STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G021	A. BUILDING _____ B. WING _____	12/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALPH SCOTT LIFESERVICES, INC/TOWN BRANCH RD	710 TOWN BRANCH RD GRAHAM, NC 27253

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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 record review and interview, the facility failed to develop an Emergency Preparedness (EP) plan including and based upon a community and facility-based risk assessment, utilizing an all-hazards approach. The finding is: The facility did not have an emergency plan	E 006		

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

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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E 006	Continued From page 1 based upon risk assessments. Review on 12/4/18 of the facility's current EP plan dated 2/21/18 revealed the plan did not provide specific information in regards to a facility-based and community-based risk assessment using an all-hazards approach including flood, fire, tornadoes, hurricanes, winter storms, bio terrorism, missing clients or other emergency types. Interview on 12/5/18 with the Director of ICF/IID confirmed no EP risk assessment had been completed utilizing an all-hazards approach.	E 006		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based	E 039		

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E 039	Continued From page 2 full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure a facility/community-based or tabletop exercise was conducted to test their emergency plan. The finding is:	E 039		

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E 039	Continued From page 3 The facility's Emergency Preparedness (EP) plan did not include completion of facility/community-based exercise or tabletop exercise. Review on 12/4/18 of the facility's EP plan dated 2/21/18 did not include a full-scale community-based or individual facility-based exercise or a tabletop exercise to test their emergency plan. Interview on 12/5/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the facility has not conducted a full-scale facility/community-based exercise or a tabletop exercise to test the effectiveness of their current emergency plan.	E 039		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure client #3's Individual Program Plan (IPP) included specific information to support his independence. This affected 1 of 3 audit clients. The finding is: Client #3's IPP did not include specific information to support his independence with clearing his placesetting after meals/snacks. During 3 of 3 mealtime/snack observations at the	W 240		

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W 240	Continued From page 4 home and day program on 12/4 - 12/5/18, staff consistently removed client #3's dirty dishes and trash after he finished eating. The client was not prompted or assisted to clear his dishes and trash. Review on 12/5/18 of client #3's IPP dated 10/25/18 revealed a need to maintain and increase his daily living/domestic skills. Additional review of the plan did not include specific instructions to support client #3 with clearing his place after meals. Interview on 12/5/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the client could assist with some aspects of clearing his place after meals.	W 240		
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. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 2 of 3 audit clients (#1, #3) received an active treatment plan consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of objective implementation, adaptive	W 249		

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equipment use, drink consistency and self-help skills. The findings are:

1. Client #3's day program objectives were not implemented as indicated.

During lunch observations at the day program on 12/4/18 from 11:14am - 11:46am, staff fed client #3 his pureed food and thickened drink. At the beginning of the meal, staff set up the client's food items before he arrived at the table. Throughout the meal, the staff wiped the client's mouth for him. Once the meal was finished, a staff removed all items and trash from the table.

Review on 12/4/18 of client #3's IPP dated 10/25/18 revealed objectives to wipe his mouth with hand-over-hand manipulation after snack/lunch, to unpack one item from his lunch bag during snack/lunch, and to hand staff his trash to throw away after snack/lunch. The plan noted all objectives were implemented on 11/1/18.

Interview on 12/15/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the objectives should have been implemented during client #3's lunch.

2. Client #3's drink was not thickened to the appropriate consistency at the day program.

During lunch observations at the day program on 12/4/18 from 11:14am - 11:46am, client #3 consumed a pureed diet with a thickened drink. The drink's consistency was similar to pudding and very thick. All food and drink items were fed to the client.

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Interview (3) on 12/5/18 with day program staff indicated all of client #3's drinks are thickened by day program staff when he attends the day program; however, they were not sure what the consistency of his drinks should be.

Review on 12/5/18 of client #3's current physician's orders dated 10/26/18 revealed the diet order, "Heart Healthy pureed; liquids nectar thick..."

Interview on 12/5/18 with the QIDP confirmed client #3 receives his liquids at a nectar thick consistency and day program staff should be preparing it as indicated.

3. Client #3's gait belt was not used as indicated.

During observations in the home throughout the survey on 12/4 - 12/5/18, client #3 wore a gait belt around his waist. Throughout the observations, various staff assisted client #3 to a standing position by holding his hands and pulling him up from his seat. Staff did not consistently use the client gait belt during these observations.

Staff interview on 12/5/18 revealed client #3 often refuses to stand if his gait belt is used. Additional interview indicated taking the client by the hands during standing works better.

Review on 12/5/18 of client #3's IPP dated 10/25/18 revealed Walking Assistance Guidelines (dated 10/16/18). The guidelines noted, "Use a gait belt to assist him to standing and to ambulate on even surfaces."

Interview on 12/5/18 with the QIDP confirmed the walking guidelines should be followed as written.

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W 249	Continued From page 7 4. Client #1 was not prompted or assisted to clear his place after a snack/meal. During a snack and 2 of 2 meal observations in the home on 12/4 - 12/5/18, staff cleared client #1's dirty dishes for him. Client #1 was not prompted or encouraged to clear his place. Staff interview on 12/5/18 revealed client #1 "could probably do it" with his left hand since his right hand has deformities. Review on 12/5/18 of client #1's IPP dated 8/30/18 revealed he can "assist/participate" with clearing his place at the table. Interview on 12/5/18 with the QIDP confirmed client #1 can possibly assist with clearing his place using a bin.	W 249		