Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL085013	A. BUILDING: _____ B. WING _____	R 12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACELAND LIVING CENTER II	1290 DENNY ROAD KING, NC 27021

(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 an annual and follow-survey on December 30, 2025.	D 000		
D 367	10A NCAC 13F .1004 (j) Medication Administration 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 observations, interviews, and record reviews, the facility failed to ensure 1 of 3 sampled residents' (#1) Electronic Medication Administration Record (eMAR) was accurate and included documentation of any omission of treatments and the reason for omission, including	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL085013	A. BUILDING: _____ B. WING _____	R 12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACELAND LIVING CENTER II	1290 DENNY ROAD KING, NC 27021

(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 1 refusals. The findings are: Review of Resident #1's current FL2 dated 03/07/25 revealed diagnoses of depression, hypothyroidism, hiatal hernia, borderline mental retardation, sleep apnea, tracheostomy, hypertension and chronic venous insufficiency. Review of Resident #1's signed physician orders dated 07/21/25 revealed compression stockings daily, apply every morning and remove at bedtime. Review of Resident #1's Licensed Health Professional Support (LHPS) assessments dated 09/12/25 and 12/12/25 revealed the task of applying and removing ace bandages and Thrombo-Embolic Deterrent (TED) hose. Review of Resident #1's October 2025, November 2025 and December 2025 (12/01/25-12/30/25) eMARs revealed entries and staff initials for every day of applying and removing compression stockings with no exceptions or refusals noted. Observation of Resident #1 during initial tour of facility at 8:37am on 12/30/25 revealed no compression stockings on his lower extremities. Second observation of Resident #1 at 10:46am on 12/30/25 revealed no compression stockings on his lower extremities. Third observation of Resident #1 at 1:22pm on 12/30/25 revealed no compression stockings on his lower extremities.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL085013	A. BUILDING: _____ B. WING _____	R 12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACELAND LIVING CENTER II	1290 DENNY ROAD KING, NC 27021

(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 2 Fourth observation of Resident #1 at 2:51pm on 12/30/25 revealed no compression stockings on his lower extremities. Observation of Resident #1's room at 3:38pm on 12/30/25 revealed four pairs of compression stockings in a dresser drawer in his room. Interview with Resident #1 at 8:37am on 12/30/25 revealed: -He had been a resident of the facility for 26 years. -He had been to the hospital several times over the past year for worsening lower extremity edema. -He was unable to apply his own compression stockings and staff were supposed to assist him with this daily, but he sometimes would not let them. Telephone interview with Resident #1's Primary Care Provider (PCP) at 2:44pm on 12/30/25 revealed: -He ordered the compression stockings in August 2024. -If Resident #1 would consistently wear compression stockings, his edema would likely decrease, as well as his repeated hospitalizations and increased risk for infections. His pain and circulation may also improve. -He was aware of Resident #1's repeated refusals to wear compressions stockings when he was an on-sight provider in 2024, but no refusals had been reported to him in 2025. -Potential negative outcomes from not wearing the compressions stockings were increased edema, pain, weeping, infections, open areas, hospitalizations and overall declining health. Telephone interview with the facility's contracted	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL085013	A. BUILDING: _____ B. WING _____	R 12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACELAND LIVING CENTER II	1290 DENNY ROAD KING, NC 27021

(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 3 provider at 3:06pm on 12/30/25 revealed: -She was aware of the order for Resident #1 to wear compression stockings daily. -She was aware of Resident #1's refusals to allow staff to apply his compression stockings but was unaware that facility staff were not documenting refusals on the eMARs. Interview with a Medication Aide (MA) at 4:21pm on 12/30/25 revealed: - She was aware of the order for Resident #1 to wear compression stockings daily. -She was aware of Resident #1's refusal to allow staff to apply his compression stockings but because she normally worked third shift, she was not primarily responsible for applying or removing them. -When Resident #1 refused medications or treatments, she would document the refusals on the eMAR and report the refusal to the facility director. Interview with the facility Director/Supervisor-in-Charge (SIC) at 4:21pm on 12/30/25 revealed: -She was aware of the order for Resident #1 to wear compression stockings daily. -She was aware that Resident #1 refused to wear his compression stockings often and reported that he would also remove them after staff put them on. -She had observed Resident #1 without his compression stockings on multiple occasions. -First shift staff (6am-1pm) were responsible for applying the compression stockings and second shift staff (1pm-9pm) were responsible for removing them. -She audited eMARs every other day. -All medication and treatment refusals should be documented on resident eMARs and indicated	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL085013	A. BUILDING: _____ B. WING _____	R 12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACELAND LIVING CENTER II	1290 DENNY ROAD KING, NC 27021

(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 4 with a circle around the staff's initials. -All refusals should be verbally communicated to the facility director daily. Interview with the facility's regional nurse at 4:21pm on 12/30/25 revealed: -She was aware of the order for Resident #1 to wear compression stockings daily. -She was aware of Resident #1's repeated refusals to wear compression stockings but was unaware that facility staff were not documenting refusals on the eMARs. -She completed eMAR audits monthly and reported refusals to PCPs. -She expected the facility director to communicate refusals to her and the PCPs. -She planned to train all staff on documentation and reporting refusals of medications and treatments. Telephone interview with the facility Administrator at 4:34pm on 12/30/25 revealed: -She was aware of Resident #1's order for compression stockings. -She was aware of Resident #1's repeated refusals to wear compression stockings but was unaware that facility staff were not documenting refusals on the eMARs. -She expected facility staff to try at least three times to administer treatments and then notify her of refusals. -Refusals should be documented on resident eMARs and list the number of attempts and specifics of each refusal. It was her expectation that this would occur going forward.	D 367		