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RALPH SCOTT LIFESERVICES, INC/VETERANS DRIVE	500 VETERANS DRIVE ELON COLLEGE, NC 27244

(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
E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop specific facility-based strategies into an all hazards risk assessment as part of their emergency plan (EP). The finding is: The facility failed to develop an all hazards risk assessment based on the specific challenges	E 006		

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

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E 006	Continued From page 1 they may encounter given where the facility is located. Review on 10/1/18 of the facility's EP was noted to contain information about general emergencies the facility staff may encounter such as tornadoes, extremely cold weather, bomb threats and hurricanes. The emergency plan however, did not contain an all hazards risk assessment that was specific to the facility. Continued review of the facility's EP revealed information regarding the residents of the group home was limited to the general information contained on an information face sheet. Interview on 10/1/18 with the Associate Director revealed no information regarding any specific hazards the direct care staff may encounter given the facility's specific location.	E 006		
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, record review and interviews, the facility failed to ensure staff were sufficiently trained to perform their jobs effectively. This affected 2 audit clients(#2, #3) and 2 non audit clients (#5 and #6). The findings include: 1. Direct care staff did not protect the privacy of client #5 during self care.	W 189		

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W 189	Continued From page 2 During observations on 10/2/18 at 7:30am direct care staff took client #6 to the bathroom and opened the door without knocking. Client #5 was in the bathroom toileting. Another direct care staff was also in the bathroom with client #5. Interview on 10/2/18 with direct care staff revealed she was trained to knock on bathroom and bedroom doors before entering where clients may be toileting or dressing. She stated she forgot to knock before entering the bathroom where client #5 was toileting. Additional interview revealed clients #5 and #6 are not able to protect their own privacy while toileting and dressing without the assistance of direct care staff. Interview on 10/2/18 with the qualified intellectual disabilities professional (QIDP) revealed direct care staff are trained to always knock first before entering bathroom and bedrooms to protect the privacy of the clients in the facility. 2. Direct care staff did not ensure client #3 received her nutritional supplement as prescribed by the physician. During observations on 10/1/18 of the supper meal at 6pm, client #3 refused to come to the dining room table to eat. Direct care staff tried at least 4 times to encourage her to come to the dining room table to eat but she refused. Verbal cues and physical assistance were provided to walk her into the dining room area however, she walked away every time. No nutritional supplement was given to client #3. During observations on 10/2/18 of breakfast at 7am direct care staff encouraged client #3 to	W 189		

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W 189	Continued From page 3	W 189		

come to the dining room to eat breakfast. Verbal cues and physical assistance were used to walk her into the dining room however, she refused to stay in the dining room. No nutritional supplement was given to client #3.

Review on 10/2/18 of client #3's quarterly physician orders dated 4/12/18 revealed she is to receive Ensure BID (twice daily) for meal refusal.

Review on 10/2/18 revealed no documentation on the October medication administration record (MAR) for client #3 indicating any Ensure was given on 10/1/18 or on 10/2/18.

Phone interview on 10/2/18 with the facility Nurse revealed direct care staff should have offered a can of Ensure on 10/1/18 when client #3 refused supper and on 10/2/18 when she refused breakfast.

3. Direct care staff did not encourage clients to assist in modifying their food.

During observations in the facility on 10/1/18 at 5:30pm-5:50pm direct care staff was in the kitchen using the food processor to grind up pork chops, apples, squash and pinto beans without the assistance of clients. During this time clients #2 and #3 were in the living room while staff read them a book.

During observations in the facility on 10/2/18 at 6:30am direct care staff was in the kitchen using the food processor to puree oatmeal, peaches and toast. Client #3 was in the hallway near the kitchen and did not participate in pureeing her food.

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Review on 10/2/18 of client #3's individual program plan (IPP) dated 7/26/18 revealed she receives a 1800 calorie heart healthy diet with pureed textured foods. She has a need to improve daily routine tasks.

Review on 10/2/18 of client #2's IPP dated 4/12/18 revealed she receives a 2,000 calorie weight reduction pureed diet with seconds of low calorie vegetables only. Additional review of the IPP revealed she requires assistance using the blender mixer and food processor.

Interview on 10/2/18 with the qualified intellectual disabilities professional (QIDP) revealed both clients #2 and #3 can assist with using the food processor and should assist with modifying their food prior to meals.

4. Direct care staff did not demonstrate the skills needed to correctly administer medications to clients.

During observations of the medication administration pass on 10/2/18 at 6:15am direct care staff administered Lorazepam (Ativan) 0.5mg. cutting the pill in half with a large pair of scissors in the medication room to client #2.

