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
	NH0476	A. BUILDING: _____ B. WING _____	11/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE RIDGE	500 LENOIR ROAD MORGANTON, NC 28655

(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	INITIAL COMMENTS An unannounced Focused Infection Control survey in conjunction with a review of the emergency preparedness for staff was conducted on 11/24/20. Additional information was obtained through 11/25/20, therefore the exit date was changed to 11/25/20. The facility was found in compliance with the rules for the licensing of nursing homes 10A NCAC 13D.2209 for Infection Control and has implemented the Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event ID# QKRX11.	L 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE