STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigations from 08/06/24 through 08/09/24 and 08/13/24 through 08/14/24.	D 000		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on interviews the facility failed to ensure personal care was provided related to residents being left in incontinence briefs for extended periods of time. The findings are: Interview with a resident's family member on 08/08/24 at 2:28pm revealed: -Her family member did not have her incontinence brief changed regularly. -The other morning she came to the Special Care Unit (SCU) and when her family member got out of bed, urine dripped all over the floor as she walked to the bathroom. Interview with a personal care aide (PCA) on 08/13/24 at 9:51am revealed: -She documented a date and time on all of the residents' adult briefs when she provided incontinence care.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 1	D 269		

-Ninety percent of the time when she came to work in the morning the residents' briefs were soaking wet and it appeared they had not been provided with incontinence care through the night.
-She reported the 2nd and 3rd shift staff to the Special Care Coordinator (SCC) for not providing assistance with incontinence care.
-Family members told her they had spoken with the SCC about incontinence care not being provided to the residents and management did not do anything about it.

Interview with a medication aide (MA) on 08/14/24 at 7:45am revealed:
-She worked 1st shift.
-About a month ago when she observed one resident wearing an incontinence brief that had been dated and timed for the previous day on 1st shift, which meant that the resident wore the same brief for all of 2nd shift and all of 3rd shift before incontinence care was provided.
-When staff provided incontinence care during first shift they initialed, dated, and timed to show when a resident's brief was changed before the end of a shift.
-The majority of residents on the SCU were "soaking wet", along with their bed linens, when she arrived for her shift 4 out of 5 days of the week.
-The briefs were still dated and timed for the previous day at the end of 1st shift.
-Many of the residents required extra showers because they were covered with and smelled like urine.
-She took pictures of the soaking wet briefs and texted the pictures to the SCC about a month ago.

Interview with the Administrator on 08/14/24 at 9:35am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 2 -Neither the SCC or the Resident Care Coordinator (RCC) informed him incontinence briefs were not being changed timely, resulting in residents' skin being exposed to urine for extended periods of time. -A family member informed him on 06/09/24 they were upset because their family member was found sitting in a chair in the hallway "wet" and a staff member was in the resident's room sitting on the couch using their cell phone. -PCAs were trained to check residents at least every two hours but were not required to document it anywhere. -The PCAs were supposed to round on all the residents and check to see if incontinence care was needed when a shift to shift report was completed. -The RCC and SCC were responsible for ensuring PCAs were checking residents but there was so much happening during shifts it was not getting done.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: FOLLOW-UP TO A TYPE A1 VIOLATION Based on these findings, the previous A1 Violation was not abated.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 3 Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 5 residents (#1 and #3) who had a history of falls with no additional safety interventions ordered or implemented to minimize future falls. The findings are: Review of the facility's undated policy and procedures for falls management revealed: -Residents would be assessed upon admission/readmission to determine fall risk status. -Residents who experienced a significant change will be reassessed to determine fall risk status. -The completed assessment would be reviewed by the Resident Care Coordinator (RCC) and discussed with the supervisor-in-charge. -If the resident assessed was at risk for falls, had experienced a recent fall, or had a history of falls, interventions would be identified and implemented. -The resident, responsible party, family members, would participate in/review the interventions. 1. Review of Resident #1's current FL2 dated 07/12/24 revealed: -Diagnoses included dementia and seizure disorder. -Current level of care was documented as special care unit (SCU). -Orientation was documented as constantly disoriented. -There was documentation Resident #1 was ambulatory and had a history of wandering behaviors. Review of Resident #1's undated Resident Register revealed:	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 4	D 270		

-There was no documentation of an admission date to the facility.
-Resident #1 had a power of attorney that signed and dated the Resident Register on 07/27/21.

Review of Resident #1's care plan dated 08/02/24 revealed:
-There was documentation Resident #1 was totally dependent on all activities of daily living (ADL's).
-The functional status related to the resident fell more than twice in the last month was documented as "yes".
-There was documentation Resident #1 demonstrated changes in her gait.

Review of Resident #1's Incident and Accident report (I/A) dated 07/02/24 at 10:30am revealed:
-Resident #1 had an unwitnessed fall and was found lying on the floor next to her bed.
-She was alert but not responsive and had "slight twitching" in her legs.
-There was no documentation of any injuries or first aid administered.
-The POA and hospice registered nurse (RN) were notified.
-There was no documentation any interventions were put into place for Resident #1.

Review of Resident #1's I/A report dated 07/17/24 at 9:15am revealed:
-Resident #1 had an unwitnessed fall and was found lying on the bathroom floor in another resident's room.
-There was documentation the hospice RN assessed Resident #1.
-There were no injuries found and no first aid was administered.
-The POA and hospice RN were notified.
-There was no documentation any intervention

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 5	D 270		

were put into place for Resident #1.

Review of Resident #1's I/A report dated 07/18/24 at 3:20pm revealed:
-Resident #1 had an unwitnessed fall and was found lying on another resident's bathroom shower floor.
-The type of injury was documented as "face and head".
-There was no documentation first aid was administered.
-There was documentation Resident #1 was transported to the emergency department (ED) for an evaluation and treatment.
-The hospice RN was notified.
-The intervention put into place was documented as Resident #1 was transported to the ED at 4:12pm.

Review of Resident #1's ED discharge instructions dated 07/18/24 at 4:35pm revealed:
-The reason for being seen was documented as a fall.
-An x-ray on the left hip was completed with no results documented.
-There was patient education documents provided for fall prevention in the home.

Review of Resident #1's hospice progress notes revealed:
-Resident #1 was admitted to hospice care on 02/07/23.
-Diagnoses included cerebrovascular disease, vascular dementia, history of falling, and a history of seizures.
-On 07/03/24 at 11:54am, the hospice RN documented an x-ray was ordered for Resident #1 due to a previous fall with pain noted to Resident #1's right hip.
-On 07/05/24 at 11:20am, the hospice RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 6	D 270		

documented Resident #1 was alert and oriented to self, independent with mobility, there was no bruising to the right hip, limp to the right leg was less, and Resident #1 had a scattered bruise to the left lower shoulder blade area assumed to be from a recent fall.
-On 07/09/24 at 8:04pm, the hospice social worker documented Resident #1 fell "last week" and required total assistance with all ADLs, was confused, and wandered the SCU during the day.
-On 07/09/24 at 9:01am, the hospice RN documented Resident #1 continued to have a limp with the right leg and rubbed the right leg while walking.
-On 07/10/24 at 12:55pm, a hospice RN documented Resident #1 fell "last week" and had increased pain to the right leg and an x-ray was completed.
-On 07/17/24 at 2:56pm, the hospice RN documented she was notified Resident #1 had an unwitnessed fall and was found by staff.
-She was visiting another resident and went to check on Resident #1 and upon entrance to the room, staff were walking Resident #1 to a chair and noted Resident #1's gait was weak and unsteady and Resident #1 needed increased assistance with mobility.
-On 07/18/24 at 4:48pm, the hospice RN documented the facility notified her that Resident #1 fell and had a large swollen area to the left eye/temple area and complained of leg pain and she called Resident #1's family member and informed the family member of Resident #1's fall on 07/18/24 with injuries including a hematoma to the head and severe pain in the resident's leg and Resident #1 was transported to the ED.
-On 07/23/24 at 7:58pm, the hospice RN documented Resident #1 remained in bed due to a significant decline and was sleeping 18 hours per day, was no longer ambulatory due to multiple

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 7	D 270		

falls occurring on 07/02/24, which required an x-ray of the right hip and pelvis as well as a strong pain medication for pain management, a fall on 07/17/24, and a third fall on 07/18/24 which resulted in Resident #1 not being able to ambulate or eat a full meal per normal or able to feed herself since the last fall occurring on 07/18/24.

Interview with the Special Care Coordinator (SCC) on 08/06/24 at 4:21pm revealed:
-The facility's management staff met weekly on Wednesdays to discuss which residents experienced falls and fall prevention interventions were documented on the I/A report.
-Management did not meet the last 2 weeks to discuss the falls that occurred.
-Resident #1 was added to the 1-hour supervision rounds after falling and the documentation was kept in a notebook at the SCU desk.

Review of the 1-hour supervision rounds notebook revealed:
-Resident #1's name was handwritten on the 1-hour supervision rounding sheet beginning on 07/21/24.
-There was no documentation of 1-hour supervision rounds for Resident #1 occurring after the falls on 07/02/24, 07/17/24, or 07/18/24.

Interview with the Resident Care Coordinator (RCC) on 08/07/24 at 2:53pm revealed:
-A 1-hour supervision rounds notebook was kept at the SCU desk and residents who needed more assistance were added to the 1-hour rounds.
-The SCC was responsible to add Resident #1 to the 1-hour rounds after Resident #1 fell on 07/02/24, 07/17/24, and 07/18/24.
-She did not know why the SCC did not add Resident #1 to the 1-hour rounds notebook until

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 8	D 270		

07/21/24.
-Resident #1 was ambulatory without the use of assistive devices and was not a high fall risk until the first fall occurring on 07/02/24.
-There was no fall prevention interventions ordered or implemented for Resident #1 after the falls on 07/02/24, 07/17/24, or 07/18/24.

Interview with Resident #1's family member on 08/07/24 at 11:13am revealed:
-Resident #1 was ambulatory without the use of assistive devices and experienced 3 falls in July 2024.
-Resident #1 hit her head with the last fall occurring on 07/18/24 and had not walked since the fall on 07/18/24.
-The hospice RN told her Resident #1 was transitioning to the end of life.
-She was not aware of any fall prevention interventions the facility was doing to try to prevent Resident #1 from falling.

Interview with a personal care aide (PCA) on 08/07/24 at 11:29am revealed:
-Resident #1 used to walk laps around the SCU.
-She worked on 07/02/24 and 07/18/24 when Resident #2 fell.
-Resident #1 still ambulated independently until the 3rd fall on 07/18/24.
-A hospice RN told her to "keep an eye" on Resident #1 after Resident #1 fell on 07/02/24 to try to prevent falls.
-She was not instructed by the medication aides (MAs), SCC, RCC, or the Administrator to implement any fall prevention interventions for Resident #1.

Interview with a second PCA on 08/07/24 at 11:36am revealed:
-Resident #1 used to be ambulatory without the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 9	D 270		

use of assistive devices.
-Resident #1 stayed in bed now since the fall on 07/18/24.
-She was told by the SCC to "just keep a check" on Resident #1 after the falls.
-She was not instructed by management to do anything differently for Resident #1 to try to prevent Resident #1 from falling.

Interview with a MA on 08/07/24 at 11:44am revealed:
-She had worked for the facility a little over a year.
-She had never known Resident #1 to fall until July 2024 when Resident #1 fell 3 times.
-After Resident #1 fell on 07/18/24, the SCC added Resident #1 to the 1-hour rounds notebook.
-The 1-hour rounds consisted of checking Resident #1's brief to see if it needed to be changed.
-She was not informed by the SCC, RCC, or Administrator to do any other interventions for fall prevention for Resident #1.

Interview with a third PCA on 08/13/24 at 9:51am revealed:
-Prior to Resident #1's fall on 07/18/24, Resident #1 was able to walk independently and feed herself and only needed assistance with getting dressed or going to the bathroom.
-Resident #1 became bedbound after a fall on 07/18/24.
-Resident #1 was not able to do anything for herself since the fall on 07/18/24.
-She was never instructed by management to implement any fall prevention interventions for Resident #1 except the SCC told her to "keep an eye" on Resident #1.
-The 1-hour rounds notebook listed the residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 10	D 270		

that needed to be toileted more often or the briefs needed to be checked every hour.