Interview on 10/2/18 with direct care staff revealed client #2 had been seen at the emergency room of the local hospital on the evening of 10/1/18. She stated the ER physician had written a new order for Lorazepam 0.5 mg. to administer anytime client #2 has a seizure. Additional interview revealed she was instructed to call the nurse before administering the Lorazepam. She stated she had contacted the facility Nurse early in the morning of 10/2/18

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W 189	Continued From page 5 when client #2 had a seizure upon awakening. She stated another direct care staff had answered the phone and relayed the message to her from the facility Nurse to administer half of the Lorazepam 0.5mg. Additional interview confirmed she did not talk to the Nurse directly and she did not clarify the physician order. In addition, direct care staff indicated she did not have a pill cutter and did not know how to cut a pill in half. Review on 10/2/18 of client #2's physician orders dated 10/1/18 revealed the following: "Lorazepam (Ativan) 0.5 mg. Take 1 tablet (0.5 total) by mouth as needed. Take 1 tablet by mouth after a seizure, but only up to three times within a 24 hour period." Interview on 10/2/18 with the qualified intellectual disabilities professional (QIDP) revealed client #2 was taken to the emergency room of the hospital on the evening of October 1, 2018 for repeated seizures. She stated client #2 had a new order for Lorazepam 0.5mg. She also confirmed the 0.5 mg Lorazepam should not have been cut in half.	W 189		
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 interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.	W 249		

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W 249	Continued From page 6	W 249		

This STANDARD is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to ensure 2 of 3 audit clients (#2, #3) received a continuous active treatment plan consisting of needed interventions and services as identified in the individual program plan (IPP) in the areas of preparing modified diets. The finding are:

Direct care staff did not assist clients #2, #3 with modifying their foods prior to meals.

During observations in the facility on 10/1/18 at 5:30pm-5:50pm direct care staff was in the kitchen using the food processor to grind up pork chops, apples, squash and pinto beans without the assistance of clients. During this time clients #2 and #3 were in the living room while staff read them a book.

During observations in the facility on 10/2/18 at 6:30am direct care staff was in the kitchen using the food processor to puree oatmeal, peaches and toast. Client #3 was in the hallway near the kitchen and did not participate in pureeing her food.

Review on 10/2/18 of client #3's IPP dated 7/26/18 revealed she receives a 1800 calorie heart healthy diet with pureed textured foods. She has a need to improve participation with daily routine tasks.

Review on 10/2/18 of client #2's IPP dated 4/12/18 revealed she receives a 2,000 calorie weight reduction pureed diet with seconds of low calorie vegetables only. Additional review of the IPP revealed she requires assistance using the

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W 249	Continued From page 7 blender mixer and food processor. Interview on 10/2/18 with the qualified intellectual disabilities professional (QIDP) revealed both clients #2 and #3 can assist with using the food processor and should assist with modifying their food prior to meals.	W 249		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide nursing services in accordance with the needs for 1 of 3 sampled clients (#2) relative to a recent emergency room visit. The findings are: a. Nursing did not instruct direct care staff regarding specific skills needed to correctly administer medications to clients. During observations of the medication administration pass on 10/2/18 at 6:15am direct care staff administered Lorazepam (Ativan) 0.5mg. cutting the pill in half with a large pair of scissors in the medication room. She then administered a half of a pill of Lorazepam 0.5 mg. to client #2. Interview on 10/2/18 with direct care staff revealed client #2 was seen at the emergency room of the local hospital on the evening of 10/1/18. She stated the ER physician had written a new order for Lorazepam 0.5 mg. to administer	W 331		

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anytime client #2 has a seizure. Additional interview revealed she was instructed to call the nurse before administering the Lorazepam. She stated she had contacted the facility Nurse early in the morning of 10/2/18 when client #2 had a seizure upon awakening. She stated another direct care staff had answered the phone and relayed the message to her from the facility Nurse to administer half of the Lorazepam 0.5mg. Additional interview confirmed she did not talk to the Nurse directly and she did not clarify the physician order. In addition, direct care staff indicated she did not have a pill cutter and did not know how to cut a pill in half.

Review on 10/2/18 of client #2's physician orders dated 10/1/18 revealed the following: "Lorazepam (Ativan) 0.5 mg. Take 1 tablet (0.5 total) by mouth as needed. Take 1 tablet by mouth after a seizure, but only up to three times within a 24 hour period."

