Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED		
					С
		NH0476	B. WING		11/09/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE	
GRACE R	IDGE	500 LENC	IR ROAD TON, NC 2865	.	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
L 000	INITIAL COMMENTS		L 000		
	was conducted from 1 11-9-2022. Event ID# intake was investigate	nplaint investigation survey 11-7-2022 through FTQEB11. The following ed NC 000193966. 1 of 1 were substantiated resulting			
L 049	.2210(A) REPORTING ABUSE, NEGLECT	G, INVESTIGATING	L 049		
	to prevent patient abu	e screening of and			
	facility failed to protect from abuse for 2 of 2 Resident #6).	ew and staff interview the et a resident's right to be free residents (Resident #5 and			
	at 1:18 PM revealed s instances in which NA residents. She stated observed when she w	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 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BOILDI			
		NH0476	B. WING		C 11/09/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
GRACE R	IDGE	500 LENC	IR ROAD		
		MORGAN	TON, NC 28655	i	
(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 049	Continued From page	e 1	L 049		
	someone yelling and The facility secretary resident's room and smechanical 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 oher wheelchair at the #5 was asking to go to Secretary stated Resasked about going to was observed to be station. The Secretary take Resident #5 to the secretary stated Resastation.	telling Resident #5 to get up. stated she peeked in the saw Resident #5 on a lift that had wheels on it. #5 was observed hanging on sal 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			
	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.				
	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 # Interview with NA #2 NA #1 was getting agresidents on the unit	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			

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 AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING		С	
		NH0476	B. WING		11/09/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GRACE R	IDGE	500 LENOI				
0.0.02.0			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 APPROPF 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	vanted to go to bed. NA #2 d at the residents and said, by you but I'm not." She also urning resident's wheelchair aled 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 vice Regulation is notified facility's becoming aware of thealth care personnel of 131E-256(a)(1).				
	facility failed to report 24 hours for 2 of 2 sa #5, Resident #6).	ew and staff interview the allegations of abuse within mpled residents (Resident				
	concern" was sent to Administrator and the The email revealed th concerned about the	6/22 written by the bject "SEPTEMBER 25th recipients to include the Director of Nursing (DON).				

Division of Health Service Regulation

STATE FORM 6899 TQEB11 If continuation sheet 3 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		NH0476	B. WING		11/09	9/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GRACE R	IDGE	500 LENOII	R ROAD ON, NC 28655	•		
	CUMMADVCT		·			
(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 050	Continued From page	e 3	L 050			
	she understood that of challenging at times, (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 the lift and looked scatted this was not are observation. Her knut to hold on to the lift, treated a resident the observe this specific do, she would expect same and honestly, so more people did". The of negligent treatment that the Secretary has	certain residents could be but this specific resident was asking nicely over and completely ignored. In have reported the yelling hat this resident (identity not cross the room on her lift as same Nursing Assistant wided). She was clinging to cared to death. The email an exaggeration, it was an ackles were white just trying The Secretary wrote, "If I way that she continued to NA (identify not provided) someone else to do the he would appreciate it if the email revealed, every bit to roverbal/emotional abuse di witnessed was always NA (identity not provided).				
	an allegation of abuse allegation stated NA at to Resident #5 in a dia a 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. The submitted until 9/28/2 Interview with the factoristances in which shinappropriate with resincident was observed.	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				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					С	
		NH0476	B. WING		11/09/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE		
		500 LENO		,		
GRACE R	IDGE		TON, NC 28655	5		
	OLIMANA DV OT				DN	
(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 SHOUL CROSS-REFERENCED TO THE APPROFINE DEFICIENCY)	D BE COMPLETE	
L 050	Continued From page	e 4	L 050			
	she heard someone y #5 to get up. The face peeked in the resident #5 on a mechanical son it. She stated Resident hanging on tight as the quickly in a circle by the quickly rolled the mechange Resident #5. The Se instance was the nex observed Resident #8 the nursing station. For to 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 shot she had received abu	relling and telling Resident ility secretary stated she it's room and saw Resident tand-up lift that had wheels sident #5 was observed be mechanical lift was rolled NA #1. The way NA #1 chanical lift could have hurt cretary stated the 2nd it day (9/25/22). She is sitting her wheelchair at Resident #5 was asking to go as Secretary stated Resident sked about going to the				
	Interview with NA #2 NA #1 described NA incident (9/24/22). Sl by a couple of resider Resident #6. The resident with the resident as confused by NA #2 go to bed. NA #2 staresidents and said, "obut I'm not". She also resident's wheelchair she communicated to to treat the residents Resident #5 that she NA #2 revealed she wincidents of abuse to communicate the incidents. She incidents of she incidents of she incidents.	on 11/8/22 at 1:45 PM stated #1 as irritated the day of the ne was getting aggravated ats on the unit to include sidents who were described 2 were saying they wanted to ted NA #1 snapped at the other people may baby you be 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.				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		, ,	E SURVEY PLETED		
				A. BUILDING:		C	
		NH0476	B. WING		11	1/09/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	. ZIP CODE	•		
			OIR ROAD	, 0052			
GRACE R	IDGE		NTON, NC 28655				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	COMPLETE DATE	
L 050	Continued From page	e 5	L 050				
	and that's who she w	ould have told. She further					
		rator contacting the facility to					
	discuss how to treat i						
	alcoded flow to troat i	regidente en erzerzz.					
	Interview with the DC	N on 11/8/22 at 2:21 PM					
	revealed staff were to	report instances of abuse					
		risor in the instance she or					
	the Administrator was	s not in the building. She					
		Administrator and herself					
		tigations. In the instance it					
		e facility would suspend the					
		tated she became aware of					
		Resident #5 on Monday					
	, ,	ame into work. She stated ident to be reported the day					
	T	The Secretary should have					
		on Saturday (9/24/22). She					
	1 -	not getting emails on her					
		e Administrator that would					
	1 .	the email dated 9/26/22 from					
	the Secretary. Allega	tions were to be reported to					
	the appropriate state	agency within 24 hours of					
	the facility knowledge	e of the allegation.					
	2. Review of the facil	ities 5-day working report					
	(investigation) dated						
	attached witness stat	ement dated 9/27/22 written					
	by Nurse # 1 who sta	ited on 9/17/22 at					
	approximately 1:30pr						
		e overheard NA #1 get very					
		hat seamed harsh in tone					
		witness statement further					
		mments such as, because					
	_	d I am doing my job, no we					
		ack in bed, that is enough d we are not putting you back					
	T -	statement continued that as					
		e corner, she noted both NA					
		itting at their desk with					
		ing in wheelchairs in the					