Interview with the SCC on 08/07/24 at 11:53am revealed:
-Resident #1 fell in another resident's bathroom on 07/18/24, hit her head, and was sent to the ED for an evaluation.
-Resident #1 was independent with ambulation without the use of assistive devices until the 3rd fall on 07/18/24 and then Resident #1 did not walk anymore.
-Resident #1 was assisted into a wheelchair and taken to the dining room for breakfast on 07/19/24 but remained in the bed after that day.
-Resident #1 was ordered a hospital bed and added to the 1-hour rounds notebook after the fall on 07/18/24 for fall prevention interventions.
-She thought she added Resident #1 to be checked with the 1-hour rounds after Resident #1 fell on 07/02/24 and 07/17/24.
-The 1-hour rounds were supposed to be completed every hour for 48 hours after a fall.
-The 1-hour rounds included checking on the resident and providing incontinence care if needed.
-The 1-hour rounds were not documented in the computer system but staff were supposed to sign their initials on the hourly time kept in the 1-hour rounds notebook.

Interview with the hospice RN on 08/07/24 at 9:56am revealed:
-Resident #1 was admitted to hospice on 02/07/23.
-Resident #1 was ambulatory and used to walk laps around the SCU frequently without the use of assistive devices.
-She assessed Resident #1 for a fall occurring on 07/02/24 and no injuries were found except for a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 11	D 270		

worsening gait.
-Resident #1 had an unwitnessed fall on 07/17/24 and she assessed Resident #1 and found no injuries.
-Resident #1 did not complain of pain after the fall and was assisted to a standing position.
-She was notified of a 3rd fall on 07/18/24 that resulted in swelling of Resident #1's left eye and continued right leg pain.
-Resident #1 was transported to the ED for an evaluation.
-Resident #1's alertness decreased since her 3rd fall on 07/18/24, and she became bed bound and non-ambulatory.
-She instructed the facility staff to increase supervision for Resident #1 after the fall on 07/02/24 due to a change in Resident #1's gait.
-The facility staff did not request any orders or ask for recommendations for fall prevention interventions for Resident #1 after the 3 falls occurring in July 2024.

Second interview with the RCC on 08/08/24 at 9:49am revealed:
-The 1-hour and 2-hour rounds were not documented by the facility staff.
-The 1-hour rounds were implemented for residents that were considered "heavy wetters" and needed more assistance with transfers that may try to get up without calling for assistance.
-The 1-hour rounds were not implemented initially for post-falls.

Telephone interview with a hospice RN Supervisor on 08/08/24 at 4:38pm revealed:
-She visited Resident #1 a couple of times.
-Resident #1 had an unwitnessed fall on 07/02/24 with no significant injuries documented in the hospice progress notes.
-Resident #1 had another unwitnessed fall on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 12	D 270		

07/17/24 with no significant injuries documented in the hospice progress notes.
-Resident #1 "took a harder" fall on 07/18/24 where she sustained a hematoma to the left eye and complained of leg pain and was sent to the ED for an evaluation.
-The fall on 07/18/24 was what most likely contributed to Resident #1's change in condition like not being able to ambulate or feed herself and caused her to be transitioned to end of life care.

Telephone interview with Resident #1's hospice provider on 08/09/24 at 4:16pm revealed:
-Resident #1 was admitted to hospice care on 02/07/23 for vascular dementia.
-She had not seen Resident #1 in person and gave orders for Resident #1 based on conversations with the hospice RN providing care to Resident #1.
-There was documentation in the hospice progress notes that the hospice RN was aware of Resident #1's fall on 07/18/24 and Resident #1 was transported to the ED for a hematoma on the head and leg pain.
-The hospice team was trying to figure out why Resident #1 fell on 07/02/24, 07/17/24, and 07/18/24 since the last fall documented for Resident #1 was on 02/07/23.
-The facility did not contact her to ask for any orders or suggestions for fall prevention interventions for Resident #1.
-Resident #1 passed away on 08/09/24.
-She expected the facility to implement fall prevention interventions to try to prevent future falls.

Interview with the Administrator on 08/07/24 at 10:48am revealed:
-He did not know why Resident #1 was not added

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 13	D 270		

to the 1-hour supervision check notebook after the fall on 07/02/24, 07/17/24, or 07/18/24.
-The SCC was responsible for making sure Resident #1 was added to the 1-hour supervision check notebook for 1-hour rounds to be completed.
-Resident #1 fell on 07/02/24 and no fall prevention interventions were added to the I/A report during the 07/03/24 meeting or implemented afterwards because Resident #1 was a hospice patient and hospice was notified of the fall.
-Resident #1 fell on 07/17/24 around 9:15am and no interventions for fall prevention were implemented during the meeting on 07/17/24 because he talked to the hospice nurse and was informed that fall prevention interventions would not help prevent Resident #1 from falling.
-Resident #1 fell on 07/18/24 and no fall prevention interventions were implemented because Resident #1 was now bedbound.

Attempted interview with Resident #1's POA on 08/07/24 at 11:05am was unsuccessful.

Refer to interview with the facility's contracted RN on 08/07/24 at 2:30pm.

Refer to interview with the RCC on 08/08/24 at 9:15am.

Refer to interview with the Administrator on 08/07/24 at 10:48am.

2. Review of Resident #3's current FL2 dated 06/27/24 revealed:
-Diagnoses included dementia and lumbar spondylosis (an age-related degeneration of the disks in the lower back).
-Current level of care was documented as special

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 14	D 270		

care unit (SCU).
-There was documentation she was semi-ambulatory and used a walker for assistance.
-Orientation was documented as intermittently disoriented.

Review of Resident #3's care plan dated 08/02/24 revealed:
-There was documentation the resident had fallen more than two times in the last month.
-There was documentation the resident demonstrated changers in her gait.
-There was documentation the resident experienced changes that required more assistance than previously required.
-There was documentation she needed limited assistance with her activities of daily living related to walking and transferring.

Review of Resident #3's Incident/Accident (I/A) Report dated 07/25/24 revealed:
-Resident #3 was found on the floor beside her bed at 8:00am.
-Local Emergency Medical Services (EMS) was called to evaluate her and she was transported to the hospital.
-Resident #3 was documented as "missing a chunk of her lip".
-Resident #3's Power of Attorney (POA) and Primary Care Provider (PCP) were notified.
-There was no documentation any type of intervention was put into place after the fall.

Interview with a medication aide (MA) on 08/14/24 at 7:45am revealed:
-She found Resident #3 on the floor beside her bed at 8:00am on 07/25/24 after she noticed she had not come to the dining room for breakfast.
-Resident #3 was positioned in such a manner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 15	D 270		

that her head was near the foot of the bed and her feet were near the head of the bed.
-There was dried blood on the wall near the head of her bed.
-Resident #3's head was bleeding and she had dried blood on her head leading her to think she had been on the floor for a while as "blood does not dry and coagulate that quick".
-She arrived for work at 7:15am that day but did not get to the SCU until 7:40am so she was not given report by 3rd shift personal care aides (PCAs) because they had already left for the day.

Review of Resident #3's local hospital emergency department (ED) notes dated 07/25/24 revealed:
-Resident #3 arrived at the ED on 07/25/24 at 9:16am via EMS.
-There was documentation Resident #3 presented at the ED from a "nursing facility" after having been found down for an unknown period of time.
-There was documentation she was apparently last checked on sometime last night (07/24/24).
-There was documentation she was found on the floor with dried blood on her face, a cut lip and bruises around her eyes.
-There was documentation it was unknown how long she was on the floor.
-There was documentation of E. coli in her urine; a urinary tract infection (UTI).

Review of Resident #3's I/A Report dated 08/02/24 revealed:
-Resident #3 fell at 1:00pm in her bathroom and was found lying on her left side between the sink and the toilet.
-Local EMS was called to evaluate her and she was transported to the hospital.
-The POA and PCP were notified.
-There was no documentation any type of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 16	D 270		

intervention was put into place after the fall.

Interview with a MA on 08/07/24 at 10:17am revealed:
-She responded to Resident #3's fall on 08/02/24.
-Resident #3 had just finished eating lunch and was using her walker to walk back to her bedroom, which was right next to the nurses' station.
-She heard Resident #3 fall and then yell.
-Resident #3 hit her head when she fell.
-Resident #3 had been weak since her fall on 07/25/24.

Review of Resident #3's local hospital ED notes dated 08/02/24 revealed:
-There was documentation Resident #3 presented at the ED at 3:20pm from a "nursing facility" after having a fall earlier in the day.
-There was documentation she had a subdural hematoma (blood on the brain).
-There was documentation she was transferred at 8:52pm to an acute facility for evaluation by a neurosurgeon.

Interview with Resident #3's POA on 08/07/24 at 11:20am revealed:
-Resident #3 had two black eyes and a "big chunk of her lip" was missing after the fall on 07/25/24.
-Food burned Resident #3's lip when she tried to eat.
-She was not really sure how the fall occurred, just that she was found on the floor by her bed.
-Resident #3 was diagnosed with a UTI at the hospital.
-The RN at the hospital told her a UTI could cause confusion and balance issues.
-Resident #3 used a walker to move around the facility and was extremely weak after the first fall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 17	D 270		

on 07/25/24.
-She was never informed of any interventions after the fall on 07/25/24.
-She thought some type of intervention should have been implemented after the fall on 07/25/24.
-The staff called 08/02/24 to inform her Resident #3 fell again and asked her if she wanted her to be sent out for evaluation.
-If someone had been walking with her after the fall on 07/25/24 she might not have fallen again on 08/02/24.
-Resident #3 was going to be transferred to a skilled nursing facility as she could no longer walk.

Interview with the Special Care Coordinator (SCC) on 08/07/24 at 3:32pm and 08/07/24 at 10:05am, 11:17am and 3:47pm revealed:
-Resident #3 fell on Thursday, 07/25/24.
-Any time a resident had a fall they were automatically placed on 1-hour checks.
-The MAs were responsible for entering residents' names into the 1-hour checks notebook that was kept at the desk in the SCU.
-In June 2024 the facility started having a falls prevention meeting each Wednesday afternoon with physical therapy, the RCC, the SCC and the Administrator to discuss any residents who had fallen the previous week so interventions could be implemented.
-Other than 1-hour checks, she never initiated a fall intervention until the fall was discussed with the PCP or the facility's Physical Therapist at the fall prevention meeting.
-The last 3 or 4 falls prevention meetings had been canceled so the 07/25/24 fall was never reviewed or had an intervention implemented.

