

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>06/16/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GRACE RIDGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 LENOIR ROAD 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>An unannounced Focused Infection Control survey in conjunction with a review of the emergency preparedness for staff was conducted on 06/16/2020. The facility was found in compliance with the rules for the licensing of nursing homes 10A NCAC 13 D 2209 for Infection Control and has implemented the Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event ID#: RJWY11.</p>	L 000		

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