If continuation sheet 9 of 12

Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		, ,	E SURVEY PLETED
						С
		NH0476	B. WING		11	1/09/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
GRACE R	IDGE		OIR ROAD			
	-	MORGAN	NTON, 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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
L 051	Review of 24-hour repan allegation of abuse allegation stated NA to Resident #5 in a dia harsh tone and had mechanical lift to take NA#1 had jerked the had white knuckles. The facility became as 9/25/22 at 2:00PM. Review of the facilitie (investigation) dated attached witness state 9/28/22 that stated shresident neglect from (9/24/22). NA #1 had negative attitude and was kind of rude speacouple of residents with her, if she was of talking to them rude. continued that at 12:3 another resident and tell all day that NA #1 brought her outside is while letting it interfer residents. Interview with the facilitie instances in which shinappropriate with residents with residents with residents.	d witnessed was always NA (identity not provided). port dated 9/28/22 revealed e occurred on 9/24/22. The #1 was overheard speaking srespectful way. NA #1 had gotten resident on a e Resident #5 to the toilet. Ifft around and Resident #5 The report further revealed ware of the allegation on s 5-day working report 10/3/22 revealed an ement by NA # 2 dated he witnessed verbal abuse, NA #1 on Saturday come into work with a poor body language. NA #1 haking with residents. A here asking what was wrong k, or telling her to stop The witness statement to PM NA #1 yelled at told her to stop. NA#2 could was aggravated and seues and feelings to work	L 051			
	she heard someone y	22. The Secretary revealed relling and telling Resident illity secretary stated she				

Division of Health Service Regulation

STATE FORM 6899 TQEB11 If continuation sheet 10 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: C NH0476 B. WING 11/09/202	
NH0476 B. WING C 11/09/202	
NH0476 B. WING 11/09/202	
11/03/202	000
	022
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
CRACE PIDGE 500 LENOIR ROAD	
GRACE RIDGE MORGANTON, NC 28655	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X5) COMPLETE DATE
L 051 Continued From page 10 L 051	
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 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 tollet 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.	

Division of Health Service Regulation

STATE FORM 6899 TQEB11 If continuation sheet 11 of 12

Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
			A. BUILDING			С
		NH0476	B. WING		11	/ 09/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GRACE R	IDGE	500 LENC				
			TON, 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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 051	Continued From page	e 11	L 051			
	abuse on 9/25/22, 9/2 Interview with the Dire	following the allegation of 26/22 and 9/27/22. ector of Nursing (DON) on vealed the facility had not				
	allegation of abuse. Sinvestigation revealed was allowed to continuthe investigation date	I there was a concern; she ue to work. As a result of d 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.					

Division of Health Service Regulation

STATE FORM 6899 TQEB11 If continuation sheet 12 of 12