STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G296	A. BUILDING _____ B. WING _____	03/20/2018

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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) COMPLETION DATE
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 4 audit clients (#4) had the right to have an informed consent obtained from both his legal guardians. The finding is: Client #4's BSP informed consent was not jointly signed by his co-guardians. Review on 3/20/18 of client #4's guardianship papers revealed he has co-guardians. Review on 3/20/18 of client #4's BSP informed consent was not signed by both of his guardians. During an interview on 3/20/18, the qualified intellectual disabilities professional (QIDP) was not aware only one of client #4's guardians had signed his BSP informed consent.	W 125	The facility will ensure all individual clients have the opportunity to exercise their rights. The QP will obtain informed consent from both legal guardians of client #4. For preventative measures, QP will ensure informed consent is obtained from all guardians on individual's BSP prior to implementation. DHSR-Mental Health APR 0 2 2018 Lic. & Cert. Section	5/18/18
W 137	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure client #5 had	W 137		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 3-28-18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 137	Continued From page 1 the right to clothes of an appropriate size and fit. This affected 1 of 4 audit clients. The finding is: Client #5's pants were too big/long. During evening observations in the home on 3/19/18, client #5 wore sweat pants. The pants were extra big in the crotch and thigh area and were extra long. Approximately 2 - 3 inches of excess fabric was noted in the crotch area and at the ankles. Additional observations in the home revealed the client's pant leg extended under his feet by approximately 2 - 3 inches as he walked throughout the home. Review on 3/20/18 of client #5's individual program plan (IPP) dated 9/8/17 revealed, "He likes to wear pants with an elastic waist, such as sweat pants..." Interview on 3/20/18 with the qualified intellectual disabilities professional (QIDP) revealed client #5 has not had any fluctuations in his weight but he does like to wear sweat pants. The QIDP acknowledged his clothes may need to be assessed for appropriate size and fit.	W 137	The facility will ensure the rights of all clients to retain and use appropriate personal possessions and clothing. The supervisor will assist client #5 with purchasing proper fitting clothes. QP will in-service train staff to ensure all individuals are wearing properly fitted clothes and the appearance checklist is being completed. IDT will monitor with weekly clinical observations until issue is resolved. For future, IDT will continue to monitor with monthly QA assessments.	5/18/18
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, interviews and document review, the facility failed to ensure staff were	W 189		

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W 189	Continued From page 2 sufficiently trained to follow proper medication administration procedures. The finding is: Staff did not follow proper documentation procedures during the medication administration. During observations of medication administration in the home on 3/20/18 at 8:00am, 8:28am and 8:40am, the medication technician (MT) assisted three clients to dispense their medications in to a pill cup. Once medications were dispensed, the MT immediately initialed the medication administration record (MAR) before the clients ingested their medicine. Immediate interview with the MT revealed they had been trained to ensure clients had ingested their medications before signing the MAR. Review of the facility's Medication Administration Training Course dated 3/11/12 and the medication administration observation form revealed, "Document immediately after administering the medication...Document accurately on the MAR immediately after giving medications with initials..." Interview on 3/20/18 with the facility's nurse confirmed MT's have been trained to ensure medications have been ingested before signing the MAR.	W 189	The facility will ensure each employee is provided with initial and continuing training that allows the employees to perform his or her duties effectively, efficiently, and competently. The Registered Nurse will in-service train staff on medication administration procedures and routine. The IDT will complete weekly medication administration observations until issue is resolved. For future, IDT will monitor with monthly observations. Facility will ensure all Medication technicians participate in medication administration recertification training.	5/18/18
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed	W 249		

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W 249	Continued From page 3 interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 4 of 4 audit clients (#3, #5, #6) received a continuous active treatment plan consisting of needed interventions and services as identified in the individual program plan (IPP) in the areas of meal preparation, adaptive equipment use, diet consistency, objective implementation and self-help skills. The findings are: 1. Client #5's adaptive gait vest was not used/worn as indicated. a. During evening observations in the home on 3/19/18 from 3:35pm - 5:29pm, client #5 wore a gait vest with attached straps over his chest. During this time, a staff followed him throughout the home and did not manipulate the gait vest as the client ambulated. During later observations from approximately 5:29pm - 5:46pm, client #5 began exhibiting behaviors such as yelling, hitting his fist/arm on walls, and hitting himself in the head and on his arms. Once the behaviors began, the staff immediately grabbed a strap on the vest and began holding/pulling/turning the client down the hallway towards his bedroom. As client #5 leaned his upper body forward, the staff consistently pulled on the vest and directed the client's movements in the opposite direction. Client #5 continued to yell and hit walls with his hands.	W 249	Facility will ensure all client's receive continuous active treatment programing which consist of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. 1. a. Habilitation Specialist will in-service all staff on the appropriate use of client #5's gait vest and gait belt. Behavior Specialist will in-service all staff on the client #5's Behavior Support Plan and his right to freedom of movement. IDT will monitor with weekly assessments until issue is resolved. For future, IDT will monitor with monthly QA assessments.	5/18/18