Review of the 1-hour supervision rounds notebook revealed there was no documentation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 18 Resident #3 was added to the notebook. Interview with a PCA on 08/13/24 at 9:51am revealed: -Staff were told by management to "keep an eye on" residents after they had falls. -There was no place to document that they were monitoring a resident after a fall. -One-hour checks were for residents who needed more frequent incontinence brief changes, not monitoring residents who had a recent fall. Interview with another MA on 08/07/24 at 3:32pm revealed: -Any time a resident fell they were "automatically" placed on 1-hour checks. -She thought Resident #3 was placed on 1-hour checks after a fall on 07/25/24. -Staff had never informed her Resident #3's name was never entered into the 1-hour checks book so there was no documentation the hourly checks occurred. -The 1-hour checks book was generally used to document checks were done on residents who needed frequent assistance with incontinence care. Interview with the facility's contracted Registered Nurse (RN) on 08/07/24 at 11:02am revealed: -Since the 07/31/24 falls prevention meeting was canceled, Resident #3's fall was never discussed and no interventions were ever initiated. -Resident #3 should have been placed on 1-hour checks but her name was never entered into the book so that did not occur either. -She did not know why Resident #3 was never entered into the 1-hour checks book. Telephone interview with Resident #3's PCP on 08/08/24 at 9:23am revealed:	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 19 -The facility informed him of Resident #3's fall on 07/25/24. -He did not know what the facility's protocol was for falls. -The facility should follow their protocol for falls and implement interventions according to their protocol. -General protocols after a fall usually included obtaining vital signs on a regular basis, having the resident wear non-slip socks, and performing neurological checks; all of which should be documented. Interview with the Administrator on 08/07/24 at 10:46am revealed no interventions were implemented after Resident 3's fall on 07/25/24 because the last meeting on 07/31/24 was canceled because physical therapy was not available to participate. Refer to interview with the facility's contracted RN on 08/07/24 at 2:30pm. Refer to interview with the RCC on 08/08/24 at 9:15am. Refer to interview with the Administrator on 08/07/24 at 10:48am. _____ Interview with the facility's contracted RN on 08/07/24 at 2:30pm revealed: -Management was meeting weekly on Wednesdays to discuss the residents who had fallen over the course of the previous week. -She informed the Administrator on 08/07/24 that fall prevention interventions needed to be ordered directly after a fall occurred and not wait to implement interventions during the next fall meeting that took place each Wednesday with management.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 20 -The facility staff did not realize new fall prevention interventions need to be ordered with each fall. -A resident that experienced a fall needed to be assessed to try to figure out what caused the fall. Interview with the RCC on 08/08/24 at 9:15am revealed: -Post fall protocol included monitoring the resident by looking for physical or mental changes. -Monitoring was not documented at this time but management had recently talked about changing how monitoring was documented. -Residents were not necessarily placed on one-hour checks after a fall. -The 1-hour checks were instituted to monitor residents who required frequent incontinence care and those that tried to get up unsupervised. Interview with the Administrator on 08/07/24 at 10:48am revealed: -A 1-hour supervision check notebook was kept at the SCU desk and residents who needed more assistance were added to the 1-hour rounds. -When a resident experienced a fall, the resident could be added to the 1-hour supervision checks. -The SCC, RCC, or other facility staff could add a resident to the 1-hour supervision check notebook. -The SCC was responsible for making sure residents were added to the 1-hour supervision check notebook for 1-hour rounds to be completed. -The management staff and physical therapy met on Wednesdays each week to discuss residents who experienced falls and would decide what fall prevention interventions to implement for a resident who fell and added the interventions to the I/A report for the fall.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 21 -The falls prevention meetings on 07/24/24 and 07/31/24 were not held because physical therapy was not available to participate. _____ The facility failed to provide supervision to Resident #1 who fell on 07/02/24, 07/17/24, and 07/18/24 and was noted to limp and have pain in her right leg after the first fall and was observed to be unsteady after the second fall. No safety interventions were implemented between the falls, resulting in Resident #1 becoming non-ambulatory after the third fall. Resident #3 fell on 07/25/24 and was diagnosed with a urinary tract infection resulting in weakness. No additional safety measures were implemented afterward. Resident #3 sustained a second fall on 08/02/24 in which she hit her head and sustained a subdural hematoma. This failure resulted in serious physical harm and constitutes an unabated A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/14/24 for this violation.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews, and record reviews the facility failed to ensure a referral and follow up to meet the acute health care needs for 1 of 6 residents (#9) related to not having an x-ray completed for 12 days after a fall.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 22 The findings are: Review of Resident #9's current FL2 dated 03/11/24 revealed: -Diagnoses included dementia, diabetes, and major cognitive disorder. -The resident was intermittently disoriented. -The resident was ambulatory without the use of an assistive device. Review of Resident #9's Care Plan dated 04/02/24 revealed: -She had no documented changes to her gait since her previous care plan. -She was independent with transfers and ambulation. Review of Resident #9's Incident/Accident report dated 07/27/24 revealed: -Resident #9 fell in another resident's room at 7:30pm. -Resident #9 was observed on the floor, independently attempting to get up on her own. -Resident #9 became combative with staff when they attempted to assist her to a standing position. -Resident #9 refused to allow staff to take her vital signs. -Resident #9 stated that she was fine and to "leave her alone." -Both Guardians and the Primary Care Provider (PCP) were notified of the fall. Review of the progress note completed by the medication aide (MA) dated 07/27/24 revealed: -Resident #9 fell in another resident's room and refused to let the MA or the personal care aide (PCA) assist her to a standing position. -Resident #9 screamed, yelled and became combative with the MA and PCA.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 23	D 273		

-Resident #9 also refused to have her vital signs taken.

Interview with the Resident Care Coordinator (RCC) on 08/12/24 at 10:14am revealed:
-Resident #9 fell in another resident's room on 07/27/24.
-The MA reported Resident #9 was combative and would not allow her or the PCA to assist her to a standing position or take her vital signs.
-Resident #9 reported to the MA that she was fine and to "leave her alone."
-Resident #9 was observed by the MA after her fall on 07/27/24 walking around.
-Resident #9 denied having pain when asked by the MA.
-On 07/29/24, she attempted to assess Resident #9, but Resident #9 did not remember having a fall and would not allow her to check her for bruising, skin tears or other injuries.
-On 07/29/24, she observed Resident #9 walking with a normal gait and Resident #9 denied being in any pain.
-On 07/30/24, one of Resident #9's guardians expressed concern to her that Resident #9 was in pain.
-While the guardian was present, the RCC assessed Resident #9 and determined there were no bruises, skin tears, or other visible injuries.
-Resident #9 was observed to be walking normally and denied having any pain.
-On 07/31/24, the RCC observed Resident #9 walking out of the dining room after lunch.
-Resident #9 was walking abnormally and was holding onto the side rail.
-The RCC asked Resident #9 what had happened and Resident #9 stated she had "done something" to her back.
-The RCC asked Resident #9 if she thought it was from her fall on 07/27/24, but Resident #9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 24	D 273		

had no recollection of her fall.
-The RCC contacted the physician and requested an order for an x-ray on 07/31/24.
-When the RCC received the physician order for an x-ray, she faxed it to the mobile x-ray company on 07/31/24.
-She did not realize until 08/05/24 that she had not received results from the x-ray that was requested for Resident #9 on 07/31/24.
-She had "assumed" a representative from the mobile x-ray company came to facility and completed the x-ray for Resident #9.
-There was not a process in place to ensure xray orders were received and completed.
-She called the mobile x-ray company on 08/05/24 and gave a verbal order for the x-ray to be completed.
-On 08/07/24 the mobile x-ray company representative came to the facility to complete the x-ray for Resident #9.
-Resident #9 was out of the facility with one of her guardians on 08/07/24 so the x-ray was not completed.
-The mobile x-ray company representative returned to the facility on 08/08/24 and completed the x-ray for Resident #9.
-She received the results on 08/09/24 that revealed Resident #9 had an "age-indeterminate compression fracture" which indicated there was a fracture but it could not be determined how old the fracture was.
-She notified the Department of Social Services, and they requested Resident #9 be seen at a local orthopedic emergency care clinic.
-She contacted one of Resident #9's guardians who came to the facility and took Resident #9 to the orthopedic clinic.
-Resident #9 was prescribed pain medication twice daily for 14 days, a physical therapy (PT) referral was given, and a lumbar binder was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 25 ordered as needed (used to reduce pain by limiting mobility of the lower back). Telephone interview with one of Resident #9's guardians on 08/12/14 at 1:50pm revealed: -She was visiting Resident #9 on 07/30/24 and was concerned because she thought Resident #9 was in pain. -The RCC came and evaluated Resident #9 and indicated there was no bruising or visible injuries. -She asked if the primary care provider (PCP) could order an x-ray and the RCC stated "I don't think she needs one." -A request was finally made by the RCC to the PCP on 07/31/24 for an x-ray. -The x-ray did not occur until 08/08/24. Attempted telephone interview with the PCP on 08/13/24 at 3:55pm and 08/14/24 at 8:02am was unsuccessful. Interview with the Administrator on 08/14/24 at 8:17am revealed: -Resident #9 refused to go to the hospital on the day her fall occurred. -When the RCC observed Resident #9 walking and holding her back, the RCC contacted the PCP for an order for mobile x-ray. -Resident #9 refused to have an x-ray. -Staff should have called the doctor back to have the order for an x-ray canceled. -Even though she needed it, Resident #9 did not want an x-ray and it was her right to refuse it.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record:	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 26	D 276		

(3) written procedures, treatments or orders from a physician or other licensed health professional; and
(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to implement physician's orders for 1 of 6 sampled residents (#7) related to checking daily blood pressures.

The findings are:

Review of Resident #7's current FL2 dated 04/29/24 revealed:
-Diagnoses included Alzheimer's disease, hypertension, and chronic kidney disease.
-There was an order to check daily blood pressures (BPs) at 10:00am, notify the primary care provider (PCP) if the systolic BP was greater than 160, administer clonidine (a medication used to decrease blood pressure) 0.1mg if the systolic BP was greater than 160.

Review of Resident #7's current FL2 dated 06/27/24 revealed:
-There was an order for clonidine 0.1mg take 1 tablet daily if the systolic BP was greater than 160.
-There was no order for daily blood pressure checks.

Review of Resident #7's Resident Register revealed:
-Resident #7 was admitted to the facility on 05/07/24.
-Resident #7 had a health care power of attorney (HCPOA).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 27 Review of Resident #7's unsigned physician's order filled out by the Resident Care Coordinator (RCC) dated 07/30/24 revealed an order to check a BP daily and if the systolic BP was greater than 160 administer clonidine 0.1mg take 1 tablet daily and recheck a BP in 1 hour. Review of Resident #7's 05/07/24-05/31/24 electronic medication administration record (eMAR) revealed: -There was no entry for daily BP checks at 10:00am. -There was no documentation of daily BP checks. -There was an entry for clonidine 0.1mg take 1 tablet daily if the systolic BP was greater than 160. -There was no documentation clonidine was administered. Review of Resident #7's 06/01/24-06/27/24 eMAR revealed: -There was no entry for daily BP checks at 10:00am. -There was no documentation of daily BP checks. -There was an entry for clonidine 0.1mg take 1 tablet daily if the systolic BP was greater than 160. -There was no documentation clonidine was administered. Review of Resident #7's vital signs and weight summary log revealed: -There was documentation of a BP checked on 07/08/24 at 2:55am with a reading of 172/76. -There was documentation of a BP checked on 07/21/24 at 10:08pm with a reading of 172/73. Interview with Resident #7's HCPOA on 08/08/24 at 2:27pm revealed:	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 28	D 276		

-She took Resident #7 to all her provider's appointments.
-Resident #7 was supposed to get daily BP readings and be administered a BP medication if Resident #7's BP was too high.
-She did not think the facility was checking Resident #7's BP daily or administering the clonidine because Resident #7's BP reading was always high when she took her to an appointment at a provider's office.
-She asked several medication aides (MAs) and the Special Care Coordinator (SCC) about Resident #7's clonidine but the staff would not tell her anything and one of the MAs told her management instructed the staff not to tell her anything even though she was Resident #7's HCPOA.

Interview with a MA on 08/09/24 at 9:51am revealed Resident #7 did not have an order to check daily BPs.

Interview with the SCC on 08/09/24 at 10:00am revealed:
-The RCC was responsible for adding medications and orders to the FL2 for the provider to sign.
-The order to check Resident #7's daily BP must have been "dropped off" when the new FL2 was filled out on 06/27/24 because there was still an order to administer clonidine daily if Resident #7's systolic BP was greater than 160.
-The only way to know whether Resident #7's clonidine should be administered by the MAs was for a BP to be checked.
-The RCC was responsible for checking all the orders on the FL2 and calling the provider to get clarification for an order if needed.
-Resident #7's HCPOA informed her "2 weeks ago" that Resident #7's BP reading was high at a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 29	D 276		

provider's office appointment, and she did not think Resident #7 was being administered clonidine.
-Resident #7's primary care provider (PCP) was notified when he saw Resident #7 but did not address the issue on whether to check Resident #7's BP daily.
-She tried to call the PCP and left a message about Resident #7's clonidine and there was no order to check daily BPs, and she did not receive a call back.
-She did not document the notification to Resident #7's PCP.

