STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014-017	A. BUILDING: _____ B. WING _____	R 05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CARI	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 and follow up survey and complaint investigations on 05/27/26 to 05/29/26.	D 000		
D 118 ✓	10A NCAC 13F .0311 (i) Other Requirements 10A NCAC 13F .0311 Other Requirements (i) In licensed facilities without live-in staff, there shall be an electrically operated call system meeting the following requirements: (1) the call system shall connect residents' bedrooms and bathrooms to a location accessible to staff; (2) residents' bedrooms shall have a resident call system activator at the resident's bed; (3) the resident call system activator shall be within reach of a resident lying on the bed; (4) the resident call system activator shall be such that it can be activated with a single action and remain on until deactivated by staff at point of origin; and (5) when activated, the call system shall activate an audible and visual signal in a location accessible to staff. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to provide an electrically operated call system that activated an audible signal accessible to staff for 1 of 5 sampled residents (#1). The findings are:	D 118	Root Cause Investigation determined that a failed call system component rendered Resident #1's call bell inoperable, and the facility lacked an interim process to ensure residents had a reliable means to summon assistance while repairs were pending. Immediate Corrective Action Upon identification of the inoperable call bell, maintenance was notified and the failed communication device was replaced. Resident #1 received increased supervision until repairs were completed to ensure the resident's needs could be promptly addressed. Systemic Correction The facility established a process requiring that residents affected by a call system malfunction be provided with an alternate means of summoning assistance and increased supervision, as indicated, until repairs are completed. Maintenance staff will be notified immediately, and repairs will be tracked until resolved. Monitoring Plan The Executive Director or designee will monitor resident call bells to ensure they are functioning properly and that residents affected by any call system malfunction are provided with an alternate means of summoning assistance until repairs are completed. Call bells will be checked weekly for four weeks and quarterly thereafter for six months to ensure continued compliance.	6/25/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christy White — TITLE: Executive Dir. — (X6) DATE: 6-26-2026

Reviewed and acknowledged 6/29/26

RP

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D 118	Continued From page 1 Review of Resident #1's current FL2 dated 10/29/25 revealed: -Diagnosis included bi-polar disorder, hypertension, fatigue and major depressive disorder. -She was semi-ambulatory and used a walker. -She was intermittently disoriented. Review of Resident #1's resident register revealed she was admitted to the facility on 12/03/25. Review of Resident #1's care plan dated 12/03/25 revealed: -She was independent in all activities of daily living except bathing. -She needed supervision with bathing. Interview with Resident #1 on 05/28/26 at 9:30am revealed: -Her call bell was currently working but it was not working when she fell a few months ago. -She fell by the heater under her window and she had to get a pillow from her bed and scoot to the bathroom to use the call bell because the call bell beside her bed was not working. -She told the aide who helped her when she had the fall that her call bell was not working. -It took maintenance about 30 days to fix it after the fall. Observation of Resident #1's room on 05/28/26 at 9:30am revealed: -On one wall of her room she had a king-sized bed and a nightstand on each side of the bed. -There was a call bell on the wall above the nightstand to the left of her bed. -The heater and window was to the right of her bed.	D 118		

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D 118	Continued From page 2 -The door to the bathroom was across from the foot of her bed. Review of Resident #1's accident report dated 03/03/26 revealed: -Resident #1 fell by the heater and was found on the floor in the bathroom after ringing the call bell. -There was no documentation Resident #1 informed staff the call bell was not working. Interview with the maintenance director on 05/28/26 at 11:34am and 1:13pm revealed: -He repaired Resident #1's call bell in late February after the Resident Care Coordinator (RCC) informed him it was not working. -He was told again on approximately 03/12/26 that it was not working. -He contacted the company immediately to come and fix it. -The company that maintained the call system came on 03/13/26 and replaced it. -He did not give her an alternative means of calling for help while the call bell was not working. Interview with the RCC on 05/28/26 at 1:20pm revealed: -Resident #1 told her the call bell by her bed was not working on 03/10/26 and she reported it to the maintenance director immediately. -She was aware it had been fixed previously. -She did not give Resident #1 an alternative means of calling for help while the bell was not working. -She "probably" asked staff to make more frequent rounds on her during that time. Interview with a Medication Aide (MA) on 03/29/26 at 7:17am revealed: -She was the MA who responded to Resident #1 on 03/03/26 when she rang the call bell in her	D 118		

