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
	HAL060147	A. BUILDING: _____ B. WING _____	06/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANSON RIDGE AT THE VILLAGES OF MECKLENBUI	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an initial survey on June 15, 2016.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 1 of 5 residents (#1) sampled was tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: Review of Resident #1's current FL2 dated 4/15/16 revealed diagnoses included prostate cancer, squamous cell carcinoma, chronic kidney disease stage 3, seborrhea kertosis, actinic kerotosis, rheumatoid arthritis, ulcerative colitis, hyperlipidemia and history of tubular granuloma. Review of Resident #1's Resident Register revealed an admission date of 6/01/16.	D 234	D234: (A) Resident #1 has now had the 2-step TB tests with all information documented (B) An audit of all resident charts has been completed. All residents TB test are complete with full documentation of date given, lot number, manufacturer, date read and results/size documented or proof from other sources are in the charts. (C) The Resident Services Director (RSD) has implemented a audit tool to follow-up on all new admissions to ensure all of (A) above has been completed and properly documented. (D) Monitoring will be done as the RN, when completing the LHPS Evaluation will verify that the TB 2-step has been completed and documented as required in (A) above. (E) An in-service was held on 6-16-16 by RN to train all of the requirements for TB testing of all residents. This was for the Resident Services Director conducted by RN. (F) All newly implemented systems will monitored by the RSD and the RN.	7-19-16

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jimmy D. Greene — TITLE: Administrator — (X6) DATE: 7-13-16

STATE FORM 6899 UC8Q11 If continuation sheet 1 of 18

Reviewed and accepted
7/15/16 KGW

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D 234	Continued From page 1 Review of Resident #1's Resident Immunization Record revealed: revealed: -A computer printed paper with 5 typed entries with columns "PPD results, Lot number, manufacturer, injection site, nurses signature, date read and result/size". -The first line had date entered documented as 6/01/16, the injection site documented as right forearm and the Resident Services Director (RSD) signature was documented under nurses signature. -The columns "lot number, manufacturer, date read and results/size were all blank. -There was no documentation of any other TB skin tests in the resident's record. Review of Resident #1's June 2016 Medication Administration Record revealed there was no documentation of TB skin placement or reading of results. Interview with the Resident Service Director (RSD) on 6/15/16 at 12:02 pm revealed: -She thought Resident #1 had the TB skin test placed and read prior to admission. -Resident #1's daughter was very involved and was to bring the TB testing in and she would check for these results. -It was possible the Admissions Coordinator had the TB skin test results in her records. -The Admissions Coordinator would give her a list of admissions and she would document when the TB Test was placed and when the TB skin test was to be read on the Medication Administration Record (MAR). -She would rely on Medication Aides (MAs) to alert her if a TB skin test was due to be read. -This was not always reliable so she had recently	D 234		

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D 234	Continued From page 2 devised a list of admissions that included dates TB skin tests were placed and when they were due to be read. -She could not remember if she had placed a TB skin test on Resident #1. -A TB skin test was not produced for Resident #1. Interview with the Administrator on 6/15/16 at 2:07 pm revealed: -The facility was to place the TB skin test upon admission or obtain the results prior to admission. -The placement and reading of the TB skin test was primarily the responsibility of the RSD. -There were other part time nurses available to read and/or place TB skin test results if necessary. -The Admissions Coordinator was also responsible for requesting and obtaining the historical TB skin test results, if possible. -It was possible that the results of Resident #1's TB skin test were available in the Admissions coordinator's office. -Resident #1's TB skin test results were not attainable. -He was not aware that Resident #1did not have TB skin tests available. Interview with the Resident#1 on 6/15/16 at 12:20 pm revealed: -He did not know if he had recieved a TB skin test. -He did not have any injections since he has been a resident at this facility.	D 234		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner	D 344		

