STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345187	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEIGHTS HEALTH & REHABILITATION	109 FOOTHILLS DRIVE 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) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced onsite complaint survey was conducted from 02/27/24 through 02/29/24. The exit conference was conducted by phone on 3/7/24. Therefore, the exit date was changed to 3/7/24. The following intake was investigated NC00213817. Two (2) of the 2 complaint allegations did not result in deficiency.	F 000		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure an order for oxygen was clarified and transcribed from a discharge summary on admission for a resident admitted following a re-hospitalization for COVID-19 (coronavirus disease) pneumonia. This deficient practice affected 1 of 2 residents reviewed for respiratory care (Resident #1). The findings included: A hospital discharge summary dated 1/9/24 indicated Resident #1's acute on chronic respiratory failure with hypoxia (oxygen not available in sufficient amounts), community acquired pneumonia, chronic obstructive	F 695	Resident #1 was already discharged from facility. A 100% audit of all residents was completed by the Unit Manger on 2/28/2024 to verify O2 orders were in place if indicated from physician. To prevent this from reoccurring education was provided on 2/28/2024 to all nursing staff by Director of Nursing or designee related to the expectation that oxygen orders be entered into electronic medical records. The admitting nurse will enter orders, a second nurse will verify orders, and a unit manager will be third checks.	3/8/24

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

Electronically Signed | 03/26/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345187	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEIGHTS HEALTH & REHABILITATION	109 FOOTHILLS DRIVE 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) COMPLETION DATE
F 695	Continued From page 1 pulmonary disease with exacerbation (COPD-disease that causes breathing difficult) and COVID-19 were resolved within the hospital stay from 1/1/24 through 1/9/24 and she had returned to her baseline oxygen requirements of 3L (liters) of oxygen via nasal cannula continuously and baseline mentation and ultimately able to be discharged on 2L oxygen via nasal cannula after the exam on the date of discharge. Resident #1 was re-admitted to the facility on 1/9/24 with diagnoses that included COPD and obstructive sleep apnea. A review of Resident #1's physician's orders revealed the following orders: No orders for oxygen therapy A nurses note dated 1/10/24 read in part ... "Resident c/o of a headache and mild nausea. VSS (vital signs), 157/77, P (pulse) 98, Resp (respirations) 20 spo2 (oxygen saturation) 94% on 4L (liters)." A provider progress note written by Nurse Practitioner (NP) dated 1/11/24 indicated Resident #1's physical assessment showed no assessor muscles usage while on 3L of oxygen via nasal cannula. A Medicare 5-day Minimum Data Set (MDS) assessment dated 1/16/24 revealed Resident #1 was cognitively intact, had no behaviors, and received oxygen while a resident. An Occupational Therapy (OT) progress note date 1/17/24 indicated Resident #1 wears 4L continuous oxygen.	F 695	Director of nursing will ensure that no nursing staff will be allowed to work until education is provided. Assistant Director of Nursing will ensure all staff are educated upon hire. The Director of Nursing or designee will conduct audits on all current resident□s medical records with oxygen orders for 4 weeks, 5 residents with oxygen orders for 4 weeks, and 2 residents with oxygen orders for 4 weeks to ensure oxygen are entered into electronic medical record. The Administrator will bring audits to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. The QAPI committee will evaluate the effectiveness of training and observations to determine if continued auditing is necessary to maintain compliance. Date of compliance: 3/8/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345187	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEIGHTS HEALTH & REHABILITATION	109 FOOTHILLS DRIVE 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) COMPLETION DATE
F 695	Continued From page 2	F 695		

An Occupational Therapy (OT) progress note date 1/18/24 indicated Resident #1 wears 4L continuous oxygen.

An Occupational Therapy (OT) progress note date 1/20/24 indicated Resident #1 wears 4L continuous oxygen.

A review of the tab labeled "vital signs" in Resident #1's medical record revealed the following entries:
1/9/24 at 6:30 PM: Resident #1 was on 4L of oxygen.
1/9/24 at 10:01 PM: Resident #1 was on 4L of oxygen.
1/10/14 at 10:40 AM: Resident #1 was on 3L of oxygen.
1/10/24 at 10:43 PM: Resident #1 was on 4L of oxygen.
1/12/24 at 5:42 AM: Resident #1 was on 2L of oxygen.
1/12/24 at 11:20 AM: Resident #1 was on 4L of oxygen.
1/12/24 at 9:57 PM: Resident #1 was on 2L of oxygen.
1/13/24 at 9:36 PM: Resident #1 was on 3L of oxygen.
1/15/24 at 11:08AM: Resident #1 was on 2L of oxygen.
1/15/24 at 9:45 PM: Resident #1 was on 3.5L of oxygen.
1/16/24 at 9:46 PM: Resident #1 was on 2L of oxygen.