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D 118	Continued From page 3 bathroom. -Resident #1 did not inform her the call bell by her bed did not work. -She was aware the call bell by her bed needed to be fixed a few weeks prior to 03/03/26. -When a call bell did not work a resident was put on 30-minute checks. Review of a work order dated 03/13/26 revealed: -The work was completed by a local telecommunications contractor. -There was documentation a bad device was replaced. Interview with the Administrator on 05/29/26 at 9:57am revealed: -When a resident did not have access to a working call bell they were placed on increased supervision, typically 1-hour checks. -The facility did not have hand bells that could be used if the call bell system did not work. -She was not informed Resident #1's call bell needed to be fixed and ultimately replaced.	D 118		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	D 270		

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D 270	Continued From page 4 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (Resident #3) who had a history of falls with no documentation of increased supervision after the falls. The findings are: Review of the facility's undated Fall Prevention Policy and Procedure revealed: -If a resident was assessed to be at high risk for falls, had experienced a recent fall, or had a history of falls, interventions would be identified and implemented. -The resident, responsible person, and family members will participate in/review the interventions. Review of Resident #3's current FL2 dated 12/31/25 revealed: -Diagnoses included Alzheimer's disease, chronic kidney disease stage 3, sensorineural hearing loss, and systemic lupus. -The recommended level of care was special care unit (SCU). -Resident #3 was ambulatory. -Resident #3 was incontinent of bowel and bladder. -Resident #3 was constantly disoriented. Review of Resident #3's Resident Register revealed: -Resident #3's admission date was 07/15/25. -Resident #3 had a Power of Attorney (POA). Review of Resident #3's Care Plan dated 02/06/26 revealed: -Resident #3 was always disoriented.	D 270	Root Cause Investigation determined that the facility lacked a process to ensure supervision and documentation of supervision after falls. Immediate Corrective Action Education with staff on proper documentation and monitoring of residents after falls and incident that require increased monitoring or support. Systemic Correction The facility revised and implemented the Falls and Head Injury Response Policy to strengthen staff response to resident falls and suspected head injuries. The revised policy requires staff to assess residents before movement, obtain and document vital signs for every fall, identify when EMS is needed, complete neurological checks when a head injury is suspected, notify appropriate parties, and document the incident according to facility procedure. Monitoring Plan Staff will be educated on the revised policy. The Administrator, Resident Care Director, or designee will monitor fall documentation for compliance weekly for 4 weeks and then quarterly for 6 months.	6/25/26

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D 270	Continued From page 5 -Resident #3 had wandering behaviors and was exit seeking. -Resident #3 was difficult to redirect. -Resident #3 required supervision with ambulation. -Resident #3 required limited assistance with dressing and grooming. -Resident #3 required extensive assistance with toileting and bathing. Review of Resident #3's incident/accident reports from July 2025 through February 2026 revealed: -There were 18 incident/accident reports documented between 07/31/25 and 02/04/26. -Some of the interventions included "30-minute checks on patient" and "increased rounding." Interview with a personal care aide (PCA) on 05/28/26 at 8:50am revealed: -When Resident #3 was admitted to the facility she was constantly disoriented but was walking independently. -She started having a lot of falls and eventually needed more help. -The staff are supposed to observe residents every 15 minutes to ensure they are present in the facility and check the residents a minimum of every 2 hours for incontinence care. -After falls staff are supposed to increase rounds for the Resident who fell. -There was no set amount of time that the rounds were increased after the fall. -There was no documentation rounds were done after Resident #3's falls occurred. Interview with a second PCA on 05/28/26 at 10:09am revealed: -Resident #3 had been independent with walking when she was admitted to the facility. -As time progressed, her walking got worse and	D 270		

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D 270	Continued From page 6 she started falling a lot. -None of the PCAs document increased rounds being done after any resident falls. Interview with the Special Care Coordinator (SCC) on 05/28/26 at 10:55am revealed: -Resident #3 had been independent with walking from her admission to the facility until just a few days before she was hospitalized in February 2026. -She had multiple falls even with interventions put in place to try and prevent the falls. -After a resident fell, the PCAs were supposed to increase supervision of the resident more frequently. -There was not a set amount of time for the PCAs to increase supervision. -There was no documentation that increased supervision occurred after Resident #3's multiple falls. Interview with the Administrator on 05/29/26 at 10:56am and 1:16pm revealed: -Resident #3 had multiple falls while at the facility. -There were always interventions put in place to prevent further falls. -Often after falls, the resident would be placed on 30-minute checks for 24 to 48 hours. -She was not aware staff was not documenting increased supervision after falls.	D 270		
D 295	10A NCAC 13F .0904(c)(6) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (6) Menus for all therapeutic diets shall be planned or reviewed by a licensed dietitian/nutritionist. The facility shall maintain	D 295		