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D 344	Continued From page 3 for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed assure medication orders were clarified for 1 of 5 sampled residents (Resident #4) who was prescribed anti-inflammatory medications (Aspirin and meloxicam). The findings are: Review of Resident #4's current FL2 dated 6/02/16 revealed: -Diagnoses included Alzheimer's Dementia, arthritis, macular degeneration and legally blind. -Physician's orders for meloxicam 7.5 mg daily with food (an anti-inflammatory medication used to treat arthritis), and Aspirin 325 mg daily (an anti-inflammatory medication used to treat minor pain). Review of Resident #4's Medication Clarification sheet dated 6/10/16 revealed: -An entry for meloxicam 7.5 mg daily with food. -No entry for Aspirin 325mg daily. -No entries written in the "add and/or change the orders" section of the form.	D 344	•D344: (A) All orders have now been verified with the physician, if they were not dated and signed within 24 hours of admission or readmission or if orders were not clear or complete or if multiple admission forms were received upon admission/ readmission and were not the same. (B) These verifications are now documented on either the FL-2 or the medication verification sheet by a Medication Aide (MA) and a second verification by the RSD. (C) Once orders are verified and documented, they will be transcribed onto the MAR by the Medication Aide. The MAR will then be checked against the orders by the RSD or another MA and initialed and dated to verify follow-up verification was done. (D) All Medication Aides will be in-serviced by 7-19-16 to train all MA's on the above process. (E) The RSD and RN will monitor this process to ensure compliance. This will also be reviewed by RN when completing LHPS evaluations and reviews.	7-19-16

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D 344	Continued From page 4 -A physician's signature dated 6/14/16. Review of Resident #4's Resident Register revealed an admission date of 6/10/16. Review of Resident #4's record revealed: -No discontinue order for Aspirin 325 mg daily. Review of Resident #4's June Medication Administration Record (MAR) on 6/15/16 revealed: -A handwritten entry for meloxicam 7.5 mg daily with food and documented as administered daily at 6:00 am from 6/12 to 6/15/16. -An entry on the back of the MAR that meloxicam was not given on 6/11/16 as it was "on order". -No entry for Aspirin. -No documentation that Resident #4 had been administered Aspirin. Interview on 6/15/16 at 12:00 pm with the Resident Services Director (RSD) revealed: -She processed the resident admission orders which included getting clarifications. -She was not aware that she had missed the Aspirin order on the Medication Clarification sheet. -She wrote the MARs from the Medication Clarification sheet. -She had not contacted the physician about the Aspirin order for a clarification. -The Medication Aides (MA) processed new orders when she was not in the facility. This included faxing orders to the pharmacy and transcribing orders onto the MAR. Interview on 6/15/16 at 12:10 pm with a Medication Aide (MA) revealed: -The RSD or a MA verified the FL2 orders were entered correctly on the MARs.	D 344		

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D 344	Continued From page 5 -If the orders did not match the MARs, the MA was to report it to the RSD. Interview on 6/15/16 at 2:10 pm with the Executive Director revealed: -The RSD and/or another nurse admitted the residents, processed the admission orders, and transcribed the medications orders onto the MAR. -MAs were not processing admission orders. -He was not aware if there was a double-check process in place to ensure accuracy of the MARs. -They did have a Registered Nurse (RN) double checking the physician orders as compared with the MAR but this was not done daily. There was no exact time frame that she did this, but the facility intended for it to be done monthly. -He expected staff to contact the physician if there were any clarifications of orders needed. -He was unaware there were inconsistencies with the FL2s, the medication clarification orders and the MARs. Telephone interview on 6/15/16 at 3:30 pm with Resident #4's family member revealed: -Resident #4 was not to be taking Aspirin as a scheduled medication since she was ordered meloxicam. -Resident #4 was only to take the Aspirin if she had a headache. -She expected the facility to administer medications as ordered by the physician. Telephone interview on 6/15/16 at 5:30 pm with Resident #4's physician revealed: -He was not aware of the inconsistency with the FL2 and the clarification order page. -If meloxicam and Aspirin had both been on the clarification order page, he would have stopped one of the medications as both were anti-inflammatory medications.	D 344		