Interview with the RCC on 08/09/24 at 11:28am revealed:
-The pharmacy added medications to the eMAR profile but she or the SCC had to check a box to trigger the blood pressures to be recorded on the eMAR.
-She only entered part of the order for Resident #7's clonidine and left off the part of the order to check BPs daily at 10:00am when she filled out the newest FL2.
-She knew Resident #7's PCP was aware that daily BPs were not being checked because she made rounds with the SCC and PCP "a few weeks ago" when Resident #7's HCPOA informed the PCP that she thought Resident #7's BPs were not being checked, but she did not know the outcome because she had to leave to go to a meeting.
-The SCC was responsible for making sure the BPs were reordered by the PCP during the rounds to make sure Resident #7's clonidine was administered when it was needed.
-Resident #7 was supposed to be getting daily BPs checked but it was "overlooked".
-She and the SCC were responsible for contacting the PCP to clarify orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 30 Telephone interview with Resident #7's PCP on 08/09/24 at 3:01pm revealed: -Resident #7's BP was supposed to be checked daily to know whether to administer clonidine to Resident #7. -He made rounds with the SCC a couple of weeks ago and gave the SCC a verbal order to check Resident #7's BP daily when Resident #7's HCPOA told him it was not being checked. -He expected the facility to check Resident #7's BP daily and administer clonidine when the systolic BP was greater than 160 because not receiving the medication could cause more damage to Resident #7's kidneys or cause Resident #7 to have a stroke. Second interview with the SCC on 08/09/24 at 3:41pm revealed: -When a PCP gave verbal orders the RCC was responsible for writing the order out for the PCP to sign because she was a licensed practical nurse (LPN). -If the RCC was unavailable, she completed rounds with the PCP but if the PCP wanted to give an order then he had to write the order himself. -She did not write out physician's orders or enter them into the eMAR profile; that was the RCC's job. -She did not remember if Resident #7's PCP gave her a verbal order to check BPs daily on Resident #7. -She was told "plenty of times" by the RCC and Administrator to enter orders on the eMAR profile, but she had never been trained how to enter orders. -The RCC had to check the box on the eMAR profile to trigger BPs to be checked because she was not trained.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 31 -The PCP did not give her a verbal order to check Resident #7's BP daily. -She had not noticed checking blood pressures was left off resident #7's eMAR. Interview with the RCC on 08/13/24 at 10:42am revealed: -Resident #7's BPs were never checked from 05/01/24-06/26/24 because the task was never entered onto the eMAR profile by her or the SCC. -She did not know why she missed ordering daily BP checks for Resident #7 when she filled out a new FL2. -The SCC took the verbal order to check Resident #7's blood pressures and would have been responsible for entering it into the eMAR profile system. Interview with the Administrator on 08/14/24 at 9:34am revealed: -Resident #7's daily BP checks were accidentally left off when the new FL2 was filled out. -The facility did not have a policy to complete eMAR audits to check for orders that needed to be clarified. -He trained the SCC how to enter orders into the eMAR system. -The SCC was responsible for entering blood pressure orders. -The missing order to take blood pressures would have been caught if chart audits had been done but they had not been completed in more than a year.	D 276		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21,	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 32	D 338		

Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure residents were provided care and services which were adequate, appropriate and in compliance with relevant federal and state laws, rules and regulations for 29 residents on the Special Care Unit (SCU) related to 3rd shift staff sleeping during their shift and for 2 of 2 sampled residents (#3 and #4) related to unnecessary isolation (#3) and having a consistently working call light (#4).

The findings are:

1. Observations at the facility on 08/14/24 at 5:30am revealed:
-There was one medication aide (MA) on duty.
-There was one personal care aide (PCA) on duty in the assisted living (AL) unit.
-There were three PCAs on duty in the SCU.

Observations in the SCU on 08/14/24 at 5:38am revealed:
-A night shift PCA ran down the hallway toward the dining room when he observed the survey team members enter the SCU.
-Two PCAs stuffed blankets into a credenza in the dining room then proceeded to walk down the hallway and into resident rooms.

Interview with the MA on 08/14/24 at 5:46am revealed:
-Within the past week she discovered two of the three third shift PCAs on duty in the SCU were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 33	D 338		

asleep during their shift.
-One of the PCAs was asleep on the couch in the SCU, and when she attempted to wake the PCA, he told her he was not asleep, he was "only resting."
-There was a previous incident during which she observed the same PCA sleeping during his shift.
-She did not report the sleeping incident that occurred a week ago because nothing ever seemed to happen when she reported the sleeping incidents to management.
-On 08/14/24 between 12:30am and 1:00am, she found a PCA asleep in the SCU in a chair that was in a resident common area.
-She told the PCA to wake up and the PCA got up and provided resident care.
-When she went to the SCU around 5:15am on 08/14/24, she observed the same PCA asleep again.
-She did not wake the PCA .
-She had to wake the same PCA at least four times in the past three months.
-The Special Care Coordinator (SCC) was aware of staff sleeping on 3rd shift in the SCU.

Interview with a 3rd shift PCA on 08/14/24 at 6:25am revealed:
-She did not know what the blankets were used for that were stuffed into the credenza.
-She did not know if she had been asleep earlier that morning during her shift.

Interview with a second 3rd shift PCA on 08/14/24 at 6:28am revealed he never slept while working either 2nd or 3rd shifts.

Interview with a third 3rd shift PCA on 08/14/24 at 6:14am revealed:
-She observed a PCA sleeping on the couch in the SCU about a week ago.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 34	D 338		

-She did not wake him because she was concentrating on getting her work done.
-She observed a PCA sitting with her eyes closed on 08/14/24 but did not wake her.

Interview with a MA on 08/14/24 at 7:45am revealed:
-About a month ago, she arrived to work at 5:30am and observed a 3rd shift staff asleep at the desk, with his head on a pillow.
-She informed the SCC.

Interview with a PCA on 08/13/24 at 9:51am revealed:
-There were times when she came to work in the morning she saw 3rd shift PCAs sleeping in the dining room and the 3rd shift MAs would wake them up.
-She reported the 3rd shift staff sleeping to the SCC.

Interview with a 2nd shift PCA on 08/14/24 at 11:40am revealed:
-He normally worked 11:00am to 11:00pm shifts.
-A resident's family member on the SCU once complained to him that they observed two night shift PCAs sleeping.

Interviews with the Administrator on 08/14/24 at 8:17am and 9:35am revealed:
-He had instructed all 3rd shift MAs to contact him directly if there was ever an issue with PCAs sleeping.
-He instructed staff to send the PCA home and he would come to the facility and work the remaining PCA's shift.
-He was not notified by the MA on 08/14/24 she had observed a PCA asleep twice during 3rd shift.
-The 3rd shift staff were supposed to clock in and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 35	D 338		

out for breaks.
-If any of the 3rd shift staff wanted to go to their cars and nap during their breaks that was fine with him.
-The 3rd shift staff should not be "napping in any resident care areas."
-The 3rd shift staff should not be sleeping on the couch or in chairs but could nap in the breakroom during their break.
-He considered sleeping on the job outside of their break time abuse and neglect.

Interview with the SCC on 08/14/24 at 10:44am revealed she had been made aware by the MA of 2 PCAs sleeping on 3rd shift about four weeks ago.

2. Review of Resident #4's current FL2 dated 10/11/23 revealed:
-Diagnoses included vascular dementia and high blood pressure.
-Resident #4 was intermittently disoriented.
-Resident #4 was semi-ambulatory with a walker.

Review of Resident #4's current Care Plan dated 04/03/24 revealed she was independent for all activities of daily living.

Interview with Resident #4 on 08/06/24 at 9:45am revealed:
-The call light in her room was not working.
-She was unable to call for assistance from staff unless she was in her bathroom, where the call light on the wall by the toilet and the call light by the shower were both working.
-She had an eye disease with a loss of vision and could not see well and sometimes needed to call staff for assistance but staff would not come when she called.
-The Maintenance Director worked on her call

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 36	D 338		

light a few days ago and told her he had done everything he could do to fix the call light.
-The Maintenance Director told her it was up to her and her family to complain to management about the call light not working so that the call light could be fixed.

Observation in Resident #4's room on 08/06/24 revealed:
-The call light was activated at 9:48am.
-No staff responded to Resident #4's activated call light between 9:48am through 10:33am.

Interview with a medication aide (MA) on 08/06/24 at 10:33am revealed:
-If Resident #4's call light was working, staff should hear "dinging" at the nurses station.
-There were also lights at the end of the hallways that lit up when a resident called for assistance.
-The lights were not lit up to alert staff assistance was needed in Resident #4's room.
-Resident #4's call light had not been working as expected for a couple of months.
-Resident #4's call light was serviced by a contracted company on 08/04/24.

Interview with a personal care aide (PCA) on 08/06/24 at 10:36am revealed:
-Resident #4's call light stopped working about a month ago but was repaired by the Maintenance Director.
-On 08/04/24, a contracted company came to the facility and worked on the entire call light system.
-Resident #4's call light was not working, but she could look for staff in the hallways if she needed assistance.

Interview with Resident #4 on 08/08/24 at 9:14am revealed:
-There had been a problem with the call light in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 37	D 338		

her room not working consistently for several months.
-The Maintenance Director would insert new batteries in the call light unit but the batteries would go dead in three to four days.
-A staff member told her to "just bang on the wall" or "holler out" for help if she needed assistance.
-She had concerns how she would get assistance if she had an emergency while she was in bed.
-There had not been an occurrence when she needed to bang on the wall or yell out for assistance "yet".

Observation in Resident #4's room on 08/08/24 at 9:36am revealed:
-There was a call light unit on the wall beside her bed.
-The call light cord was on the side table beside her bed.
-When the button on the call light cord was pressed, it did not activate.
-When the button on the call light unit on the wall was pressed, it did not activate.

Interview with the Maintenance Director on 08/08/24 at 9:44am revealed:
-There had been ongoing problems for about six months with the call light system in Resident #4's room.
-The call light in Resident #4's bedroom was battery operated.
-The batteries had to be changed at least every two weeks.
-He checked the call light unit several times a day when he was at work between 7:00am and 5:00pm Monday through Friday.
-He was unsure if anyone checked Resident #4's call light system at night or on weekends in his absence.
-The company that originally installed the call light

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 38	D 338		

system had come to the facility within the last six months to work on her unit, but the issue had not been resolved.
-An engineer from the company came last week to look at Resident #4's wall unit again and changed the power board that operated her unit, but that did not correct the problem.
-It was his responsibility to ensure her call light system batteries were working and to replace them as needed.

Interview with a PCA on 08/08/24 at 10:55am revealed:
-Resident #4 had problems with her call light for at least 3 months.
-If they were aware of an issue they were supposed to complete 15-30 minute checks on the person until the call light issue was resolved.
-She had never completed 15-30 minute checks for Resident #4.

Interview with the Resident Care Coordinator (RCC) on 08/09/24 at 9:48am revealed:
-She was unsure how long there had been a problem with Resident #4's call light.
-If any resident's call light system was not functioning, they would provide 15-30 minute rounds on them until the issue was resolved.
-She was aware the Maintenance Director had tried to change out the batteries in Resident #4's call light unit multiple times, but whatever the problem was had not been corrected.