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D 295	Continued From page 7 verification of the licensed dietitian/nutritionist's approval of the therapeutic diets. This Rule is not met as evidenced by: Based on observation, interviews and record reviews the facility failed to have the facility's therapeutic diet menus reviewed and approved by a Registered Dietitian (RD). The findings are: Observation of the kitchen during initial tour on 05/27/26 at 11:46am revealed: -There was a listing of all residents who had a therapeutic diet posted by the cook's serving station. -There was a binder next to the cook's serving station that contained the therapeutic diet menus. Review of the facility's therapeutic diets revealed they served a chopped diet, a ground diet, a pureed diet and finger foods. Review of the facility's Spring/Summer therapeutic diet menus revealed: -The menus were developed by the facility's contracted food vendor. -There was a therapeutic diet menu for an International Dysphagia Diet Standardization Initiative (IDDSI) Level 7 easy to chew. -There was a therapeutic diet menu for an IDDSI Level 4 pureed. -There was a therapeutic diet menu for a finger	D 295	Root Cause Investigation determined that the facility lacked a process to ensure therapeutic diets received the required review and approval by a Registered Dietitian. Immediate Corrective Action Upon identification of the deficiency, all therapeutic diets were submitted to a Registered Dietitian for review and approval. Dietary staff were notified of any recommendations or changes resulting from the review. Systemic Correction The facility established a process to ensure that all therapeutic diets are reviewed and approved by a Registered Dietitian as required. Therapeutic diet reviews will be obtained upon implementation of new diets and whenever changes to therapeutic diet menus are made. Documentation of Registered Dietitian review and approval will be maintained by the facility. Monitoring Plan The Executive Director or designee will monitor therapeutic diet documentation to ensure required Registered Dietitian review and approval has been obtained. Documentation will be reviewed weekly for four weeks and quarterly thereafter for six months to ensure continued compliance.	6/25/26

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D 295	Continued From page 8 food diet. -There was no documentation an RD reviewed or approved the therapeutic menus. Interview with the RD from the facility's contracted food vendor on 05/28/26 at 4:25pm revealed: -She was the corporate menu specialist at the facility's contracted food vendor. -The facility had a contract with the food vendor to develop and provide menus. -There were multiple levels of contracts and the facility did not pay for the level that provided an RD's review and approval. -It was the facility's responsibility to have an RD from the state of North Carolina review and approve the menus because the food vendor did not have RDs in every state they worked in. Interview with the facility's Director of Business Development and Marketing on 05/28/26 at 4:45pm revealed: -The facility's corporate office had an employee who negotiated contracts with the food vendor. -He thought the contract they had with the food vendor provided both menu development and RD review and approval. -He did not know the menus in the kitchen were not reviewed and approved by an RD. Interview with the Administrator on 05/28/26 at 4:45pm revealed: -The facility received new menus this past spring from the contracted food vendor. -She thought the RD at the food vendor reviewed and approved them when she developed them.	D 295		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service	D 296		

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D 296	Continued From page 9 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observation, interviews and record reviews the facility failed to have matching therapeutic diet menus for 2 of 3 sampled residents (#6 and #7) with physician-ordered therapeutic diets for guidance of food service staff related to a mechanical soft diet (#6) and a ground diet (#7). The findings are: Observation of the kitchen during initial tour on 05/27/26 at 11:46am revealed: -There was a listing of all residents who had a therapeutic diet posted by the cook's serving station. -There was a binder next to the cook's serving station that contained the therapeutic diet menus. Review of the facility's Spring/Summer therapeutic diet menus revealed: -The menus were developed by the facility's contracted food vendor. -There was not a menu for a mechanical soft diet or a ground diet. 1. Review of Resident #6's current FL2 dated	D 296	Root Cause Investigation determined that the facility lacked a process to ensure therapeutic menus for mechanically altered diets were developed and maintained to correspond with the regular menu and residents' prescribed dietary needs. Immediate Corrective Action Upon identification of the deficiency, therapeutic menus for mechanically altered diets were developed to correspond with the regular menu and implemented for resident use. The menus were submitted to the Registered Dietitian for review and approval. Systemic Correction The facility established a process to ensure therapeutic menus for mechanically altered diets are developed, maintained, and updated to correspond with the regular menu and residents' prescribed dietary needs. All therapeutic menus and subsequent revisions will be submitted to the Registered Dietitian for review and approval, and documentation of approval will be maintained by the facility. Monitoring Plan The Executive Director or designee will monitor therapeutic menus for mechanically altered diets to ensure they correspond with the regular menu and that required Registered Dietitian review and approval have been obtained. Documentation will be reviewed weekly for four weeks and quarterly thereafter for six months to ensure continued compliance.	6/25/26