Interview on 10/2/18 with the qualified intellectual disabilities professional (QIDP) revealed client #2 was taken to the emergency room of the hospital on the evening of October 1, 2018 for repeated seizures. She stated client #2 had a new order for Lorazepam 0.5mg. She also confirmed the 0.5 mg Lorazepam should not have been cut in half.

b. Nursing did not follow up with direct care staff or with client #2 after an emergency room visit on 10/1/18.

Interview on 10/2/18 with the direct care staff administering medication during g the medication administration pass revealed she called the Nurse a few minutes before and she instructed her to administer," Half of a Lorazepam" to client

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W 331	Continued From page 9 #2. She explained that client #2 had visited the emergency room the evening before on 10/1/18 and had a new physician order for Lorazepam 0.5 mg to be given after any seizure. She stated client #2 had an additional seizure early the morning of 10/2/18 and so she had contacted the Nurse. Additional interview revealed the facility Nurse had not been to the facility to check on client #2 since her return to the facility or to inservice staff on her new physician orders. Interview on 10/2/18 with the qualified intellectual disabilities professional (QIDP) revealed client #2 was taken to the emergency room of the hospital on the evening of October 1, 2018 for repeated seizures. She stated client #2 had a new order for Lorazepam 0.5mg. She confirmed the facility Nurse had not been to the facility to inservice staff on the new physician order or to visually check on client #2. In addition, she could not locate the written order for the Lorazepam 0.5mg. written by the ER physician on 10/1/18.	W 331		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #3 received all nutritional supplements as ordered by the physician. This affected 1 of 3 audit clients (#3) . The finding is: During observations on 10/1/18 of the supper	W 368		

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W 368	Continued From page 10 meal at 6pm, client #3 refused to come to the dining room table to eat. Direct care staff tried at least 4 times to encourage her to come to the dining room table to eat but she refused. Verbal cues and physical assistance were provided to walk her into the dining room area however, she walked away every time. During observations on 10/2/18 of breakfast at 7am direct care staff encouraged client #3 to come to the dining room to eat breakfast. verbal cues and physical assistance were used to walk her into the dining room however, she refused to stay in the dining room. Review on 10/2/18 of client #3's quarterly physician orders dated 4/12/18 revealed she is to receive Ensure BID (twice daily) for meal refusal. Review on 10/2/18 revealed no documentation on the October medication administration record (MAR) for client #3 indicating any Ensure was given on 10/1/18 or on 10/2/18. Phone interview on 10/2/18 with the facility Nurse revealed direct care staff should have offered a can of Ensure on 10/1/18 when client #3 refused supper and on 10/2/18 when she refused breakfast.	W 368		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by:	W 369		

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The facility failed to assure medications administered to 1 of 3 sampled clients (#2) was administered without error as evidenced by observation, interview and record verification. The finding is:

Client #2 did not receive prescribed medication for her seizure disorder as ordered by the physician.

During observations of the medication administration pass on 10/2/18 at 6:15am direct care staff administered the following medications to client #2: Lorazepam (Ativan) 0.5mg. (1/2 pill equally 0.25mg.) Divalproex Sodium 125 mg. (1), Calcium 500 mg. plus Vitamin D (1), Escitalopram10mg. (1) Levetiracetam 500mg. (1), Vimpat 150mg. (1).

Review on 10/2/18 of client #2's physician orders dated 10/1/18 revealed the following: "Lorazepam (Ativan) 0.5 mg. Take 1 tablet (0.5 total) by mouth as needed. Take 1 tablet by mouth after a seizure, but only up to three times within a 24 hour period."

Review on 10/2/18 of client #2's physician orders dated 8/28/18 revealed the following: Divalproex Sodium 125 mg. (1), Calcium 500 mg. plus Vitamin D (1), Escitalopram10mg. (1) Levetiracetam 500mg. (1), Vimpat 150mg. (1).

Interview on 10/2/18 with the direct care staff administering the medication revealed she called the Nurse and she instructed her to administer," Half of a Lorazepam".

Interview on 10/2/18 with the qualified intellectual disabilities professional (QIDP) revealed client #2

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W 369	Continued From page 12 had been at the emergency room(ER) at a local hospital on the evening of 10/2/18 for repeated seizures. She stated the ER Physician had added an order for Lorazepam 0.5mg. after any seizure. The direct care staff were instructed to contact the Nurse before administering. Additional interview on 10/2/18 with the direct care staff revealed she had not given 0.5 mg of Lorazepam because she cut the pill into half with a pair of scissors during the medication pass.	W 369		