STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GRACE VILLAGE ASSISTED LIVING & MEMORY CAR	501 RIVER BEND DRIVE GRANITE FALLS, NC 28630

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D 000	Initial Comments The Adult Care Licensure Section and the Caldwell County Department of Social Services conducted an annual survey and complaint investigation on 06/10/25 and 06/11/25. Two complaint investigations were completed, one complaint investigation was initiated on 05/30/25 and a second investigation was initiated by Caldwell County Department of Social Services on 06/06/25.	D 000		
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: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a licensed practitioner for 3 of 4 residents (# 3, #6, and #8,) observed during the 8:00am medication pass on 06/11/25 related to a supplement to increase calcium and vitamin D (#6) and a supplement used to treat vitamin deficiency (#6), a supplement used to prevent high cholesterol (#3), and a supplement used for eye health (#8). The findings are: The medication error rate was 12% as evidenced by the observation of 4 errors out of 32	D 358		

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opportunities during the 12:00pm medication pass on 06/10/25 and 8:00am medication pass on 06/11/25.

Review of the facility's medication administration policy revealed prior to removing the medication from the container, check the label against the order on the medication administration record (MAR).

1. Review of Resident #6's current FL2 dated 02/07/25 revealed diagnoses included unspecified dementia without behavioral disturbance, permanent atrial fibrillation, essential hypertension, falls, and hypothyroidism.

a. Review of Resident #6's primary care provider (PCP) order dated 05/14/25 revealed calcium citrate/vitamin D 315mg-200u (used to supplement calcium and vitamin D levels) take two tablets daily.

Observation of the morning medication pass on 06/11/25 at 7:55am revealed:
-The medication aide (MA) prepared nine oral medications including calcium 500mg plus vitamin D 25mcg (1,000iu) for administration to Resident #6 as she compared the medications displayed on the electronic medication administration record (eMAR).
-At 8:07am, the MA administered the nine oral medications to Resident #6 and documented the administration on the June 2025 eMAR.

Review of Resident #6's April 2025 eMAR revealed:
-There was an entry for calcium citrate/vitamin D 315mg-200u take two tablets daily scheduled at 8:00am.
-Calcium citrate/vitamin D 315mg-200u was

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documented as administered as ordered from 04/01/25-04/30/25.

Review of Resident #6's May 2025 eMAR revealed:
-There was an entry for calcium citrate/vitamin D 315mg-200u take two tablets daily scheduled at 8:00am.
-Calcium citrate/vitamin D 315mg-200u was documented as administered as ordered from 05/01/25-05/31/25.

Review of Resident #6's June 2025 eMAR revealed:
-There was an entry for calcium citrate/vitamin D 315mg-200u take two tablets daily scheduled at 8:00am.
-Calcium citrate/vitamin D 315mg-200u was documented as administered as ordered from 06/01/25-06/11/25.

Interview with a MA on 06/11/25 at 11:45am revealed:
-She administered the calcium 500mg plus vitamin D 25mcg (1,000iu) as a substitute for calcium citrate/vitamin D 315mg-200u.
-She knew the strength of the calcium 500mg plus vitamin D 25mcg (1,000iu) did not match the entry on the eMAR.
-She administered the calcium 500mg plus vitamin D 25mcg (1,000iu) because that was what Resident #6's family provided.

Interview with the Special Care Coordinator (SCC) on 06/11/25 at 11:54am revealed:
-Resident #6's family member provided Resident #6's calcium/vitamin D supplement.
-She did a medication cart audit one to two weeks ago.
-She did not notice a discrepancy in Resident

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#6's calcium/vitamin D supplement during the recent medication cart audit.
-Resident #6's family member may have brought a new bottle of calcium/vitamin D supplement on a recent visit.