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D 296	Continued From page 10 02/17/26 revealed: -Diagnosis included pneumonia and gastroesophageal reflux disease (GERD). -There was an order for a mechanical soft diet. Review of the facility's Spring/Summer therapeutic diet menus revealed: -It did not contain a menu for a mechanical soft diet. -There was a therapeutic diet menu for an International Dysphagia Diet Standardization Initiative (IDDSI) Level 7 easy to chew. Refer to interview with the Food Service Director (FSD) on 05/29/26 at 2:07pm. Refer to telephone interview with the RD from the facility's contracted food vendor on 05/28/26 at 4:25pm. Refer to interview with the facility's Director of Business Development and Marketing on 05/28/26 at 4:45pm. Refer to interview with the Administrator on 05/28/26 at 4:45pm. 2. Review of Resident #7's current FL2 dated 01/14/26 revealed: -Diagnosis included diabetes, dementia and hypertension. -There was an order for a regular ground diet. Review of the facility's Spring/Summer therapeutic diet menus revealed: -It did not contain a menu for a regular ground diet. -There was a therapeutic diet menu for an International Dysphagia Diet Standardization Initiative (IDDSI) Level 7 easy to chew.	D 296		

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D 296	Continued From page 11 Refer to Interview with the Food Service Director (FSD) on 05/29/26 at 2:07pm. Refer to telephone Interview with the RD from the facility's contracted food vendor on 05/28/26 at 4:25pm. Refer to Interview with the facility's Director of Business Development and Marketing on 05/28/26 at 4:45pm. Refer to Interview with the Administrator on 05/28/26 at 4:45pm. --- Interview with the Food Service Director (FSD) on 05/29/26 at 2:07pm revealed: -Se learned the facility would be changing to new menus when she received an email from the contracted food vendor representative in the winter that informed her the new Spring/Summer menus were available for download. -The new menus did not contain a menu for mechanical soft menu or a menu for a ground diet. -The facility did not have access to the Registered Dietitian (RD) that developed the new menus so it was up to her to decipher and interpret the changes. -She decided the IDDSI level 7 easy to chew menu best matched the diet orders so the dietary staff used that as guidance when preparing food for mechanical soft diets and ground diets. Telephone interview with the RD from the facility's contracted food vendor on 05/28/26 at 4:25pm revealed: -She was the corporate menu specialist at the	D 296		

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D 296	Continued From page 12 facility's contracted food vendor. -The facility had a contract with the food vendor to develop and provide menus but the contract did not include providing education on menus. -There were multiple levels of contracts and the facility did not pay for the level that provided education or menus for a mechanical soft diet or a ground diet. -The menu that was provided included a therapeutic diet menu for an IDDSI Level 7 easy to chew diet that could be used for a mechanical soft diet. -She could provide an IDDSI Level 5 Minced and Moist diet menu that could be used for a ground diet but the facility's contract did not include that level of menu planning. Interview with the facility's Director of Business Development and Marketing on 05/28/26 at 4:45pm revealed: -The facility's corporate office had an employee who negotiated contracts with the food vendor. -He thought the contract they had with the food vendor provided access to the RD for education and menu development for all types of diet orders including mechanical soft and ground because it had always been that way in the past. Interview with the Administrator on 05/28/26 at 4:45pm revealed: -The facility received new menus this past spring from the contracted food vendor. -She did not know the new menus did not have menus for mechanical soft or ground diets.	D 296		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service	D 310		