Interview with a MA on 08/09/24 at 11:54am revealed:
-Resident #4 had told her the call light system did not always work in her room.
-She told Resident #4 to just "holler out" and they would be able to hear her if she needed assistance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 39	D 338		

Interview with the Administrator on 08/09/24 at 3:36pm revealed:
-Resident #4's call light system issues started in May of 2024.
-The battery in Resident #4's call light unit drained very quickly.
-The battery in her call light unit had to be changed weekly.
-They have been troubleshooting the issue for several weeks.

3. Review of Resident #3's current FL2 dated 06/27/24 revealed:
-Diagnoses included dementia and lumbar spondylosis (an age-related degeneration of the disks in the lower back).
-Current level of care was documented as special care unit (SCU).
-There was documention she was semi-ambulatory and used a walker for assistance.
-Orientation was documented as intermittently disoriented.

Review of Resident #3's care plan dated 08/02/24 revealed:
-There was documentation she needed assistance while eating.
-The box was checked "yes" answering the question "Are there changes that require more assistance than previously?".
-There was documentation she needed limited assistance with her activities of daily living related to walking and transferring.

Review of Resident #3's Incident & Accident (I/A) Report dated 07/25/24 revealed:
-Resident #3 fell in her bedroom on 07/25/24.
-Resident #3 was "missing a chunk of her lip".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 40	D 338		

Review of Resident #3's local hospital emergency department (ED) notes dated 07/25/24 revealed:
-Resident #3 arrived at the ED on 07/25/24 at 9:16am via EMS.
-There was documentation Resident #3 presented at the ED from a nursing facility after having been found down for an unknown period of time.
-There was documentation of E. coli in her urine; a urinary tract infection (UTI).

Interview with Resident #3's family member on 08/07/24 at 11:20am revealed:
-Resident #3 had a fall on Thursday 07/25/24 and was taken to the local hospital.
-She brought Resident #3 back to the facility after her hospital evaluation and had been told by the discharge nurse at the hospital that Resident #3 was not contagious related to her UTI.
-On Saturday 07/27/24 around 7:30pm she received a call from the facility informing her that Resident #3's urine culture from her recent hospital trip came back positive for E. coli and that she was going to start on an antibiotic and staff would need to wear a mask and gloves when interacting with her.
-When she came to the facility a few days later to visit Resident #3 there was a personal protective equipment (PPE) cart outside the room.
-When she came the next day about 1:00pm Resident #3 still had the PPE cart outside her room and when she entered the room she saw Resident #3 sitting in a chair.
-There was a cold, uneaten lunch tray on her lap and staff were not in her room assisting her with the meal.
-On the windowsill was a cold, uneaten breakfast tray.
-She saw 3 trashcans overflowing with trash and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 41	D 338		

there were about ten beverage glasses scattered around the room with various amounts of liquid in them and the floor was dirty and had not been swept.
-She was informed by the personal care aide (PCA) that Resident #3 was in isolation because E. coli was "in the blood".
-She contacted the hospital and obtained a copy of Resident #3's medical records and a nurse in the emergency department informed her the E. coli was in Resident #3's urine, not in her blood and isolation was not necessary.
-The nurse in the emergency department told her a UTI could cause confusion and balance issues.
-She went to the facility on 08/01/24 to inform the staff that Resident #3 was placed in isolation unnecessarily.
-She spoke with the Resident Care Coordinator (RCC) who knew Resident #3 was in isolation.
-She told the RCC that she felt like her family member "was being treated like an animal, with food just tossed into her room and left alone".
-The RCC said a resident should never be left alone during a meal because it was a choking hazard.
-She showed the RCC the hospital report and told her about the conversation with the nurse and requested Resident #3 be removed from isolation.
-She went back to Resident #3's room and found Resident #3 in bed with a cold plate of food on a chair pushed up close to her bed.
-Resident #3 told her she was hungry and she did not know there was food in the chair.
-She thought staff should have sat with her to encourage her to eat, as people with dementia needed to be prompted to eat.
-She was angry that Resident #3 was placed in isolation unnecessarily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 42	D 338		

Interview with the Special Care Coordinator (SCC) on 08/06/24 at 4:40pm and 08/07/24 at 10:05am, 11:17am, 3:32pm and 3:47pm revealed:
-Resident #3 went to the ED on 07/25/24 due to a fall.
-In the evening on 07/27/24 a medication aide (MA) answered a call from the local hospital informing her Resident #3 had E. coli and needed to start on an antibiotic.
-Staff were initially told by the MA who received the phone call, the E. coli was in her blood, so Resident #3 was placed on isolation precautions which meant a PPE cart was placed outside her door and staff wore PPE if they entered the room, the resident ate her meals in her room and medications were administered in her room.
-Resident #3 was on isolation precautions from 07/27/24 after supper until 08/01/24 and should have received the same care as if she was not on isolation and the PCAs should have provided housekeeping services.
-Sometime the next week the facility received a faxed report, and it was discovered the E. coli was only in her urine, so isolation precautions were removed.

Interview with a MA on 08/07/24 at 3:32pm revealed:
-She received a phone call about 6:00pm on 07/27/24 from the local hospital informing her Resident #3 was E. coli positive and needed to start an antibiotic but she could not recall if they told her if the E. coli was in the urine or in the blood.
-She was not sure what she needed to do so she called the SCC who was away from the facility.
-The SCC instructed her to put Resident #3 on isolation precautions and for all staff to wear PPE.
-Sometime that evening or early the next day a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 43	D 338		

PPE cart was placed outside Resident #3's room and all staff were informed the resident was on isolation precautions.
-While on isolation precautions, Resident #3 did not exit her room, she ate all meals in her room and staff checked on her every hour.
-Staff did not stay with Resident #3 while she ate; they only delivered her meal tray and then would go back an hour later to retrieve her tray so it could go back to the kitchen.

Interview with the RCC on 08/07/24 at 9:00am and 08/08/24 at 9:15am revealed:
-On 07/27/24 the facility received a phone call from the local hospital informing them Resident #3 had E. coli "in her blood", so she was started on isolation precautions.
-The written report was faxed to the facility on Tuesday 07/30/24 in the afternoon at which point the SCC scanned the report into her file.
-She did not read the full report until the family member brought a copy to the facility and questioned why Resident #3 was in isolation.
-While reading the report with the family member it was discovered the E. coli was in the urine and not in the blood.
-The isolation precautions were removed after the Administrator read the report and confirmed Resident #3 did not need to be in isolation.
-When a resident was in isolation they should receive the same level of care as when they were not in isolation and the PCAs should provide housekeeping services.
-Resident #3 should never have eaten her meals unsupervised; it was a choking hazard.
-Housekeeping did not enter a resident's room if they were on isolation so it was the responsibility of the PCA to empty trash, and do general cleaning in the room.
-She did not know why staff were not aware they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 44	D 338		

should be cleaning Resident #3's room while she was in isolation.

Interview with a MA on 08/07/24 at 10:17am revealed:
-Resident #3 started isolation on Saturday, 07/27/24 in the evening after it was discovered she had an infection.
-She was told to remove Resident #3 from isolation on Thursday, 08/01/24.
-While in isolation the MAs administered Resident #3's medications in her room while wearing PPE and the PCAs checked on her hourly.

Interview with a PCA on 08/07/24 at 3:05pm revealed:
-The MAs or the SCC informed the PCAs when a resident was placed on hourly checks, and she was never told to check on Resident #3 hourly.
-While in isolation Resident #3 was checked on every two hours.
-She took Resident #3's meal trays to her but did not stay with her during the meal.

Telephone interview with Resident #3's PCP on 08/08/24 at 9:23am revealed:
-He could not remember if Resident #3 was in isolation when he saw her on 07/30/24.
-It was reported to him by staff that E. coli was in her blood.
-Resident #3 did not need to be in isolation due to E. coli.
-If Resident #3 care plan documented she needed supervision during meals she should not eat by herself in her room.

Interview with the Administrator on 08/07/24 at 10:48am revealed:
-A 1-hour supervision check notebook was kept at the SCU desk and residents who needed more

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 45 assistance were added to the 1-hour rounds. -When a resident experienced a fall, the resident could be added to the 1-hour supervision checks. -The SCC, RCC, or other facility staff could add a resident to the 1-hour supervision check notebook. -The SCC was responsible for making sure residents were added to the 1-hour supervision check notebook for 1-hour rounds to be completed. -The SCC decided when a resident needed to be placed on isolation if they had an infection. _____ The facility failed to ensure resident rights were maintained for 29 residents in the Special Care Unit (SCU) when a 3rd shift staff was found sleeping during their shift and when they failed to provide routine care and assistance during meals for Resident #3 when she was placed on an unnecessary level of isolation precautions for five days due to a UTI and failed to provide Resident #4 with a working call light. This failure was detrimental to the health of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/08/24 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 29, 2024.	D 338		
D 349	10A NCAC 13F .1002 (f) Medication Orders 10A NCAC 13F .1002 Medication Orders (f) The facility shall assure that all current orders for medications or treatments, including standing	D 349		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 349	Continued From page 46	D 349		

orders and orders for self-administration are reviewed and signed by the resident's physician or prescribing practitioner at least every six months.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure all current orders for medications and treatments were reviewed and signed by the resident's physician or prescribing practitioner at least every six months for 2 of 5 sampled residents (#2 and #4).

The findings are:

1. Review of Resident #2's current FL2 dated 10/18/23 revealed:
-Diagnoses included chest pain and hypertensive urgency.
-There was an order for acetaminophen (used to treat pain) 325mg two tablets every 4 hours as needed, acetaminophen (used to treat pain) 500mg two tablets every 4 hours as needed with a maximum use of three days, albuterol (used to treat breathing problems) 90mcg two puffs every 6 hours as needed, alprazolam (used to treat anxiety) 0.5mg tablet one-half tablet (0.25mg) twice daily as needed, amlodipine (used to treat high blood pressure) 5mg tablet daily, aspirin (used to treat pain) 81mg twice daily, ferrous sulfate (used to treat an iron deficiency) with no information regarding dosage or administration, flonase (used to relieve allergies) 50mcg with no information regarding administration, guaifenesin (used to treat chest congestion) 100mg tablet every 4 hours as needed, hydralazine (used to treat high blood pressure) 50 mg three times daily, atorvastatin (used to treat high cholesterol)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 349	Continued From page 47	D 349		

10mg at night, Benefiber (used to treat constipation) 2 grams daily, clonidine (used to treat high blood pressure), dicyclomine (used to treat irritable bowel syndrome) 30mg daily, doxycycline (used to treat infections) 100mg twice daily, emetrol (used to treat nausea and vomiting) 15ml every fifteen minutes as needed, lisinopril (used to treat high blood pressure) 20mg twice daily, loperamide (used to treat diarrhea) 3 mg two capsules every 6 hours as needed, Maalox (used to treat stomach upset) 30ml daily as needed, meclizine (used to treat nausea and vomiting) 12.5mg three times daily as needed, metoprolol succinate (used to treat chest pain and high blood pressure) 100mg daily, and melatonin (used to treat insomnia) 5mg every night.

Review of Resident #2's physician's orders revealed there was no six month medical provider renewal of all medications and treatments for Resident #2.

Refer to interview with the Resident Care Coordinator (RCC) on 08/08/24 at 2:53pm.

Refer to interview with the Administrator on 08/09/24 at 4:37pm.