Telephone interview with Resident #6's PCP on 06/11/25 at 3:12pm revealed:
-She ordered the calcium citrate/vitamin D as a supplement for most of her "senior patients."
-She ordered the calcium citrate/vitamin D 315mg-200u strength for Resident #6, but was aware families often provided the supplements and she was "liberal" with what the families provided.

Based on observations, interviews, and record reviews it was determined that Resident #6 was not interviewable.

Refer to the interview with the Administrator on 06/11/25 at 5:23pm.

b. Review of Resident #6's primary care provider (PCP) order dated 05/14/25 revealed Certavite Senior (used to treat vitamin deficiency) one tablet daily.

Observation of the morning medication pass on 06/11/25 at 7:55am revealed:
-The medication aide (MA) prepared nine oral medications including one discount store brand adult multivitamin with minerals gummy for administration to Resident #6 as she compared the medications displayed on the electronic medication administration record (eMAR).
-At 8:07am, the MA administered the nine oral medications to Resident #6 and documented the administration on the June 2025 eMAR.

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Review of Resident #6's April 2025 eMAR revealed:
-There was an entry for Certavite Senior one tablet daily scheduled at 8:00am.
-The Certavite Senior was documented as administered as ordered from 04/01/25-04/30/25.

Review of Resident #6's May 2025 eMAR revealed:
-There was an entry for Certavite Senior one tablet daily scheduled at 8:00am.
-The Certavite Senior was documented as administered as ordered from 05/01/25-05/31/25.

Review of Resident #6's June 2025 eMAR revealed:
-There was an entry for Certavite Senior one tablet daily scheduled at 8:00am.
-The Certavite Senior was documented as administered as ordered from 06/01/25-06/10/25.

Interview with a MA on 06/11/25 at 11:45am revealed:
-She administered the one discount store brand adult multivitamin with minerals gummy as a substitute for Certavite Senior that morning on medication pass.
-She administered the discount store brand adult multivitamin with minerals gummy because that was what Resident #6's family provided.

Interview with the Special Care Coordinator (SCC) on 06/11/25 at 11:54am revealed:
-Resident #6's family member provided Resident #6's adult multivitamin with minerals supplement.
-She did a medication cart audit one to two weeks ago.
-She did not notice a discrepancy in Resident #6's discount store brand adult multivitamin with minerals supplement rather than the Certavite

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Senior supplement during the recent medication cart audit.
-Resident #6's family member may have brought a new bottle of adult multivitamin with minerals supplement on a recent visit.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 06/11/25 at 12:20pm revealed:
-The family provided Resident #6's multivitamin with minerals supplement.
-He could not attest the discount store generic adult multivitamin with minerals supplement was comparable to the Certavite Senior without contacting the manufacturer of the generic adult multivitamin with minerals.

Telephone interview with Resident #6's PCP on 06/11/25 at 3:12pm revealed:
-She ordered the Certavite Senior as a vitamin and mineral supplement.
-She ordered the Certavite Senior brand for Resident #6, but was aware families often provided the supplements and she was "liberal" with what the families provided.

Based on observations, interviews, and record reviews it was determined that Resident #6 was not interviewable.

Refer to the interview with the Administrator on 06/11/25 at 5:23pm.

2. Review of Resident #3's FL2 dated 05/29/24 revealed diagnoses included chronic obstructive pulmonary disease, long term use of anticoagulants, difficulty in walking, and oropharyngeal dysphagia.

Review of Resident #3's primary care provider

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(PCP) order dated 05/14/25 revealed ultra omega3 (a supplement used to reduce cholesterol) 1400mg one capsule daily.

Review of Resident #3's subsequent PCP order dated 06/11/25 revealed ultra omega3 1400mg one capsule daily.

Observation of the morning medication pass on 06/11/25 at 8:14am revealed:
-The medication aide (MA) prepared seven oral medications including one soft gel fish oil 1,000mg with 300mg of omega3 supplement for administration to Resident #3 as she compared the medications displayed on the electronic medication administration record (eMAR).
-At 8:25am, the MA administered the seven oral medications to Resident #3 and documented the administration on the June 2025 eMAR.