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	HAL014-017	A. BUILDING: _____ B. WING _____	R 05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE VILLAGE ASSISTED LIVING & MEMORY CARI	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 310	Continued From page 13 (e) Therapeutic Diets In Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to serve a therapeutic diet as ordered to 1 of 3 sampled residents (#6) related to an order for nectar thick liquids. The findings are: Review of Resident #6's current FL2 dated 02/17/26 revealed: -Diagnosis included pneumonia and gastroesophageal reflux disease (GERD). -There was an order for nectar thick liquids. Observation during the lunch meal service on 05/27/26 at 12:16pm revealed: -He was served ice water and coffee that were not nectar thick. -The Resident Care Coordinator (RCC) removed it immediately when it was brought to her attention. Observation of the beverage cart for the lunch meal service on 05/27/26 at 12:16pm revealed powder to thicken beverges was not on the cart. Interview with Resident #6 on 05/27/26 at 12:15pm revealed he was usually served thickened liquids. Interview with the Speech Language Pathologist on 05/27/26 at 12:17pm revealed: -She worked for the rehabilitation services that	D 310	Root Cause Investigation determined that the facility lacked a process to ensure therapeutic diet modifications, including prescribed liquid consistencies, were consistently provided in accordance with physician orders. Immediate Corrective Action Upon identification of the deficiency, Resident #6's liquid consistency was immediately corrected to nectar-thick as ordered. The resident's physician and responsible party were notified, and the resident was monitored for any adverse effects. Systemic Correction The facility established a process to ensure therapeutic diet modifications, including prescribed liquid consistencies, are communicated and provided in accordance with physician orders. Current diet orders will be maintained in a readily accessible location for dietary and direct care staff, and changes to diet orders will be promptly communicated to appropriate staff to ensure residents receive meals and liquids consistent with their prescribed dietary needs. Monitoring Plan The Executive Director or designee will monitor meal service to ensure therapeutic diet modifications, including prescribed liquid consistencies, are provided in accordance with physician orders. Meal observations and diet order documentation will be reviewed weekly for four weeks and quarterly thereafter for six months to ensure continued compliance.	6/25/26

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D 310	Continued From page 14 was housed at the facility and was able to monitor Resident #6's meals regularly. -Resident #6 always received his liquids thickened as ordered. -He received nectar thick liquids because he was hospitalized with aspiration pneumonia about six months ago. -While he was in the hospital for aspiration pneumonia he had a Modified Barium Swallowing Study (MBSS) (a test that determined swallowing function). -The MBSS indicated Resident #6 needed nectar thick liquids in order to swallow liquids safely. -He had an order to repeat the MBSS ordered but she did not know when it was scheduled. -She anticipated he would "pass" the MBSS because she had been providing therapy to him and doing trials of thin liquids and he was not displaying any difficulty swallowing because he had a good cough reflex. -If he drank thin liquids "he could get aspiration pneumonia but probably no more of a risk than any of us." Interview with a personal care aide (PCA) on 05/27/26 at 12:43pm revealed: -Resident #6 received nectar thick liquids. -Dietary staff prepared a cart containing beverages to serve at the meal and PCAs got it from the kitchen when it was time to serve. -Dietary staff were responsible for thickening liquids because they kept the powder to thicken it in the kitchen. -PCAs could serve liquids that were commercially prethickened. -Drinks were distributed to residents before she got into the dining room so she did not know who gave him liquids that were not nectar thick. Interview with another PCA on 05/27/26 at	D 310		

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D 310	Continued From page 15 12:51pm revealed: -Resident #6 received nectar thick liquids. -She thought the activity director distributed drinks to Resident #6 at lunch. Interview with the activity director on 06/27/26 at 1:30pm revealed: -Resident #6 received nectar thick liquids. -He did not serve Resident #6 drinks at lunch and thought a PCA distributed them. Interview with another PCA on 06/28/26 at 8:22am revealed: -Resident #6 received nectar thick liquids. -The Food Service Director (FSD) usually thickened the coffee for Resident #6 because the powder was kept in the kitchen. Interview with the FSD on 05/27/26 at 12:40pm revealed PCAs were responsible for thickening liquids, not dietary staff. Interview with the RCC on 05/28/26 at 10:04am revealed: -The staff in the kitchen prepared the liquids that needed to be thickened. -The PCAs had access to cartons of prethickened liquids. -Whoever served the liquids to Resident #6 did it accidentally. Interview with Resident #6's primary care provider (PCP) on 05/28/26 at 4:14pm revealed: -Resident #6 was currently ordered nectar thick liquids but she anticipated he would be able to return to thin liquids after the MBSS was completed. -Resident #6 had a MBSS scheduled for the following week. -He was at minimal risk of developing aspiration	D 310		

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D 310	Continued From page 16 pneumonia. Interview with the Administrator on 05/27/26 at 1:15pm revealed she expected all staff to serve diets as ordered and that included Resident #6's nectar thick liquids.	D 310		