2. Review of Resident #4's current FL2 dated 10/11/23 revealed:
-Diagnoses included vascular dementia and high blood pressure.
-There was an order for albuterol (used to treat breathing problems) 90mcg two puffs every 6 hours as needed, bethanechol chloride (used to treat urinary retention) 10mg tablet three times daily, Vitamin D3 (used to maintain healthy bones) 25mcg tablet daily, ipratropium bromide (used to treat seasonal allergies) 21mcg 2 spays

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 349	Continued From page 48	D 349		

in each nostril three times daily, losartan (used to treat high blood pressure) 100mg tablet daily, magnesium oxide (used to treat constipation, indigestion and headaches) 400mg tablet daily, metoprolol (used to treat high blood pressure) 75mg (25mg - 3 tablets) twice daily, Miralax (used to treat constipation) 17grams with 4-8 ounces of liquid daily, pantoprazole (used to treat gastric reflux) 40mg tablet daily, senna (used to treat constipation) 8.6-50mg - 2 tablets twice daily, Seroquel (used to treat major depressive disorder) 50mg tablet daily, and Tylenol (used to treat pain) 325mg tablet - 2 tablets (650mg) every 4 hours as needed.

Review of Resident #4's physician's orders revealed there was no six month medical provider renewal of all medications and treatments for Resident #4.

Refer to interview with the Resident Care Coordinator (RCC) on 08/08/24 at 2:53pm.

Refer to interview with the Administrator on 08/09/24 at 4:37pm.

_____

Interview with the Resident Care Coordinator (RCC) on 08/08/24 at 2:53pm revealed:
-Resident #2 did not have six month medications orders in her record.
-Resident #2 did not use the facility's contracted primary care provider (PCP) and it was often difficult getting orders from them.
-She was responsible for ensuring the current medication and treatment orders were updated and signed by the PCP every six months.

Interview with the Administrator on 08/09/24 at 4:37pm revealed:
-Physician's order needed to be updated every six

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 349	Continued From page 49 months. -The RCC was responsible for ensuring this was completed. -Resident #2 and Resident #4 both had PCPs outside the facility. -It was challenging at times getting six month orders from outside PCPs.	D 349		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#1 and #3) related to an anti-seizure medication (#1) and eye drops to treat seasonal allergies (#3). The findings are: Review of the facility's undated Medication Administration Policy revealed: -It was the responsibility of each medication aide (MA) to make sure a resident did not run out of medication. -The label must be read 3 times before	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 50	D 358		

administering a medication.
-All medications administered were documented on the medication administration record (MAR).
-Each resident will have medications available in accordance with the physician's order.
-The Resident Care Coordinator and designated MA may call or fax reorders for medications to the pharmacy.
-MAs will request refills for medications on a timely basis.
-Medications will be administered from the medication cart by comparing the MAR with the medications.
-Five rights (right resident, right drug, right dose, right route, and right time) are applied for a recommended three-time process for each medication being administered.
-If a medication with a current, active order could not be found the medication cart, the pharmacy was to be contacted for a refill.

1. Review of Resident #1's current FL2 dated 07/12/24 revealed:
-Diagnoses included dementia and seizure disorder.
-Current level of care was documented as special care unit (SCU).
-Orientation was documented as constantly disoriented.

Review of Resident #1's Resident Register revealed:
-There was no documentation of an admission date to the facility.
-Resident #1 had a power of attorney that signed and dated the resident register on 07/27/21.

Review of Resident #1's physician's orders dated 07/12/24 revealed:
-Ativan (used to treat seizures) 2mg take 1 tablet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 51	D 358		

as needed for seizures and repeat in 20 minutes if ineffective for a maximum of 2 doses in 24 hours.
-Ativan (used to treat anxiety) 0.5mg take 1/2 tablet (0.25mg) every 6 hours as needed for anxiety.

Review of Resident #1's 07/12/24-07/31/24 electronic medication administration record (eMAR) revealed:
-There was an entry for Ativan 2mg take 1 tablet every 20 minutes as needed for seizures and repeat in 20 minutes if ineffective for a maximum of 2 doses in 24 hours.
-There was documentation Ativan 2mg was administered on 07/04/24 at 9:20am and was documented as ineffective.
-There was documentation Ativan 2mg was administered on 07/17/24 at 9:31am and was documented as effective.
-There was no documentation a second dose was administered on 07/04/24 20 minutes after the ineffective initial dose.

Observation of Resident #1's medications on hand on 08/07/24 at 4:18pm revealed:
-There was no Ativan 2mg available for administration.
-There was a bottle labeled Ativan 0.5mg take ½ tablet every 6 hours as needed for anxiety.

Review of Resident #1's narcotics control sheet log revealed:
-A handwritten entry for Ativan 0.5mg take ½ tablet every 6 hours as needed.
-There was documentation Ativan 0.5mg take ½ tablet every 6 hours as needed for anxiety was administered on 07/04/24 at 8:00am with a remaining balance of 55 tablets available.
-There was documentation Ativan 0.5mg take ½

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 52	D 358		

tablet every 6 hours as needed for anxiety was administered on 07/17/24 at 8:00am with a remaining balance of 54 tablets available.
-There was no control sheet log available for Ativan 2mg take 1 tablet every 20 minutes for seizure activity for a maximum of 2 doses in 24 hours.

Interview with a medication aide (MA) on 08/07/24 at 4:28pm revealed:
-Resident #1 did not have Ativan 2mg tablets available to administer.
-There was a bottle containing Ativan 0.5mg take ½ tablets available to administer every 6 hours as needed for anxiety to Resident #1.
-The Special Care Coordinator (SCC) completed the last medication cart audit, but she did not know when it was completed.
-She had never administered Ativan 2mg to Resident #1 for seizure activity.

Interview with a second MA on 08/08/24 at 9:29am revealed:
-Resident #1 started having seizure-like activity about 6 months ago.
-Resident #1 was having slight convulsions on 07/17/24 and she called the hospice registered nurse (RN) who told her to administer Ativan 2mg to Resident #1.
-She administered the Ativan 0.5mg ½ tablet for anxiety instead of the ordered 2mg for seizures because she did not realize the Ativan was a different dose.
-She documented she administered Resident #1's Ativan 2mg for seizures on the eMAR by mistake because she did not realize Resident #1 had Ativan ordered for two different reasons with different dosages.
-She knew she was supposed to check the dosage of Resident #1's Ativan before she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 53	D 358		

administered it but only checked the name of the medication.
-She was responsible to request refills for medications when the medication was unavailable, but she did not know the dosage of Ativan was different.
-The SCC and Resident Care Coordinator (RCC) were responsible for medication cart audits to also make sure medications were available to administer.

Interview with the RCC on 08/08/24 at 9:49am revealed:
-The MAs were responsible to request medication refills from the pharmacy when a medication was missing from the cart or in low supply.
-The medication cart audits were not documented anywhere.
-She did not know when the last medication cart audit was completed because the audits were random and completed every few months by the SCC on the SCU.
-The MAs were supposed to follow the 5 rights (Medication, dosage, time, quantity, and route) when administering medications.
-When a new prescription was needed the MA would tell her or the SCC and the resident's provider would be contacted.

Telephone interview with the facility's contracted pharmacy on 08/08/24 at 10:11am revealed:
-The pharmacy did not receive a fax from the facility with a prescription for Resident #1's Ativan 2mg dated 07/12/24.
-Only some of Resident #1's medications were dispensed by the pharmacy because they were just a back-up pharmacy to Resident #1's preferred local pharmacy.
-Resident #1's Ativan 2mg was never dispensed to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 54	D 358		

-They entered all the resident's medications on the profile for the eMAR, but they did not enter the Ativan 2mg on the eMAR and someone at the facility must have entered it.
-The facility was able to access the profile of the eMAR for the residents and make changes as needed.

Telephone interview with a pharmacy technician from Resident #1's local pharmacy on 08/08/24 at 10:42am revealed:
-Resident #1's Ativan 2mg was dispensed on 09/14/23 in the quantity of 2 tablets with no refills.
-The pharmacy never received a new prescription for Resident #1's Ativan 2mg take 1 tablet every 20 minutes as needed for seizure activity with a maximum of 2 doses in 24 hours.
-The facility did not fax a new order for Resident #1's Ativan 2mg.

Telephone interview with Resident #1's hospice registered nurse (RN) Supervisor on 08/08/24 at 4:38pm revealed:
-Resident #1 was ordered Ativan 2mg take 1 tablet every 20 minutes for seizure activity for a maximum of 2 doses beginning on 03/26/23 when the hospice RN observed seizure-like activity with shaking multiple times in 20-minutes.
-Resident #1 was also ordered Ativan 0.5mg take ½ tablet every 6 hours for agitation.
-The Ativan 2mg order was last renewed on 07/12/24 for Resident #1.
-The Ativan 2mg dosage was required to be administered to stop seizure activity in Resident #1.
-Resident #1 being administered the 0.25mg dosage of Ativan on 07/04/24 and 07/17/24 for seizures would have been too low a dosage and would not bring Resident #1 out of the seizure and could have caused Resident #1 to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 55	D 358		

experience another seizure on 07/18/24 when Resident #1 fell.

Interview with the SCC on 08/09/24 at 9:30am revealed:
-MAs were supposed to request medication refills for medications unavailable to administer.
-MAs were supposed to administer medications by comparing the dosage of the medication with the eMAR.
-She did not know two MAs administered the wrong dosage of Ativan to Resident #1 on 07/04/24 and 07/17/24 when Resident #1 needed the Ativan for seizures.
-If Resident #1's Ativan 2mg was unavailable to administer, the MAs should have notified her, and the medication could have been requested to be dispensed by the facility's contracted pharmacy or an alternate pharmacy.
-The MAs did not notify her that Resident #1's Ativan 2mg was unavailable to administer.
-She occasionally completed medication cart audits to make sure all medications were available to administer but the last cart audit she completed was several months ago.
-Medication cart audits were not documented.

Interview with a RN from the facility's contracted pharmacy on 08/09/24 at 11:22am revealed:
-She completed medication cart audits for the facility every "3 to 4 months".
-The last cart audit was completed in July 2024.
-She checked for expired medications and made sure the multi-dose medications were labeled with a date when opened.
-She was not responsible for checking to make sure that all medications for residents were available to administer.

Telephone interview with Resident #1's hospice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 56	D 358		

provider on 08/09/24 at 4:16pm revealed:
-She prescribed Ativan 2mg to Resident #1 to stop seizure activity.
-Ativan 0.25mg would not be sufficient to bring Resident #1 out of a seizure.
-By Resident #1 receiving too small a dosage of Ativan, it could have caused increased seizure activity which may have contributed to Resident #1 falling.
-She expected the facility to administer Resident #1 the Ativan 2mg as ordered for seizures.

Interview with the Administrator on 08/08/24 at 11:45am revealed:
-The MAs were responsible for requesting refills for medications from the pharmacy when the medication was unavailable.
-If a new prescription was needed for a medication, the MA was supposed to notify the SCC or RCC to obtain a new prescription from the provider.
-Refill request for controlled substances could not be completed electronically and a sticker with the medication information was applied to a medication refill paper and faxed to the pharmacy.
-He did not know why Resident #1's Ativan 2mg was unavailable for administration.
-The facility did not currently have a policy in place for how often medication cart audits to check for available medications were completed.
-The facility did not complete MAR audits to make sure medications were administered as ordered.
-The MAs were responsible for following the 5 rights of medication administration when administering medications including checking the dosage of medication.