Review of Resident #3's April 2025 eMAR revealed:
-There was an entry for ultra omega3 1400mg one capsule daily scheduled at 8:00am.
-The ultra omega3 1400mg capsule was documented as administered as ordered from 04/01/25-04/30/25.

Review of Resident #3's May 2025 eMAR revealed:
-There was an entry for ultra omega3 1400mg one capsule daily scheduled at 8:00am.
-The ultra omega3 1400mg capsule was documented as administered as ordered from 05/01/25-05/31/25.

Review of Resident #3's June 2025 eMAR revealed:
-There was an entry for ultra omega3 1400mg one capsule daily scheduled at 8:00am.

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-The ultra omega3 1400mg capsule was documented as administered as ordered from 06/01/25-06/10/25.

Interview with the Resident Care Coordinator (RCC) on 06/11/25 at 12:50pm revealed:
-Resident #3's omega3 supplement was provided by his family.
-She did not know why the strength of the omega3 supplement was different than what was ordered by his PCP.

Telephone interview with Resident #3's PCP on 06/11/25 at 3:12pm revealed she ordered the ultra omega3 1400mg supplement for Resident #3 at the request of his family as a proactive measure to prevent high cholesterol.

Refer to the interview with the Administrator on 06/11/25 at 5:23pm.

3. Review of Resident #8's current FL2 dated 04/07/25 revealed:
-Diagnoses included dementia, osteoporosis, and hypothyroidism.
-There was an order for Preservision Areds one twice daily.

Review of Resident #8's primary care provider (PCP) order dated 05/14/25 revealed Preservision Areds once daily.

Observation of the morning medication pass on 06/11/25 at 8:14am revealed:
-The medication aide (MA) prepared eight oral medications including for administration to Resident #8 as she compared the medications displayed on the electronic medication administration record (eMAR).
-There was an eMAR entry for Preservision Areds

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one capsule.
-There was no Preservision Areds available for administration.
-At 8:36am, the MA administered the eight oral medications to Resident #8 and documented the administration on the June 2025 eMAR.

Interview with the MA on 06/11/25 at 8:30am revealed:
-There was no Preservision Areds available for Resident #8.
-The Preservision Areds had already been requested for refill from the facility's contracted pharmacy, but it had not yet arrived to the facility.

Review of Resident #8's June 2025 eMAR revealed:
-There was an entry for Preservision Areds (used for eye health) one capsule twice daily scheduled at 8:00am and 8:00pm.
-The Preservision Areds was documented as administered on 16 occurrences out of 21 opportunities from 06/01/25-06/11/25.
-On 06/05/25 at 8:00am, on 06/10/25 at 8:00am an 8:00pm, and on 06/11/25 at 8:00am, the Preservision Areds was documented as not administered as "Hold/see progress note."

Telephone interview with a representative from the facility's contracted pharmacy on 06/11/25 at 10:42am revealed:
-The Preservision Areds one tablet twice daily order was still active for Resident #8.
-They last sent Preservision Areds a 30-day supply for Resident #8 on 05/06/25.

Interview with the Resident Care Coordinator (RCC) on 06/11/25 at 12:50pm revealed:
-She discovered Resident #8's Preservision Areds were out of supply on 06/09/25 when she

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D 358	Continued From page 9 administered medications. -She called the facility's contracted pharmacy on 06/09/25 and requested a refill. -They told her the Preservision Areds would not be available to send to the facility until 06/10/25 or 06/11/25. Telephone interview with Resident #8's PCP on 06/11/25 at 3:12pm revealed she ordered Resident #8 Preservision Areds for eye health. Based on observations, interviews, and record reviews it was determined that Resident #8 was not interviewable. Refer to the interview with the Administrator on 06/11/25 at 5:23pm. _____ Interview with the Administrator on 06/11/25 at 5:23pm revealed: -The medication aides(MAs) were responsible for verifying the supplements provided by families for residents were the same as what the PCP ordered. -The MAs should check the medication label with the entry on the eMAR and ensure they were the same strength prior to administering the medication. -It was the responsibility of the MAs, the Special Care Coordinator (SCC), and the Resident Care Coordinator (RCC) to ensure the medications prescribed were available for administration.	D 358		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan	D 464		