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W 249	Continued From page 4 Immediate interview with the staff involved revealed client #5 wears the gait belt "when he is up...to keep him from falling." Additional interview indicated the gait belt is also used for his behaviors to "keep him from hitting walls and bruising himself." b. During morning observations in the home on 3/20/18 at 7:20am, client #5 walked into the dining area from his bedroom with a staff walking beside him holding onto his T-shirt. The client was not wearing his gait vest or a gait belt. After finishing his breakfast, client #5 walked back to his bedroom as a staff walked with him holding onto his T-shirt. Immediate interview with the staff involved indicated the client wears the gait vest because "he's a fall risk." Additional interview with another staff on 3/20/18 revealed client #5 wears the gait vest "when he gets up and dressed". Review on 3/20/18 of client #5's IPP dated 9/8/17 revealed a physician's order dated 9/5/17 for "Gait belt or vest for ambulation assistance." Additional review of the plan noted under adaptive equipment, "Gait belt or vest... To use to assist him when walking...On him during all waking hours-[Client #5's] discretion... Staff should encourage [Client #5] to wear the belt or vest." Further review of the record did not indicate instructions to use the gait belt or vest to address behaviors. Interview on 3/20/18 with the qualified intellectual disabilities professional (QIDP) confirmed the gait belt and vest had been implemented after client #5 had several falls. Additional interview	W 249	1. b. The Habilitation Specialist will in-service all staff on when client #5 wears his gait vest or belt and on how to use the prompt sequence. The IDT will meet to discuss how to address client #5's refusal of the gait belt or vest and how to best meet his needs. Staff will be in-serviced trained on any changes or recommendations. IDT will monitor with weekly observations until issue is resolved. For future, IDT will monitor with monthly observations and/or QA assessments.	5/18/18

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W 249	Continued From page 5 indicated the vest/belt should be used with client #5 during ambulation due to his fall risk. The QIDP revealed the gait belt and vest should not be used to address client #5's behaviors. 2. Staff did not monitor client #5 at arm's reach as indicated. During observations in the home throughout the survey from 3:35pm - 6:10pm on 3/19/18 and 7:50am - 9:16a on 3/20/18, client #5 wore a gait vest secured around his chest area. Throughout this time, a staff sporadically walked next to or near client #5 within reach of him. However, during these observations, the staff more consistently walked 5 - 8 feet behind the client or were not near him at all. For example, on 3/19/18 at 3:59pm, client #5 stood at the kitchen counter while the staff working with him stood several feet away at the entry to the hallway. At 4:29pm, the staff working with him stood at the refrigerator filling her cup with ice while client #5 went down the hallway. On 3/20/18 at 7:52am, the staff working with him went into another client's bedroom while client #5 walked several feet away to the dining room. At 7:56am, the staff working with him stood in the doorway of another client's bedroom while client #5 walked several feet away to the kitchen area. Staff interviews (2) on 3/20/18 revealed client #5 has a one-on-one staff with him because they have to be "in arm's reach" of him because he is at risk for falls. Review on 3/20/18 of client #5's physician's orders dated 8/22/17 noted an order for, "Arms reach distance by staff when [Client #5] is up and ambulating to maintain safety." Additional review	W 249	2. The IDT will meet to discuss client #5's needs during ambulation to ensure his safety and ensure to implement and train all staff. The QP will ensure IDT recommendations are implemented in a timely manner. Habilitation Specialist will in-service staff on monitoring and supports provided for client #5 while he is ambulating. IDT will monitor with weekly observations and make changes as needed for client #5's safety. For future, IDT will monitor with monthly observations.	5/18/18