Division of Health Service Regulation

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(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		
GRACE R	IDGE	500 LENOI	R ROAD			
ONAGE IX		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	NA #1 had been spear #1 revealed Resident understand I can't go statement further revealed resident understand I can't go statement further revealed "we will be very lucky into the office over the got to learn some pat speaking to her in the respectful and not accept the following the residents we revealed "problem idea reported by a teamma concerned with NA #1 (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. rmination dated 10/3/22 entification" that stated it was ate that they were I's interaction with a resident wided) on 9/24/22. They ng 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 e same concerns regarding tions; your expressed nd disrespectful statements if 22, the charge nurse office after overhearing your sident #6. The charge nurse ing to the resident in a loud, harsh tone. These reported do not support our behavior	L 050			
	stated that on 9/17/22 room. She stated the	#1 on 11/8/22 at 1:04 PM 2 she was in the medication are were multiple residents at Jurse # 1 sated that she				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPL	EIED
		NH0476	B. WING		11/0	; 9/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GRACE R	IDGE	500 LENOII				
		MORGANT	ON, NC 28655	5		
(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 050	Continued From page	e 7	L 050			
	heard NA #1 getting I was overheard saying nurse said so", and "y bed". Nurse #1 state nursing station, NA # Nurse #1 stated she I the oncoming nurse or reported the incident she should have repowriting her 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 facilities Interview with the Adra AM revealed allegation to the appropriate state the facilities knowledge.	oud with a resident. NA#1 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. N on 11/8/22 at 2:21 PM were to be reported to the ency within 24 hours of the the allegation. She stated ade aware of the incident v/17/22 until the facility began the incident reported for tness statement was nt should have been and was not reported within les knowledge. ministrator on 11/9/22 at 9:08 ons of abuse were to report te agency within 24 hours of tge. The Administrator stated sible for communicating				
L 051	.2210(C) REPORTIN ABUSE, NEGLECT	G, INVESTIGATING	L 051			
	allegations of any act (1), shall document a					

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Division of Health Service Regulation