Attempted interview with Resident #1's POA on 08/07/24 at 11:05am was unsuccessful.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 57 2. Review of Resident #3's current FL2 dated 06/27/24 revealed: -Diagnoses included dementia and lumbar spondylosis (an age-related degeneration of the disks in the lower back). -There was an order for Pataday ophthalmic solution 0.2% (an over-the-counter eye drop to treat allergies) to be administered to both eyes daily. Observation of meds on hand on 08/08/24 at 10:55am revealed: -Pataday ophthalmic solution 0.2% was not available for administration. -Visine, multi-action allergy eye drops were available and documented with Resident #3's name. Interview with a MA on 08/08/24 at 10:55am revealed: -Resident #3's family member provided the eye drops. -Visine, multi-action allergy eye drops were used for the Pataday eye drops that were listed on the MAR. -As soon as the Visine was gone, a refill request would be submitted to the pharmacy for the Pataday eye drops. Review of Resident #3's June 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Pataday ophthalmic solution 0.2% daily to both eyes with an original start date of 04/05/24. -There was documentation Pataday ophthalmic solution 0.2% was administered 30 of 30 opportunities.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 58	D 358		

Review of Resident #3's July 2024 eMAR revealed:
-There was an entry for Pataday ophthalmic solution 0.2% daily to both eyes.
-There was documentation Pataday ophthalmic solution 0.2% was administered 07/01/24 through 07/06/24, 07/08/24 through 07/18/24, 07/20/24 through 07/23/24 and 07/27/24 through 07/31/24.
-There was documentation Pataday ophthalmic solution 0.2% was not administered on 07/07/24, 07/19/24, 07/24/24, 07/26/24 with "other/see progress note" as the reason why they were not administered.
-There was documentation Pataday ophthalmic solution 0.2% was not administered on 07/25/24 with "hospitalized" as the reason why they were not administered.

Review of Resident #3's August 2024 eMAR revealed:
-There was an entry for Pataday ophthalmic solution 0.2% daily to both eyes.
-There was documentation Pataday ophthalmic solution 0.2% was administered 2 of 2 opportunities on 08/01/24 and 08/02/24.

Interview with a second MA on 08/09/24 at 8:55am revealed:
-The family provided Resident #3's eye drops.
-She matched the eye drops to the eMAR but could not remember if she administered the Visine in place of the Pataday eye drops.

Interview with the RCC on 08/08/24 at 11:15am revealed:
-Resident #3's family provided the Pataday eye drops when she was admitted in 03/2024 and informed the facility that she would continue to provide them.
-She had the pharmacy enter the order into the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 59	D 358		

eMAR system but requested they not be dispensed because the family would provide them.
-"She guessed" Resident #3's family brought the Visine eye drops when the original Pataday eye drops ran out.
-The MAs were responsible for confirming they were administering the correct eye drops.
-She was unable to retrieve progress notes documented in the eMAR system by the MAs that documented the reason why a medication was not administered.

Interview with the SCC on 08/09/24 at 9:55am revealed:
-Resident #3's family provided the eye drops and "must have brought the wrong brand the last time she needed a refill".
-The MAs were supposed to confirm they were administering the correct eye drop before they administered them.
-She was not responsible for completing cart audits.
-The MA who was responsible for completing cart audits had not done them in 3 or 4 months.
-If cart audits were completed routinely the error would have been caught.

Interview with the Administrator on 08/08/24 at 11:45am revealed he expected the MAs to notify the SCC that a different eye drop was provided by the family and the SCC should have asked the family to bring the correct one.

_____

The facility failed to administer Resident #1's Ativan 2mg (used for seizure activity) when Resident #1 had a seizure on 07/04/24 and 07/17/24 and was administered Ativan 0.25mg (used for anxiety) instead resulting in the Ativan dosage being ineffective at stopping the seizure.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 60 This failure was detrimental to the health of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/08/24 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 29, 2024.	D 358		
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure medications were administered within one hour before or one hour after the prescribed time for 2 of 3 sampled residents related to alprazolam (given for anxiety) and doxycycline hyclate (given to treat infection) (#2) and insulin (#7). The findings are: Review of the facility's undated Liberalized Medication Pass Guidelines revealed: -Medications will be administered as followed, unless they are on the exception list or otherwise indicated by the provider. -Once daily medications will be given between 7am and 11pm (time code AMLIB). -Twice daily medications will be given between	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 364	Continued From page 61	D 364		

7am and 11am and 7pm and 11pm (time code BIDLIB).
-Medications scheduled with meals will be scheduled for meal times.
-Medications ordered to be given with a specific hourly requirement will be scheduled appropriately.
-The exception list included diabetic medications, seizure medications, pain medications, respiratory medications, anticoagulants proton pump inhibitors, thyroid preparations and bisphosphanates.

1. Review of Resident #2's current FL2 dated 10/18/23 revealed:
-Diagnoses included chest pain and hypertensive urgency.
-There was an order for alprazolam 0.50mg tablet twice daily.
-There was an order for doxycycline hyclate 100mg tablet twice daily.

Interview with Resident #2 during initial tour on 08/06/24 at 9:41am revealed:
-She had concerns about her medication administration.
-She knew the staff had a window of time to give medications.
-She was receiving her morning medications late several times a week.

Review of Resident #2's July 2024 electronic medication administration record (eMAR) revealed:
-An entry for alprazolam 0.50mg tablet twice daily.
-Administration times for alprazolam were 8:00am and 8:00pm.
-An entry for doxycycline hyclate 100mg tablet twice daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 364	Continued From page 62	D 364		

-Administration times for doxycycline hyclate were 8:30am and 4:30pm.

Review of Resident #2's August 2024 eMAR revealed:
-An entry for alprazolam 0.50mg tablet twice daily.
-Administration times for alprazolam were 8:00am and 8:00pm.
-An entry for doxycycline hyclate 100mg tablet twice daily.
-Administration times for doxycycline hyclate were 8:30am and 4:30pm.

Review of the Time of Medication Adminstration Report for 07/23/24 through 07/31/24 revealed:
-Alprazolam 0.50mg tablet was administered at 10:50am on 07/23/24.
-Alprazolam 0.50mg tablet was administered at 9:52am on 07/28/24.
-Alprazolam 0.50mg tablet was administered at 10:25am on 07/29/24.
-Alprazolam 0.50mg tablet was administered at 11:14am on 07/30/24.
-Alprazolam 0.50mg tablet was administered at 10:15am on 07/31/24.
-Doxycycline Hyclate 100mg tablet was administered at 10:50am on 07/23/24.
-Doxycycline Hyclate 100mg tablet was administered at 9:52am on 07/28/24.
-Doxycycline Hyclate 100mg tablet was administered at 10:25am on 07/29/24.
-Doxycycline Hyclate 100mg tablet was administered at 11:14am on 07/30/24.
-Doxycycline Hyclate 100mg tablet was administered at 10:15am on 07/31/24.

Review of the Time of Medication Adminstration Report for 08/01/24 through 08/06/24 revealed:
-Alprazolam 0.50mg tablet was administered at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 364	Continued From page 63	D 364		

10:35am on 08/01/24.
-Alprazolam 0.50mg tablet was administered at 10:16am on 08/03/24.
-Alprazolam 0.50mg tablet was administered at 9:38am on 08/04/24.
-Doxycycline Hyclate 100mg tablet was administered at 10:36am on 08/01/24.
-Doxycycline Hyclate 100mg tablet was administered at 10:16am on 08/03/24.

Interview with the Resident Care Coordinator (RCC) on 08/06/24 at 5:18pm revealed:
-Resident #2 wanted to receive her medications precisely at the time they were due.
-She told the medication aides (MAs) to administer her medications first.

Interview with a MA on 08/07/24 at 9:23am revealed:
-Resident #2 worried about receiving her medications on time, especially if there was a new MA.
-If medications have "lib" beside the am or pm dose, that meant they were on a "liberalized" medication pass.
-A liberalized medication pass meant there was one hour before and three hours after the scheduled medication administration time that a medication could be administered.
-She often got busy and would not sign off on Resident #2's medication until later in the morning.
-Resident #2 had never been on a liberalized medication pass.

Telephone interview with a MA on 08/07/24 at 12:28pm revealed:
-She was told by the Administrator between three and four months ago that all residents were on a liberalized medication pass.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 364	Continued From page 64 -If a resident was on a liberalized medication pass, the medication could be administered up to four hours after the scheduled time on the eMAR. -She had to assist the PCAs on the floor with resident care and showers, so her medication administration was often later than an hour after the scheduled medication administration time. Interview with Resident #2 on 08/07/24 at 4:53pm revealed: -She had spoken with the Administrator about getting her medications late. -She felt like they were always making up some excuse because she was still not getting her medications on time. -She understood they had an hour before and an hour after the scheduled time to give medications, but she was being administered her medications outside of that timeframe. Interview with the RCC on 08/09/24 at 9:48am revealed: -Resident #2 was not on a liberalized medication pass. -All of Resident #2's medications should be administered an hour before to an hour after the scheduled administration time. Interview with the Administrator on 08/09/24 at 4:37pm revealed: -It had been his understanding from a pharmacy representative that all residents in the facility were on a liberalized medication pass. -If a resident was not on a liberalized medication pass, the MAs had an hour before an hour after the scheduled time to administer medications timely. 2. Review of Resident #7's current FL2 dated 06/27/24 revealed diagnoses included	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 364	Continued From page 65	D 364		

Alzheimer's disease and type 2 diabetes.

Interview with Resident #7's family member on 08/08/24 at 2:28pm revealed:
-Resident #3 was prescribed insulin four times a day.
-Sometimes the insulin was administered late.
-On 08/07/24 the morning insulin was not administered until after 10:00am.

Interview with the Special Care Coordinator (SCC) on 08/06/24 at 10:13am revealed medications that were not part of the liberalized medication pass were sometimes administered late because the medication aides (MAs) had so many medications to administer.

Interview with a MA on 08/09/24 at 9:41am revealed:
-Resident #7's insulins were supposed to be administered one hour before or no later than one hour after the scheduled time.
-Medications that were documented on the eMAR as AM-LIB meant the medication could be administered any time from 6:00am until noon.

a. Review of Resident #7's current FL2 dated 06/27/24 revealed there was an order for Humalog 100unit/ml Kwikpen (a short-acting insulin used to treat high blood sugars) inject three times daily per sliding scale: 150-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, 401-450=12 units, 451-500=15 units, 501-550= 20 units, greater than 551= 22 units and notify provider.

Review of Resident #7's July 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Humalog 100unit/ml

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 364	Continued From page 66	D 364		

Kwikpen inject three times daily at 8:00am, 12:30pm and 5:30pm per sliding scale: 150-200=2 unit, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, 401-450=12 units, 451-500=15 units, 501-550= 20 units, greater than 551= 22 units and notify provider.
-There was documentation 50 of 99 blood sugar readings required administration of insulin per the sliding scale.

Review of Resident #7's July 2024 Time of Medication Administration Report revealed:
-There was documentation Humalog was administered greater than one hour after administration time on 17 of the 50 occasions.
-There was documentation the 8:00am dose of Humalog was administered at 9:17am on 07/03/24, 9:36am on 07/09/24, at 9:24am on 07/10/24, at 11:29am on 07/11/24, at 9:52am on 07/20/24, at 10:09am on 07/22/24 and at 9:54am on 07/29/24.
-There was documentation the 12:30pm dose of Humalog was administered at 1:33pm on 07/05/24, at 1:44pm on 07/07/24, at 2:26pm on 07/10/24, at 1:39pm on 07/11/24, at 2:47pm on 07/14/24, at 2:44pm on 07/23/24, at 2:06pm on 07/27/24, at 2:33pm on 07/28/24 and at 2:18pm on 07/31/24.
-Resident #7 was administered her 5:30pm dose of Humalog at 7:43pm on 07/26/24.

Review of Resident #7's August 2024 eMAR revealed:
-There was an entry for Humalog 100unit/ml Kwikpen inject three times daily at 8:00am, 12:30pm and 5:30pm per sliding scale: 150-200=2 unit, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, 401-450=12 units, 451-500=15 units, 501-550=

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 364	Continued From page 67	D 364		

20 units, greater than 551= 22 units and notify provider.
-There was documentation 17 of 25 blood sugar readings required administration of insulin per the sliding scale.