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W 249	Continued From page 6 of the client's IPP dated 9/8/17 revealed, "At this time due to his increase in unsteady gate, it has been recommended that [Client #5] be with in staff's arm reach when he is ambulating (walking around)." Interview on 3/20/18 with the QIDP confirmed client #5 should be in arm's reach of staff when he is ambulating due to recent falls. The QIDP acknowledged several feet away from the client would not be considered arm's reach. 3. Client #5 was not assisted or encouraged to participate in meaningful activities in the home. Throughout evening observations in the home on 3/19/18 from approximately 3:35pm - 6:10pm, a consistently followed client #5 within the home or walked with him to/from various areas of the home. The client asked staff for paper at 5:29pm and was told no paper was available. With the exception of briefly manipulating soft blocks on a table in his bedroom at 5:35pm, client #5 was not provide activities. Staff interview on 3/19/18 revealed client #5 likes paper and markers but will attempt to put these items in his mouth. Review on 3/20/18 of client #5's IPP dated 9/8/17 revealed, "He is creative, he enjoys writing and drawing pictures...[Client #5] loves music. He listens to older music such as 'The Temptations' and old country hits. He will dance when he hears a song he likes. Therefore he should always have a functioning radio." Additional review of the plan indicated, "He likes to listen to his radio and draw in the privacy of his bedroom." The plan also noted the client had achieved an	W 249	3. IDT will explore obtaining client #5's preferred activities and include completion of a leisure/recreation assessment. QP will revise IPP to reflect current leisure activities for client #5 and in-service staff on updated information. IDT will complete weekly assessments until issue is resolved. For future, IDT will continue to monitor with monthly QA assessments.	5/18/18

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W 249	Continued From page 7 objective to attend to a task for 2 minutes when provided 2 or fewer verbal cues. Interview on 3/20/18 with the QIDP confirmed client #5 likes to draw and listen to music and prefers to be in his bedroom. Additional interview indicated the client will participate in matching activities and also likes to help in the kitchen. The QIDP acknowledged client #5 should be offered activities in the home. 4. Client #5's medication administration skills were not integrated as indicated. During observations of medication administration in the home on 3/20/18 at 8:00am, client #5 participated with the administration of his medications by assisting to punch his pills and taking his medications. Review on 3/20/18 of client #5's IPP dated 9/8/17 revealed the client had achieved objectives to state his last name before taking his medication and to state his entire name before taking his medications. Interview on 3/20/18 with the QIDP acknowledged completed objectives should be integrated as appropriate in order to ensure maintenance of achieved skills. 5. Client #6's liquid consistency was not followed during medication administration. During observations of medication administration in the home on 3/20/18 at 8:28am, client #6 ingested his medications with thin liquids (water). Review on 3/20/18 of client #6's physician's	W 249	4. Habilitation Specialist will in-service staff on client #5's ability to state his name and to continue to state his name during medication administration. IDT will monitor with weekly medication administration observations. For future, IDT will monitor with monthly QA assessments and ensure achieved objectives are being implemented to maintain clients skills. 5. Registered Nurse will ensure that all staff are in-serviced that all liquids for client #6 are to be nectar consistency, including during medication administration. The IDT will monitor with weekly observations until issue is resolved. For future, the IDT will monitor with monthly QA assessments.	5/18/18 5/18/18

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W 249	Continued From page 8 orders dated 3/8/18 revealed, "...Nectar thick liquids". Interview on 3/20/18 with the QIDP confirmed client #6 was recently ordered to have nectar thickened liquids due to swallowing difficulties. 6. Client #3 was not given the opportunity to feed himself. During dinner observations in the home on 3/19/18, client #3 was observed sitting at the table looking behind himself and down at his plate. Further observations revealed staff sitting next to client #3 and giving him three verbal prompts to pick up his spoon, so he can begin eating. After the third verbal prompt staff proceeded to pick up client #3's spoon and began to feed him his entire meal. Observations at the day program during lunch on 3/19/18 revealed client #3 was independently able to feed himself without any physical assistance from staff. Also during breakfast observations in the home on 3/20/18, client #3 fed himself independently. During an interview on 3/19/18, staff working with client #3 stated it's "not part of his plan". Further interview revealed client #3 is "shy" around strangers during meal time and he will just sit there and not eat. Review on 3/20/18 of client #3's pre-admission summary dated 2/28/17 noted, "...can independently feed himself." During an interview on 3/20/18, the QIDP confirmed staff should not have fed client #3. Further interview revealed staff should have given him time to feed himself without giving any	W 249	6. Habilitation Specialist will in-service all staff on client #3's ability to feed himself independently and ensure staff are using the prompt sequence with client #3. The IDT will monitor with weekly QA assessments until issue is resolved. For future, the IDT will monitor with monthly assessments.	5/18/18

