STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060172	A. BUILDING: _____ B. WING _____	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANSON RIDGE ASSISTED LIVING & MEMORY CARE	13910 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 conducted an annual survey and follow-up survey on April 08, 2025-April 09, 2025	D 000		
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 observations, record reviews, and interviews, the facility failed to administer medications as ordered for 1 of 3 residents observed during the medication pass (Resident #6) related to a medication to treat mood disorders. The findings are: The medication error rate was 3.4% as evidenced by the observation of 1 error out of 29 opportunities during the 8:00am medication pass on 04/09/25. Review of Resident #6's current FL2 dated 04/01/25 revealed: -Diagnoses included dementia. -Her current level of care was the Special Care Unit (SCU). -She was intermittently disoriented.	D 358		

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D 358	Continued From page 1 Review of a Primary Care Provider's order dated 03/11/25 revealed Resident #6 was to receive quetiapine (a medication to treat mood disorders) 50mg, one tablet twice daily. Review of Resident #6 Primary Care Provider's (PCP) orders dated 04/01/25 revealed there was an order for quetiapine 50mg, one tablet twice daily. Observation of the medication pass on 04/09/25 at 8:26am revealed: -The medication aide (MA) removed a medication bottle of quetiapine 25mg from the medication cart for Resident #6. -The MA removed one tablet of quetiapine 25mg and placed it in the medication cup for Resident #6. -The MA administered quetiapine 25mg, one tablet to Resident #6. Observation of Resident #6's medications on hand on 04/09/25 at 1:39pm revealed: -There was a prescription bottle of quetiapine 25mg for Resident #6. -There was a Directions Changed label on the bottle indicating "Refer to Chart". -The Directions Changed label covered the quantity to administer. -The label indicated quetiapine 25mg, 90 tablets were dispensed for Resident #6 and no refills remained. -There were 40 tablets and one half tablet of quetiapine 25mg remaining in the bottle. Interview with a Pharmacist with Resident #6's pharmacy on 04/09/25 at 2:52pm revealed: -Resident #6 had a current order for quetiapine 25mg, one tablet nightly. -Quetiapine 25mg, 90 tablets was last dispensed	D 358		

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D 358	Continued From page 2 on 01/14/25. -They did not receive Resident #6's PCP order dated 03/11/25 for quetiapine 50mg, one tablet twice daily. -If Resident #6 received a lower than prescribed dose of quetiapine she could experience restlessness. Interview with a MA on 04/09/25 at 1:44pm revealed: -When she administered Resident #6's quetiapine 25mg to her that morning (04/09/25) she should have administered two tablets, not one. -When she compared the label on the bottle of Resident #6's quetiapine with the order in the electronic Medication Administration Record (eMAR) system, she compared number of tablets only, she did not compare the dosage. -She was nervous and forgot to check the dosage when administering Resident #6's quetiapine 25mg. Interview with the Special Care Unit Coordinator (SCC) on 04/09/25 at 1:54pm revealed: -The MA was trained to compare the label on the medication bottle with the order in the eMAR system when she took the MA course after she was hired at the facility. -The MA should have used the seven rights of medication administration, including the right medication, the right dosage, and the right quantity of tablets when administering Resident #6's quetiapine. -If there was any discrepancy between a medication label and the order in the eMAR system, the MA should have contacted her, the Resident Care Coordinator (RCC) or the PCP for clarification.	D 358		

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D 358	Continued From page 3 Interview with the Administrator on 04/09/25 at 3:06pm revealed: -The MAs were responsible for administering medications according to the medication orders in the eMAR system. -She expected the MAs to compare medication labels with the medication order in the eMAR system when administering residents' medications. -If there were any discrepancies between the medication label and the order in the eMAR system, the MA was responsible for contacting the RCC, SCC or PCP for clarification. Attempted telephone interview with Resident #6's PCP on 04/09/25 at 3:25pm was unsuccessful.	D 358		