Review of Resident #7's August 2024 Time of Medication Administration Report revealed:
- There was documentation Humalog was administered greater than 1 hour after administration time on 2 of the 17 occasions.
- There was documentation the12:30pm dose of Humalog was administered at 2:25pm on 08/05/24 and 2:32pm on 08/08/24.

b. Review of Resident #7's current FL2 dated 06/27/24 revealed there was an order for Lantus Solostar 100 units/ml, inject 28 units subcutaneously at bedtime.

Review of Resident #7's July 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Lantus Solostar, inject 28 units at 8:00pm.
-There was documentation Lantus Solostar was administered 30 of 31 opportunities.
-There was documentation Lantus Solostar was not administered on 07/09/24 with the reason "no insulin required".

Review of Resident #7's July 2024 Time of Medication Administration Report revealed:
-There was documentation the Lantus Solostar was administered greater than 1 after administration time on 12 of the 30 occasions.
-There was documentation the 8:00pm dose of Lantus Solostar was administered at 9:43pm on 07/02/24, at 9:23pm on 07/06/24, at 9:23pm on 07/12/24, at 10:00pm on 07/13/24, at 9:27pm on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 364	Continued From page 68 07/14/24, at 10:48pm on 07/22/24, at 9:14pm on 07/23/24, at 9:09pm on 07/24/24, at 10:18pm on 07/25/24, at 22:54pm on 07/27/24, at 10:24pm on 07/28/24, and 11:01pm on 07/31/24. Review of Resident #7's August 2024 eMAR revealed: -There was an entry for Lantus Solostar, inject 28 units at 8:00pm. -There was documentation Lantus Solostar was administered on 7 of 8 opportunities. -There was documentation Lantus Solostar was not administered on 08/01/24 with the reason "other/see progress note". Review of Resident #7's August 2024 Time of Medication Administration Report revealed: -There was documentation the Lantus Solostar was administered greater than 1 hour after administration time on 5 of the 7 occasions. -There was documentation the 8:00pm dose of Lantus Solostar was administered at 9:19pm on 08/01/24, at 9:17pm on 08/03/24, at 9:51pm on 08/05/24, at 9:37pm on 08/07/24 and 10:38pm on 08/09/24. Interview with the Administrator on 08/09/24 at 4:37pm revealed: -It had been his understanding from a pharmacy representative that all residents in the facility were on a liberalized medication pass. -If a resident was not on a liberalized medication pass, the MAs had an hour before an hour after the scheduled time to administer medications timely.	D 364		
D 367	10A NCAC 13F .1004(j) Medication Administration	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 69	D 367		

10A NCAC 13F .1004 Medication Administration
(j) The resident's medication administration record (MAR) shall be accurate and include the following:
(1) resident's name;
(2) name of the medication or treatment order;
(3) strength and dosage or quantity of medication administered;
(4) instructions for administering the medication or treatment;
(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observation, interviews, and record reviews, the facility failed to ensure the electronic medication administration records (eMAR) were accurate for 1 of 5 sampled residents (#1) related to inaccurate documentation of a medication to treat seizures.

The findings are:

Review of the facility's undated Medication Administration Policy revealed:
-All medications administered were documented on the eMAR.
-Each resident will have medications available in accordance with the physician's order.
-Medications will be administered from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 70	D 367		

medication cart by comparing the MAR with the medications.
-Five rights (right resident, right drug, right dose, right route, and right time) are applied for a recommended three-time process for each medication being administered.

Review of Resident #1's current FL2 dated 07/12/24 revealed:
-Diagnoses included dementia and seizure disorder.
-Current level of care was documented as special care unit (SCU).
-Orientation was documented as constantly disoriented.

Review of Resident #1's physician's orders dated 07/12/24 revealed there was an order for Ativan (used to treat seizures) 2mg take 1 tablet every 20 minutes as needed for seizures and repeat in 20 minutes if ineffective for a maximum of 2 doses in 24 hours.

Review of Resident #1's 07/12/24-07/31/24 electronic medication administration record (eMAR) revealed:
-There was an entry for Ativan 2mg take 1 tablet every 20 minutes as needed for seizures and repeat in 20 minutes if ineffective for a maximum of 2 doses in 24 hours.
-There was documentation Ativan 2mg was administered on 07/04/24 at 9:20am and was documented as ineffective.
-There was documentation Ativan 2mg was administered on 07/17/24 at 9:31am and was documented as effective.

Observation of Resident #1's medications on hand on 08/07/24 at 4:18pm revealed:
-There was no Ativan 2mg available for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 71	D 367		

administration.
-There was a bottle labeled Ativan 0.5mg take ½ tablet every 6 hours as needed for anxiety.

Review of Resident #1's narcotics control sheet log revealed:
-There was a control sheet with a handwritten entry for Ativan 0.5mg take ½ tablet every 6 hours as needed.
-There was documentation Ativan 0.5mg take ½ tablet every 6 hours as needed for anxiety was administered on 07/04/24 at 8:00am with a remaining balance of 55 tablets available.
-There was documentation Ativan 0.5mg take ½ tablet every 6 hours as needed for anxiety was administered on 07/17/24 at 8:00am with a remaining balance of 54 tablets available.
-There was no control sheet log available for Ativan 2mg take 1 tablet every 20 minutes for seizure activity for a maximum of 2 doses in 24 hours.

Telephone interview with the facility's contracted pharmacy on 08/08/24 at 10:11am revealed:
-The pharmacy did not receive a fax from the facility with a prescription for Resident #1's Ativan 2mg dated 07/12/24.
-Only some of Resident #1's medications were dispensed by the pharmacy because they were just a back-up pharmacy to Resident #1's preferred local pharmacy.
-Resident #1's Ativan 2mg was never dispensed to the facility.
-The pharmacy entered all the resident's medications on the profile for the eMAR, but they did not enter the Ativan 2mg on the eMAR and someone at the facility must have entered it.
-The facility was able to access the profile of the eMAR for the residents and make changes as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 72 Telephone interview with a pharmacy technician from Resident #1's local pharmacy on 08/08/24 at 10:42am revealed: -Resident #1's Ativan 2mg was dispensed on 09/14/23 in the quantity of 2 tablets with no refills. -The pharmacy never received a new prescription for Resident #1's Ativan 2mg take 1 tablet every 20 minutes as needed for seizure activity with a maximum of 2 doses in 24 hours. -The facility did not fax a new order for Resident #1's Ativan 2mg dated 07/12/24. Interview with a medication aide (MA) on 08/07/24 at 4:28pm revealed: -Resident #1 did not have Ativan 2mg tablets available to administer. -There was a bottle with Ativan 0.5mg take ½ tablet available to administer to Resident #1. Interview with a second MA on 08/08/24 at 9:29am revealed: -Resident #1 started having seizure like activity about 6 months ago. -Resident #1 was having slight convulsions on 07/17/24 and she called the hospice registered nurse (RN) who told her to administer Ativan to Resident #1. -She administered the Ativan 0.5mg ½ tablet for anxiety instead of the ordered 2mg for seizures because she did not realize the Ativan was a different dose. -She documented she administered Resident #1's Ativan 2mg for seizures on the eMAR by mistake because she did not realize Resident #1 had Ativan ordered for two different reasons with different dosages. Interview with the SCC on 08/09/24 at 9:30am revealed:	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 73 -MAs were supposed to request medication refills for medications unavailable to administer. -MAs were supposed to administer medications by comparing the dosage of the medication with the eMAR. -She did not know two MAs documented the wrong dosage of Ativan administered to Resident #1 on 07/04/24 and 07/17/24 when Resident #1 needed the Ativan for seizures. -If Resident #1's Ativan 2mg was unavailable to administer, the MAs should have notified her, and the medication could have been requested to be dispensed by the facility's contracted pharmacy or an alternate pharmacy. -The MAs did not notify her that Resident #1's Ativan 2mg was unavailable to administer. -She expected the MAs to accurately document on the eMAR the correct medication and dosage administered. -The facility did not have a policy that she was aware of for completing MAR audits. -She had never completed a MAR audit to make sure medications were administered and documented correctly. Interview with the Administrator on 08/08/24 at 11:45am revealed: -The facility did not have a policy regarding completing MAR audits to make sure medications were documented and administered as ordered. -No eMAR audits were completed by the facility. -The MAs should not have documented on the eMAR Resident #1's Ativan 2mg as administered if the medication was unavailable. -He expected the MAs to document medication administration accurately on the eMAR.	D 367		
D 392	10A NCAC 13F .1008 (a) Controlled Substances	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 74 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure readily retrievable records that accurately reconciled the receipt and administration of controlled substances for 2 or 4 sampled residents (#2 and #6) with orders to treat anxiety (#2) and to treat pain (#6). The findings are: 1. Review of Resident #2's current FL2 dated 10/18/23 revealed: -Diagnoses included chest pain and hypertensive urgency. -There was an order for alprazolam (a medication used to treat anxiety) 0.5mg tablet each morning and at bedtime. Review of Resident #2's August 2024 electronic medication administration record (eMAR) revealed: -There was an entry for alprazolam 0.5mg tablet each morning and at bedtime. -Scheduled administration time for the morning dose was 8:00am. -Scheduled administration time for the evening dose was 8:00pm. Observation of Resident #2's medications on hand on 08/08/24 at 12:16pm revealed:	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 75	D 392		

-There was a medication card with seven alprazolam 0.5mg tablets remaining.
-The controlled drug disposition form revealed there were eight alprazolam 0.5mg tablets remaining.

Refer to interview with the Medication Aide (MA) on 08/08/24 at 12:19pm.

Refer to interview with the Resident Care Coordinator (RCC) on 08/09/24 at 9:48am.

Refer to interview with the Administrator on 08/09/24 at 4:37pm.

2. Review of Resident #6's current FL2 dated 03/11/24 revealed:
-Diagnoses included Alzheimer's disease, osteoporosis, and gastric reflux.
-There was an order for tramadol (a medication used to treat pain) 25mg tablet daily.

Review of Resident #6's August 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for tramadol HCL 50mg tablet take one-half tablet (25mg) once daily for pain.
-Scheduled administration time for the daily dose was 8:30am.

Observation of Resident #6's medications on hand on 08/08/24 at 12:23pm revealed:
-There was a medication card with 14 tramadol 50mg one-half tablets (25mg) remaining.
-The controlled drug disposition form revealed there were 15 tramadol 50mg one-half tablets (25mg) remaining.

Refer to interview with the MA on 08/08/24 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R-C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 76 12:19pm. Refer to interview with the RCC on 08/09/24 at 9:38am. Refer to interview with the Administrator on 08/09/24 at 4:37pm. _____ Interview with the MA on 08/08/24 at 12:19pm revealed: -She did not sign off on all the controlled drug disposition forms until the end of her morning medication pass. -She usually signed off on all the narcotics on the controlled drug disposition form between 10:00am and 11:00am. -She knew she was supposed to sign off on the controlled drug disposition form as she gave medications, but she normally did not sign off on the narcotics until she had completed her morning medication pass. Interview with the RCC on 08/09/24 at 9:38am revealed: -The MAs have been told they must document on the eMAR and the controlled drug disposition form when they administer a narcotic. -The MAs should not be waiting until the end of their medication pass to document on the controlled drug disposition form. Interview with the Administrator on 08/09/24 at 4:37pm revealed: -The MAs were supposed to document on the controlled drug disposition form as soon as a narcotic was administered. -The pharmacy gave a training to the MAs that included this information in July 2024.	D 392		