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D 344	Continued From page 6 -The facility had not contacted him about the Aspirin order, but he was "glad she was not receiving it". Review of a physician's order for Resident #4 received via telephone by the facility on 6/15/16 at 5:00 pm revealed an order to discontinue Aspirin.	D 344	•D358: (A) Orders for Resident #1 were immediately corrected.	7-19-16
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 1 of 3 residents (#1) observed during medication administration which included errors with administration of prednisone. The findings are: A. Review of Resident #1's current FL2 dated 4/15/16 revealed: -The diagnoses included prostate cancer, squamous cell carcinoma, chronic kidney disease stage 3, seborrhea keratosis, actinic keratosis, rheumatoid arthritis, ulcerative colitis, hyperlipidemia and history of tubular granuloma. -A physician's order for prednisone 5 mg 1 and	D 358	(B) All Medication Aides and RSD will be in-serviced by 7-19-16 to ensure that all orders on admission, and per fax, or per physician visits are processed/ transcribed before the next med pass is due. MA's will sign and date indicting their review. (C) The RSD will then to be notified so they can do a follow-up check and they will sign and date indicating their review. (D) All Medication Aides will be in-serviced by 7-19-16 on process of checking MAR with the bottle label times 3. They have also been in-serviced to count the number pills ordered to ensure count is correct. (E) Medication Aides were also in-serviced that their initials must be on MARs, orders, faxes to the pharmacy and/or physicians orders for accountability and training. (F) The RSD will monitor this process to ensure compliance. The RN will also review when completing the LHPS evaluations and reviews.	

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D 358	Continued From page 7 1/2 tablets daily. Review of Resident #1's record revealed: -A printed email with an attachment from the physician's office which documented the physician's office had seen Resident #1 in the office on 6/09/16 and there were changes made to his medications. -The printed attachment named "Resident #1 - Instructions" included a physician's order dated 6/09/16 for "Prednisone 10mg: currently taking 20mg. Reduce to 15 mg daily. Give 1 and 1/2 tablets daily." -There was not a signature on the physician order instructions. -There was no computerized name or signature. Review of the June 2016 Medication Administration Record (MAR) revealed: -An hand written entry dated 6/12/16 for prednisone 15 mg and documented as administered once daily at 8:00 a.m. -An entry for prednisone 10mg 2 tablets once daily and documented as administered from 6/01/16-6/12/16 and discontinued on 6/12/16. -There were no initials on the entries to indicate who made the entry changes. Observation during the 8:00 am medication pass on 6/15/16 revealed: -At 8:55 am the Medication Aide (MA) pulled Resident #1's bottle of prednisone 5mg tablets from the medication cart. -She put two tablets in the medication cup along with 3 other tablets. -Resident #1 was administered the medications and swallowed them without difficulty. -The MA documented administration immediately after the medication was administered.	D 358		

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D 358	Continued From page 8 Observation of the bottle of prednisone 5mg revealed: -There were 10 and one half, 5mg prednisone tablets. -The medication was filled on 3/21/16. Interview with the MA on 6/15/16 at 9:00 am revealed: -She thought she put 3 tablets of prednisone 5mg tablets in the medication cup. -The order was recently decreased and Resident #1 was taking 20mg. -She knew the MAR had an entry for prednisone 15mg and giving two tablets was only 10mg. -The bottle of prednisone 5mg was brought in with Resident #1 upon admission. -She did not process the order dated 6/09/16 for prednisone 15mg daily and did not know why the order was started on 6/12/16 rather than 6/09/16. -When the MAs received an order they were to fax it to the pharmacy, write the new order on the MAR, document in the resident's records and inform the responsible party of the changes. Interview with the Resident Service Director (RSD) on 6/15/16 at 12:21 pm revealed: -She was aware the prednisone had been decreased from 20mg to 15mg daily. -She was not aware the MAR did not specify to administer 3 - 5 mg prednisone tablets and it instructed to give 15mg daily, leaving out the quantity of tablets to be administered. -The MAs could obtain orders from the fax machine, the email or from physician visits, but the MAs were not permitted to take telephone orders. -It was the MAs responsibility to take new orders, fax them to the pharmacy and enter them onto the MAR. -The next shift MA was responsible for checking	D 358		