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S ND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPL A RUM PLAN OF CORRECTION COMPL COMPL		SURVEY			
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _	A. BUILDING:		LETED
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		NH0476	B. WING		11	/09/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	ΓE, ZIP CODE		
		500 LENG	OIR ROAD			
GRACE R	IDGE	MORGAN	NTON, NC 28655			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		COMPLETE DATE
				DEFICIENCY)	
L 051	Continued From page	. 8	L 051			
2001	Continued i form page	5 0	2001			
	This Rule is not met	as avidanced by:				
		ew and staff interview the				
		uard residents following an				
	, ,	r 1 of 2 residents (Resident				
	#5).					
	,					
	The findings included	:				
		22 written by the Secretary				
	-	TEMBER 25th concern"				
		to include the Administrator				
		ursing (DON). The email				
		cretary apologized for ion on Sunday morning				
		revealed the Secretary was				
		t the neglect and verbal				
	_	ssed. The concern further				
		ood that certain residents				
	could be challenging	at times, but this specific				
	resident (identity not p	provided) was asking nicely				
	over and over and wa	s being completely ignored.				
	In hindsight she shou	ld have reported the yelling				
		hat this resident (identity not				
	, , , ,	cross the room on her lift				
		s same Nursing Assistant				
		vided). She was clinging to				
		ared to death. The email				
		n exaggeration, it was an ckles were white just trying				
		The Secretary wrote, "If I				
		way that she continued to				
		NA (identify not provided)				
	-	someone else to do the				
		he would appreciate it if				
	-	email revealed, every bit of				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		NH0476	B. WING		C 11/09/2022	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	11100/2022	\neg
ODAGE D	IDOE	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	:
L 051	that the Secretary had centered around one 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 whith 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 facilities in the proportion of the provided in the shresidents.	or verbal/emotional abuse d witnessed was always NA (identity not provided). port dated 9/28/22 revealed a occurred on 9/24/22. The #1 was overheard speaking srespectful way. NA #1 had gotten resident on a a Resident #5 to the toilet. lift around and Resident #5 the report further revealed ware of the allegation on see 5-day working report 10/3/22 revealed an ement by NA # 2 dated he witnessed verbal abuse, NA #1 on Saturday a come into work with a poor body language. NA #1 aking with residents. A here asking what was wrong k, or telling her to stop. The witness statement told her to stop. NA#2 could was aggravated and seues and feelings to work	L 051			
		22. The Secretary revealed relling and telling Resident				

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Division	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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		NH0476	B. WING		11/09/2022	
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NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	1	
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GRACE R	IDGE	MORGAN	ITON, NC 2865	5		
			17011, 110 20001			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	()	
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		
TAG	REGULATORY OR I	LOC IDENTIFY TING INFORMATION)	TAG	DEFICIENCY)	VIAIL 57.112	
				/		
L 051	Continued From page	10	L 051			
	oonanaoa i rom paga					
	#5 to get up. The fac	ility secretary stated she				
		it's room and saw Resident				
		tand-up lift that had wheels				
		sident #5 was observed				
		e mechanical lift was rolled				
		NA #1. The way NA #1				
	quickly rolled the med	chanical lift could have hurt				
	Resident #5. The Se	cretary stated the 2nd				
	instance was the nex	•				
		5 sitting her wheelchair at				
		-				
		Resident #5 was asking to go				
		Secretary stated Resident				
	#5 would frequently a	sked about going to the				
	toilet or to bed. NA#	1 was observed to be				
	standing at the nursin	g station. The Secretary				
	•	#1 to take Resident #5 to				
		responded by saying, "in a				
		rt. The Secretary stated that				
		ise 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				
		ne was getting aggravated				
	, , ,	nts on the unit to include				
	'	sidents who were described				
		sidents who were described				
	as confused by					
		ey wanted to go to bed. NA				
	#2 stated NA #1 snap	ped at the residents and				
	said, "other people m	ay baby you but I'm not."				
	I	A #1 as turning resident's				
	wheelchair hatefully.	•				
	_	#1 that she didn't have to				
	treat the residents tha					
		wasn't in the mood today.				
	NA #2 revealed she v	vas supposed to report				
	incidents of abuse to	the nurse who would				
		dent to the DON or the				
	Administrator.					
	, willing a dioi.		I		1	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		NU0476	B. WING		C 44/00/0000
NAME OF P	ROVIDER OR SUPPLIER	NH0476 STREET ADD	RESS, CITY, STA	TE. ZIP CODE	11/09/2022
GRACE R	IDGE	500 LENOI	R ROAD		
			ON, NC 2865		
(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 051	Continued From page	e 11	L 051		
L 051	Review of the facilitie NA #1 worked 3 days abuse on 9/25/22, 9/2 Interview with the Director of 11/8/22 at 2:21 PM received NA #1 from allegation of abuse. Sinvestigation revealed was allowed to continuthe investigation date from the schedule on Interview with the Adr AM revealed NA#1 w following the allegation	s staffing schedule revealed following the allegation of 26/22 and 9/27/22. ector of Nursing (DON) on evealed the facility had not her duties following the She stated until the dithere was a concern; she use to work. As a result of d 9/28/22 she was removed	L 051		

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