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In addition to the requirements in Rules .0801 and .0802 of this Subchapter, the facility shall:
(1) Within 30 days of admission to the special care unit and quarterly thereafter, develop a written
resident profile containing assessment data that describes the resident's behavioral patterns, selfhelp abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment.
(2) Develop or revise the resident's care plan required in Rule .0802 of this Subchapter based on the
resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities.

This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to ensure 3 of 5 sampled resident (#5, #6, and #7) had a written profile completed within 30 days of admission to the Special Care Unit (SCU) and quarterly therafter.

The findings are:

1. Review of Resident #5's current FL2 dated 08/09/24 revealed diagnoses included dementia.

Review of Resident #5's Resident Register revealed she was admitted to the facility on 10/06/21.

Review of Resident #5's Care Plan dated 02/24/25 revealed:
-It was completed by the Special Care Coordinator (SCC) but it was not signed.

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D 464	Continued From page 11 -It was not signed by the primary care provider (PCP). Review of Resident 5's record revealed there was no documentation quarterly care plans were completed. Refer to the interview with the SCC on 06/11/25 at 11:44am. Refer to interviews with the Administrator on 06/10/25 at 2:41pm and 06/11/25 at 8:55am and 4:45pm. 2. Review of Resident #6's current FL2 dated 02/07/25 revealed diagnoses included dementia. Review of Resident #6's Resident Register revealed she was admitted to the facility on 02/27/25. Review of Resident 6's record revealed: -There was documentation a Resident Profile was completed on 02/28/25 but it was not signed by the SCC or the PCP. -There was no documentation a quarterly care plan was completed in May 2025. Refer to the interview with the Special Care Coordinator (SCC) on 06/11/25 at 11:44am. Refer to interviews with the Administrator on 06/10/25 at 2:41pm and 06/11/25 at 8:55am and 4:45pm. 3. Review of Resident #7's current FL2 dated 03/27/25 revealed diagnoses included late onset Alzheimer's. Review of Resident #7's Resident Register revealed an admission date was not documented.	D 464		

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D 464	Continued From page 12 Review of the facility's April 2025 census report revealed Resident #7 was admitted to the facility on 04/07/25. Review of Resident #7's record revealed there was no documentation of a completed resident profile. Refer to the interview with the Special Care Coordinator (SCC) on 06/11/25 at 11:44am. Refer to the interviews with the Administrator on 06/10/25 at 2:41pm and 06/11/25 at 8:55am and 4:45pm. _____ Interview with the Special Care Coordinator (SCC) on 06/11/25 at 11:44am revealed: -She had been in her current role for about a month. -She completed the care plans, printed them for the physician to sign, and scanned them back into the system once completed. -She was responsible for ensuring resident care plans were signed by a physician. -She was not sure why some of the care plans were not completed and signed by a physician. Interviews with the Administrator on 06/10/25 at 2:41pm and 06/11/25 at 8:55am and 4:45pm revealed: -She could not locate signed Care Plans. -The Care Plans were completed by the previously employed SCC. -A Care Plan was completed electronically, printed out and then signed by the SCC and the PCP. -After the signatures were documented it was scanned into the electronic medical record. -She did not know why the previously employed	D 464		

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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 464	Continued From page 13 SCC did not obtain signatures and scan it into the system. -She did not know why the SCC did not complete quarterly care plans. -She was ultimately responsible for ensuring the Care Plans were signed and quarterly care plans were completed.	D 464		