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D 358	Continued From page 9 the new entries and order changes to verify accuracy. -She did expect the MAs would process the orders the same day that they were received. -It was possible the MAs did not process the order on the 9th because it did not have a physician's signature. -She did not know if the order had been faxed to the pharmacy or if they had faxed the order to the physician for a signature. -She did not know who processed the order on 6/12/16. Interview with the Administrator on 6/15/16 at 2:07 pm revealed: -The part time Registered Nurse was currently auditing all the records to ensure accuracy of orders and other required documentation. -He was unsure of the exact process of order implementation and relied on the professional nursing staff to ensure orders were complete, accurate and administered as the physician intended. -He was unsure why the prednisone order dated 6/09/16 was not started until 6/12/16. -The MAs were not permitted to take telephone orders. -The MAs were expected to fax the new orders to the pharmacy and transcribe them onto the MARs when they were received. -He was unaware that the MA was observed administering the incorrect dose of prednisone during the morning medication pass. Interview with Resident #1's Primary Care Physician on 6/15/16 at 4:56 pm revealed: -He was unaware that the MA had administered the incorrect dose of prednisone during the morning medication pass on 6/15/16. -He expected to be informed of medication errors	D 358		

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D 358	Continued From page 10 within 24 hours. -There were no serious heath implications of Resident #1 having received 10mg of prednisone rather than the prescribed 15mg dose today. -The correct dosage of prednisone to be administered was 15 mg.	D 358	•D367: (A) The MAR now includes the epinephrine pen and arthritis pain rub for Resident #5 . T (B) Medication Aides are required to process orders and transcribe to MAR with their initials..	7-19-16
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the Medication Administration Records (MARs) were accurate for 2 of 5 sampled residents (Residents #4 and #5) with physician's orders for Aspirin,	D 367	(C) The RSD or their designee will do follow-up checks for completeness and accuracy and will initial MAR. (F) All orders which includes resident #4 and resident #5 have now been verified with the physician, if they were not dated and signed within 24 hours of admission or readmission or if orders were not clear or complete or if multiple admission forms were received upon admission/readmission and were not the same. (G) These verifications are now documented on either the FL-2 or the medication verification sheet by a Medication Aide (MA) and a second verification by the RSD. (H) Once orders are verified and documented, they will be transcribed onto the MAR by the Medication Aide. The MAR will then be checked against the orders by the RSD or another MA and initialed and dated to verify follow-up verification was done.	

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D 367	Continued From page 11 epinephrine pen and arthritis pain rub medication. The findings are: A. Review of Resident #4's current FL2 dated 6/02/16 revealed: -Diagnoses included Alzheimer's Dementia, arthritis, macular degeneration and legally blind. -Physician's orders for meloxicam 7.5 mg daily with food (an anti-inflammatory medication used to treat arthritis), and Aspirin 325 mg daily (an anti-inflammatory medication used to treat minor pain). Review of Resident #4's Medication Clarification sheet dated 6/10/16 revealed: -An entry for meloxicam 7.5 mg daily with food. -No entry for Aspirin 325mg daily. -No entries written in the "add and/or change the orders" section of the form. -A physician's signature dated 6/14/16. Review of Resident #4's Resident Register revealed an admission date of 6/10/16. Review of Resident #4's record revealed: -No discontinue order for Aspirin 325 mg daily. Review of Resident #4's June Medication Administration Record (MAR) on 6/15/16 revealed: -A handwritten entry for meloxicam 7.5 mg daily with food and documented as administered daily at 6:00 am from 6/12 to 6/15/16. -An entry on the back of the MAR that meloxicam was not given on 6/11/16 as it was "on order". -No entry for Aspirin. -No documentation that Resident #4 had been administered Aspirin.	D 367	(D) All Medication Aides will be in-serviced by 7-19-16 to train all MA's on the above process. (E) The RSD and RN will monitor this process to ensure compliance. The RN will monitor when the LHPS evaluations and quarterly reviews.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060147	A. BUILDING: _____ B. WING _____	06/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANSON RIDGE AT THE VILLAGES OF MECKLENBUI	13325 HUNTON LANE HUNTERSVILLE, NC 28078