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W 249	Continued From page 9 physical assistance. 7. Client #3 was not afforded privacy. During morning observations in the home on 3/20/18 from approximately 7:10am until 7:18am, client #3 was sitting on the toilet with the door open. At approximately 7:11am, a staff person walked by, but did not close the door or give client #3 any prompts to close the door himself. At 7:18am, another staff person walked by and physically closed the door. During an interview on 3/20/18, staff revealed client #3 has had training in regards to his privacy. Staff revealed client #3 "Does not like a closed door and will open it back up" when it is closed. Review on 3/20/18 of client #3's IPP dated 2/16/18 indicated, "...he does require assistance for privacy." Additional review on 3/20/18 of client #3's Adaptive Behavior Inventory (ABI) dated 2/9/18 revealed he needs assistance to close the door for privacy. Further review of client #3's IPP revealed he has a goal for closing doors for privacy. During an interview on 3/20/18, the QIDP confirmed staff should have ensured the bathroom door was closed for client #3's privacy. 8. Client #6 was not prompted to utilize a napkin. During dinner observations in the home on 3/19/18, client #6 stood up from the table and walked past a staff person. Further observations revealed client #6 had food on his chin. Staff at no time prompted client #6 to wipe his mouth	W 249	7. Habilitation Specialist will in-service all staff on client #3's needs regarding privacy and client #3's program for closing doors for privacy. IDT will monitor with weekly assessments until issue is resolved. For future, the IDT will monitor with monthly QA assessments. 8. Habilitation Specialist will ensure client #6 ABI is updated to reflect his current needs. Habilitation Specialist will in-service all staff on client #6's ability to wipe his mouth. IDT will monitor with weekly QA assessments until issue is resolved. For future, IDT will monitor with monthly assessments.	5/18/18 5/18/18

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W 249	Continued From page 10 during or after eating his dinner. Client #6 was observed having a napkin at his place setting. Review on 3/20/18 of client #6's ABI dated 3/28/17 revealed he can independently use a napkin while eating. During an interview on 3/20/18, the QIDP confirmed client #6 should have been prompted to utilize his napkin. 9. Clients #3 and #6 were not prompted to participate in meal preparation. During morning observations in the home on 3/20/18 at 6:23am, the Cream of Wheat and grits were in pots cooking on the stove and the muffins were in the oven cooking. At no time were clients #3 or #6 prompted to come into the kitchen to assist with meal preparation. Additional observations revealed staff preparing chicken broth for client #6. Client #6 was not prompted to participate with this task. Further observations revealed client #6 was in the bathroom when the surveyors entered the home and client #3 was still in the bed. During an interview on 3/20/18, the staff revealed she made the entire breakfast because the clients were still in the bed. Review on 3/20/18 of client #3's IPP dated 2/16/18 indicated, "He will participate and help cook...but needs encouragement, prompts, assistance and monitoring." Review on 3/20/18 of client #6's ABI dated 3/28/17 indicated he can independently pour. Further review revealed he would need	W 249	9. The Habilitation Specialist will train all staff on the appropriate procedures for meal preparation and ensure all clients are participating in meal preparations. IDT will monitor with weekly assessments until issue is resolved. For future, IDT will monitor with monthly QA assessments.	5/18/18

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W 249	Continued From page 11 assistance with making muffins. During an interview on 3/20/18, the QIDP confirmed clients #3 and #6 should have been given the opportunity to assist with cooking breakfast.	W 249		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observations, record/document review and interviews, the facility failed to ensure data was collected in accordance with individual program plan (IPP) objectives. This affected 2 of 4 audit clients (#3, #5). The findings are: 1. Client #5's behavior incident was not documented. During evening observations in the home on 3/19/18 from approximately 5:29pm - 5:46pm, client #5 exhibited behaviors such as yelling, hitting his fist/arm on walls, and hitting himself in the head and on his arms. Review on 3/20/18 of client #5's behavior support plan (BSP) dated 10/26/17 revealed the objective, "[Client #5] rate of disruptive behavior will decrease to 0 episodes per month for 6 consecutive months." Additional review of the BSP identified target behaviors of verbal	W 252	Facility will ensure data is collected in accordance with all clients program plan objectives. 1. Behavior Specialist will in-service all staff that client #5's behavior incidents are documented accordingly. IDT will monitor with weekly assessments and ensure documentations is being completed, until issue is resolved. For future, IDT will monitor with monthly assessments.	5/18/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G296	A. BUILDING _____ B. WING _____	03/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONERIDGE	222 UNION HEIGHTS BOULEVARD SALISBURY, NC 28144