An interview with the Assistant Director of Nursing on 2/28/24 at 8:57 AM revealed she was unsure who should have transcribed the order on admission, but she acknowledged Resident #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345187	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEIGHTS HEALTH & REHABILITATION	109 FOOTHILLS DRIVE 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) COMPLETION DATE
F 695	Continued From page 3 had continuous use oxygen in place since her readmission on 1/9/24 and she should have had an order entered into the electronic medical record on the date of admission which would clarify the correct liters of oxygen Resident #1 should receive via nasal cannula. An interview with the Nurse Practitioner on 2/29/24 at 10:45 AM revealed she was somewhat familiar with Resident #1 and her history. She stated Resident #1 was oxygen dependent and Resident #1 should have orders to reflect her continuous usage in the facility. An interview with the Medical Director on 3/5/24 at 2:54 PM revealed he was somewhat familiar with Resident #1. He stated he was aware of her having a history of COPD and oxygen dependency. He stated he was not aware the facility had not obtained a physician's order for usage of her oxygen following re-admission to the facility. He acknowledged Resident #1 should have an order to reflect her continuous usage in the facility.	F 695		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records.	F 842		3/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345187	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEIGHTS HEALTH & REHABILITATION	109 FOOTHILLS DRIVE 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) COMPLETION DATE
F 842	Continued From page 4	F 842		

§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345187	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEIGHTS HEALTH & REHABILITATION	109 FOOTHILLS DRIVE 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) COMPLETION DATE
F 842	Continued From page 5 legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to document vital signs and an assessment when a resident complained of shortness of breath. This deficient practice affected 1 of 2 residents reviewed for inaccurate medical record (Resident #1). The findings included: Resident #1 was re-admitted to the facility on 1/9/24 with diagnoses that included chronic obstructive pulmonary disease (COPD), obstructive sleep apnea, chronic pain syndrome with uncomplicated opioid dependence, and generalized anxiety disorder. A. An interview with Nurse Aide (NA) #3 on 2/29/24 at 9:11 AM revealed she was very familiar with Resident #1 and had worked with her several times and was assigned to work with Resident #1 from 7:00 AM to 3:00 PM on 1/20/24. She stated Resident #1 usually got out of bed for therapy but recalled saying she felt more "tired" and "short of	F 842	Resident #1 was already discharged from facility. A 100% audit of all residents was completed by the Director of Nursing, Assistant Director of Nursing, and Nurse Manager on 3/25/2024 to verify all vital signs were entered into the medical record. To prevent this from reoccurring education was provided on 3/25/2024 to all CNAs and nursing staff by Director of Nursing or designee related to the expectation that all vital signs are entered into the medical record when completed. CNAs will ensure they record it on the vitals sheets after notifying the nurse and the nurse will ensure it is entered into the medical record prior to the end of the shift. No nursing staff will be allowed to work until education is provided. The Director of Nursing will ensure that no nursing staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345187	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEIGHTS HEALTH & REHABILITATION	109 FOOTHILLS DRIVE 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) COMPLETION DATE
F 842	Continued From page 6 breath" with a slight cough on 1/20/24 between late morning or early afternoon. NA#3 said she took the resident's vitals every day even when the nurse did not assign them as part of the daily vitals required to be obtained for her shift but could not recall exactly what they were on that day. A review of the medical record revealed there were no vital signs recorded by Nurse Aide (NA) #3 (or on her behalf by Medication Aide (MA) #1 or Nurse #1) on 1/20/24. B. An interview with Nurse #1 was conducted on 2/28/24 at 3:09 PM. Nurse #1 was asked if she performed an assessment on Resident #1 and documented it in the medical record, Nurse #1 was unable to locate any documentation in the medical record to reflect an assessment was completed. Nurse #1 was able to recall Resident #1 being short of breath and assessing her to be having a "panic attack" on 1/20/24; however, the only documentation Nurse #1 made was on the Medication Administration Record when she provided medications at 6:33 PM to Resident #1 for anxiety and pain.	F 842	will be allowed to work until education is provided. Assistant Director of Nursing will ensure that this education is added to the new hire education. The Director of Nursing or designee will conduct audits on all current resident□s to ensure all vitals are in their medical records for 4 weeks, 5 residents for 4 weeks, and 2 residents for 4 weeks. The Administrator will bring audits to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. The QAPI committee will evaluate the effectiveness of training and observations to determine if continued auditing is necessary to maintain compliance. Date of compliance: 3/26/2024.	