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D 367	Continued From page 12 Interview on 6/15/16 at 12:00 pm with the Resident Services Director (RSD) revealed: -She processed the resident admission orders which included getting clarifications. -She was not aware that she had missed the Aspirin order on the Medication Clarification sheet. -She wrote the MARs from the Medication Clarification sheet. -The Medication Aides (MA) processed new orders when she was not in the facility. This included faxing orders to the pharmacy and transcribing orders onto the MAR. Telephone interview on 6/15/16 at 3:30 pm with Resident #4's family member revealed: -Resident #4 was not to be taking Aspirin as a scheduled medication since she was ordered meloxicam. -Resident #4 was only to take the Aspirin if she had a headache. -She expected the facility to administer medications as ordered by the physician. Telephone interview on 6/15/16 at 5:30 pm with Resident #4's physician revealed: -He was not aware of the inconsistency with the FL2 and the clarification order page. -If meloxicam and Aspirin had both been on the clarification order page, he would have stopped one of the medications as both were anti-inflammatory medications. -The facility had not contacted him about the Aspirin order, but he was "glad she was not receiving it". Refer to interview on 6/15/16 at 12:10 pm with a Medication Aide (MA) Refer to interview on 6/15/16 at 2:10 pm with the	D 367		

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D 367	Continued From page 13 Executive Director Review of a physician's order for Resident #4 received via telephone by the facility on 6/15/16 at 5:00 pm revealed an order to discontinue Aspirin. B. Review of Resident #5's current FL2 dated 2/08/16 revealed: -The diagnoses included dementia, hypertensive heart disease, hyperlipidemia, prostate enlargement, obstructive sleep apnea, hypothyroidism, erectile dysfunction and depression. -A physician's order for an epinephrine pen 0.3mg/ml prn bee sting and arthritis pain rub to right knee every 6 hours as needed for pain. Review of Resident #5's Medication Clarification Sheet dated 5/17/16 revealed: -An order for epinephrine pen 0.3mg/ml prn bee sting. -An order for arthritis pain rub to right knee every 6 hours as needed for pain. Review of Resident #5's record revealed: -No discontinue order for epinephrine pen 0.3mg/ml prn bee sting. -No discontinue order for arthritis pain rub to right knee every 6 hours as needed for pain. . Review of Resident #5's May Medication Administration Record (MAR) on 6/15/16 revealed: -No entry for epinephrine pen 0.3mg/ml prn bee sting. -No entry for arthritis pain rub to right knee every 6 ours as needed for pain. Review of Resident #5's June MAR on 6/15/16 revealed: -No entry for epinephrine pen 0.3mg/ml prn bee	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 367	Continued From page 14 sting. -No entry for arthritis pain rub to right knee every 6 ours as needed for pain. Observation of the Resident #5's medication on hand revealed: -One box containing a 4 ounce tube of arthritis rub. -A box containing one epinephrine 0.3mg/ml pen. Interview on 6/15/16 at 12:00 pm with the Resident Services Director (RSD) revealed: -She processed the resident admission orders which included getting clarifications. -She or the MAs transcribed the new admission orders onto the MARs. -She was aware that the epinephrine pen and the arthritis rub were not on the MARs because the consulting pharmacist made her aware of this yesterday. -The MAs on the next shift were responsible for checking all orders that were transcribed onto the MARs to ensure accuracy. Telephone interview on 6/15/16 at 4:58 pm with Resident #5's physician revealed: -He was not aware of the inconsistency with the FL2, clarification order sheet as compared with the MAR. -Resident #5 should have the epinephrine pen available for use in the event he get stung by a bee. -Resident #5 had only complained of pain in his ribs and was given a prescription for this. -Resident #5 had not required the epinephrine pen since admission. Refer to Interview on 6/15/16 at 12:10 pm with a Medication Aide (MA).	D 367		