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W 252	Continued From page 12 disruption, property disruption, self-injurious behavior, physical aggression, invasion of privacy, excess fluid intake and refusal to cooperate. Further review of the plan noted, "All episodes of behavior requiring the use of redirection procedures, blocking or benign restraint procedures will be documented on the Behavior Intervention Data Sheet indicating all required data." Review on 3/20/18 of client #5's behavior data sheet revealed no documentation of the 3/19/18 behavior incident. Interview on 3/20/18 with the qualified intellectual disabilities professional (QIDP) confirmed all target behaviors exhibited by client #5 should be documented. 2. Data relative to the accomplishment of 3 of 8 training objectives was not documented for client #5. Review on 3/20/18 of client #5's IPP dated 9/8/17 revealed the following objectives with missing data: a. Provided two different attributes (imitation bills vs. non-money) , Client #5 will sort bills with 60% accuracy for 2 consecutive months (implemented 3/12/18). The objective noted, "Data will be collected on the appropriate data sheet at least 3 times a week...2nd shift". Additional review of the March '18 data sheet revealed no data had been collected since implementation. b. Client #5 will independently dry his entire head area with 80% accuracy for a period of 2 consecutive months (implemented 3/12/18). The	W 252	2. and 3. Habilitation Specialist will in-service all staff on documentation for all clients programs. The IDT will ensure data is being collected by completing weekly program checks until issue is resolved. For future, the IDT will continue to monitor with monthly QA assessments.	5/18/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G296	A. BUILDING _____ B. WING _____	03/20/2018

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W 252	Continued From page 13 objective indicated, "Training should occur daily with data collected at least 3 times a week." Additional review of the March '18 data sheet noted data had been collected twice on 3/14/18 and 3/15/18. c. Client #5 will independently was the tops of his hands with 80% accuracy for 2 consecutive months (implemented 3/12/18). The objective noted, "Data will be collected on the appropriate data sheet daily. Training will occur at every opportunity." Additional review of the March '18 data sheet indicated data had been collected twice on 3/14/18 and 3/15/18. Interview on 3/20/18 with the QIDP confirmed objective data should be collected in accordance with the plan. 3. Client #3's objective for privacy was not documented. Review on 3/19/18 of client #3's privacy objective dated 4/1/18 revealed, "[Client #3] will close doors for privacy." Further review indicated, "DATA COLLECTION: ...data collected at least three times per week". Additional review revealed last documentation occurred on 3/12/18. During an interview on 3/20/18, the QIDP confirmed documentation for client #3's privacy goal should have been completed.	W 252		
W 481	MENUS CFR(s): 483.480(c)(2) Menus for food actually served must be kept on file for 30 days. This STANDARD is not met as evidenced by:	W 481		

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	34G296	A. BUILDING _____ B. WING _____	03/20/2018

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W 481	Continued From page 14 Based on observations, interviews and document review, the facility failed to ensure a record of foods actually served was kept. The finding is: Food substitutions were not documented. During dinner observations in the home on 3/19/18, clients consumed Tilapia, yams and peas at the meal. Review on 3/19/18 of the dinner menu revealed Salmon, mashed potatoes and green beans. Staff interview on 3/19/18 revealed several food items had to be "substituted" for dinner. Additional interview on 3/20/18 indicated they "usually don't" document food substitutions and have never been told to do so. Review on 3/20/18 of the home's food substitution book revealed the last substitution had been documented on 7/27/17. No current documentation could be located. Interview on 3/20/18 with the qualified intellectual disabilities professional (QIDP) confirmed staff should document food substitutions as indicated.	W 481	The facility will ensure a record of foods served is kept and food substitutions are being documented. Habilitation Specialist will in-service all staff on documentation of food substitution. The IDT will monitor with weekly assessments until issue is resolved. For future, the IDT will monitor with monthly assessments to ensure food substitution documentation continues.	5/18/18

RHA Health Services NC, LLC
211 Roseman Lane
Cleveland, NC 27013

March 28, 2018

Wilma Worsley-Diggs, M. Ed., QIDP
Facility Survey Consultant 1
MH Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Dear Ms. Worsley-Diggs,

Please find the attached state form indicating a plan of correction for the deficiencies cited in the March 19-20, 2018, Recertification Survey Conducted at Stoneridge, 222 Union Heights Blvd., Salisbury NC 28146. I have signed and dated page 1 of the plan of corrections. The team would like to officially invite the survey team back for follow-up to deficiencies cited.

We would like to thank you for your continued commitment to quality services. We appreciate your recommendations and input extended to us. Please do not hesitate to call if you have any questions or concerns. Again, thank you for your continued commitment.

Sincerely,

Lisa Jones, Administrator