

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NH0476</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>04/10/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GRACE RIDGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 LENOIR ROAD</b> <b>MORGANTON, NC 28655</b>
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(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
{L 000}	<p><b>INITIAL COMMENTS</b></p> <p>On April 10, 2018, The Division of Health Service Regulation, Nursing Home Licensure and Certification conducted a revisit (paper follow up). The facility was found to be in compliance effective April 2, 2018.</p>	{L 000}		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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