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D 367	Continued From page 15 Refer to interview on 6/15/16 at 2:10 pm with the Executive Director. Interview on 6/15/16 at 12:10 pm with a Medication Aide (MA) revealed: -The RSD or a MA verified the FL2 orders were entered correctly on the MARs. -If the orders did not match the MARs, the MA was to report it to the RSD. Interview on 6/15/16 at 2:10 pm with the Executive Director revealed: -The RSD and/or another nurse admitted the residents, processed the admission orders, and transcribed the medications orders onto the MAR. -MAs were not processing admission orders. -He was not aware if there was a double-check process in place to ensure accuracy of the MARs. -They did have a Registered Nurse (RN) double checking the physician orders as compared with the MAR but this was not done daily. There was no exact time frame that she did this, but the facility intended for it to be done monthly. -He expected staff to contact the physician if there were any clarifications of orders needed. -He was unaware there were inconsistencies with the FL2s, the medication clarification orders and the MARs.	D 367		

Warth, Lisa J

From: Director - Ranson Ridge <director@ransonridgeal.com>
Sent: Friday, July 15, 2016 11:05 AM
To: Warth, Lisa J
Cc: hkeziah@oldeknoxcommons.com; 'Linda Howard'
Subject: RE: Ranson Ridge at the Villages of Mecklenburg 2016-06-15 SOD UC8Q11
Attachments: Statement Of Deficiencies And Plan Of Correction.pdf

Importance: High

Hi Lisa,

Attached you will find the POC for the Survey that was conducted at Ranson Ridge on June 16, 2016.

I enjoyed meeting you and Heather and look forward to working with you in the future.

If you have any issues with the POC please contact me by e-mail or I can be reached at 336-596-4918.

Thanks
Jimmy Greene

From: Warth, Lisa J [mailto:Lisa.Warth@dhhs.nc.gov]
Sent: Tuesday, July 05, 2016 12:37 PM
To: 'director@ransonridgeal.com'
Cc: dhsr.adultcare.email_west2; 'mark.rowe@mecklenburgcountync.gov'
Subject: Ranson Ridge at the Villages of Mecklenburg 2016-06-15 SOD UC8Q11

Dear Ms. Howard:

Please find the Statement of Deficiencies and accompanying letter for the Initial licensing Survey on June 15, 2016 attached to this e-mail. If the Statement of Deficiencies includes citations or violations for which a plan of correction is required, please read the attached letter carefully for instruction on completing the plan of correction. **PLEASE NOTE: WE WILL NOT ACCEPT A FAXED PLAN OF CORRECTION!** We are unable to accept faxed reports at this time; therefore, a copy must be mailed to our office or e-mailed to the survey team leader. Please make sure the copy you mail or e-mail to us is SIGNED AND DATED or it will not be accepted. A response to the plan of correction will be sent ONLY if the plan of correction is not approved. Please retain a copy for your files.

The attached letter also contains information regarding your right to request an Informal Dispute Resolution (IDR) of any cited deficiencies or violations. For more information about the IDR process please visit our website at http://www.ncdhhs.gov/dhsr/acls/idr.html.

If you have any questions regarding the information provided in or attached to this email, please call 704-617-8087. Please be aware that information sent via electronic mail is immediately available for release to the public. Therefore, the information contained in and attached to this e-mail is now public information.

Sincerely,

Lisa Warth RN
Licensure Consultant
Adult Care Licensure Section
Division of Health Service Regulation

STAR RATING
If the Statement of Deficiencies attached to this email is a result of an annual, follow-up or complaint inspection a star rating certificate and worksheet will be issued within 45 days of the date of this email. If you would like to know more information about the NC Star Rated Certificate Program or view facility ratings, please visit the star rating website at http://www.ncdhhs.gov/dhsr/acls/star/index.html. If you have questions about this facility's star rating or the rating program in general, please send an email with your questions to the star rating customer service email address at DHSR.AdultCare.Star@lists.ncmail.net.

Lisa Warth , RN
Nurse Consultant
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Nothing Compares