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DHSR-MH Licensure Sect

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 _____	12/03/2019

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

(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 120	SERVICES PROVIDED WITH OUTSIDE SOURCES CFR(s): 483.410(d)(3) The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the day program failed to ensure that 2 of 5 audited clients (#2 and #5) had opportunities for independence with meal guidelines. The findings are: Staff did not provide verbal prompts or physical assistance during lunch for clients #2 and #5. A. During observations at the day program on 12/2/19 at 11:00 am, Staff A was observed holding the lunch bag for client #5, removing the contents and transferring the food on a plate. Review on 12/2/19 of the individual program plan (IPP) dated 6/1/19 revealed that some new goals had been written and implemented for client #5 on 11/1/19. The goal stated that [client #5] would unpack his lunch with verbal prompts. During an interview on 12/3/19 with the QIDP, he shared that client #5 was capable of setting the table, packing and unpacking his lunch. B. During observations at the day program on 12/2/19 at 11:00 am, Staff B was observed fixing plate of food for client #2 as well as reheated before feeding client. Client #2 was not involved with the meal preparation. Review on 12/3/19 of the IPP dated 8/29/19	W 120	W120: By 1/15/20, The AD of the day program will retrain staff on the importance of allowing individuals particularly client #2 and client #5 to be as independent as possible by following goals and mealtime guidelines that are already in place but being aware of any behaviors that may arise. Furthermore all IWS goals/mealtime guidelines will be reviewed as well. A copy of the trainings will be filed in the personnel records. Members of the coordinating staff will monitor as well as document the observations on a weekly basis to make sure that the individuals are being given the opportunity to be as independent as possible while following the goals and guidelines already in place. The weekly observations will eventually fade to monthly monitoring as appropriate. A copy of the documentation/observations will be forwarded to the QIDP and Director of ICF for review.	Feb. 1st 2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: ICF Assistant Director (X6) DATE: 01/08/2020

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 120	Continued From page 1 revealed that client #2 could assist with pouring puree liquids/foods, beverage and set up and clean up his place at the table. During an interview on 12/3/19 with the assistant director (AD), she shared that client #2 could become tactile defensive with his right hand but staff should attempt to involve him in bringing his thick it container to the table and assist him to stir his food.	W 120		
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 observations, record review and staff interviews, the facility failed to ensure that 1 of 5 audited clients (#3) was afforded dignity regarding the use of disposable incontinence pads on furniture. The finding is: Facility placed disposable incontinence pads on client #2's chair to satisfy the parents request. During observation in the home on 12/2/19 at 5:40 pm, client #3 was seated in wheelchair and was ready to have a seat in his personal lift recliner. Staff C was seen leaving the living room, returning with a disposable incontinence pad and placing it in the seat of the recliner chair. Client #3 was then assisted by Staff C to sit down in the recliner, on top of the pad, that was still exposed. Client #3 remained in the chair until dinner was	W 125	W125: By 1/10/20, The QP along with the IDT team will meet to assess the need for incontinence pads on the furniture for client #3. If needed, incontinence pad guidelines will be implemented and staff will receive training. The team will also review and retrain on client #3 existing guidelines regarding incontinence. Furthermore all IWS guidelines for incontinence and the possible need for incontinence pads will be reviewed as well. A copy of the trainings will be filed in personnel records. Members of the coordinating staff will monitor the execution of the individual incontinence guidelines as well as document observations weekly, and then fade to monthly monitoring as appropriate. A copy of the documentation/observations will be forwarded to the QIDP and Director of ICF for review.	Feb. 1st 2020

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W 125	Continued From page 2 served at 6:20 pm. An additional observation in the home on 12/3/19 at 6:45 am, revealed that a disposable incontinence pad was rolled up and placed on the left arm of client #3's unoccupied chair. Client #3 was sitting at the dining room table, eating breakfast. Further, client #3 left the house to board the van on 12/3/19 at 7:50 am and used his wheelchair for transport. No disposable incontinence pad was observed while client #3 was seated in his wheelchair. A review on 12/3/19 of client #3's nursing evaluation dated October 2019 outlined guidance for incontinence care. Client #3 wore adult disposable protection/underwear with an incontinence insert. Staff were advised to check on client #3 every 2 hours while awake for wet/soiled briefs. The insert should be changed every hour. An additional review on 12/3/19 of client #3's "incontinence/approval to place Chux on personal chair guideline" last reviewed on 10/1/19 revealed that the "guardians have brought their concern to the staff and qualified professional (QP) that [client #3] needs to have a Chux placed on his personal chair regularly when he uses it. The guardians believe that [client #3] is not always honest with staff, when asked if he needs to go to the bathroom because his attention is focused on something else. The interdisciplinary team (IDT) determined that [client #3], along with being incontinent does have issues of frequent urinary tract infections (UTI's) and maladaptive behaviors whereby he, may wet through his adult undergarments despite the staff's effort to frequently check him."*	W 125	Continued....	Feb. 1st 2020

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W 125	Continued From page 3 During an interview with the QP on 12/2/19 revealed that the disposable incontinence pad was placed in client #3's at the request of his parents, who wanted to protect the fabric of the chair. The facility had approved guidelines to use the pad in the chair and that no one else used the chair besides client #3.	W 125		
W 260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to update the current individual program plan (IPP) to reflect current mobility skills for 1 of 5 audit clients (#2). The findings are: Facility failed to ensure consistent nursing, physical therapy and IPP assessments for client #2. During observations on from 12/2/19-12/3/19, client #2 was transported in his wheelchair and the chair was pushed throughout his environment by staff. Review on 12/3/19 of the 2018 and 2019 physical therapy assessments it was noted that client #2 used a narrow adult wheelchair that was in a state of disrepair. He had poor posture in the wheelchair and was unable of repositioning himself. He required maximum assistance with	W 260	W260: By 1/13/20, The QP, RN, and PT will meet, reevaluate, and retrain staff on client #2 mobility skills/guidelines. Furthermore all IWS mobility guidelines will be reevaluated as well. A copy of the trainings will be filed in the personnel records. Members of the coordinating staff will monitor the execution of the individual guideline and document observations weekly, and fade to monthly monitoring as appropriate. A copy of documentation/observations will be forwarded to the QIDP and Director of ICF for review.	Feb. 1st 2020

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W 260	Continued From page 4 wheelchair mobility and also also resisted the use of the Pacer walker. Additional review on 12/3/19, the annual nursing evaluation dated 8/23/19, mentioned that client #2 had limited ability to propel chair in environment. In addition, the IPP dated 8/29/19 revealed that client #2 could propel his wheelchair using his feet but needed total assistance with wheelchair mobility. There had been several attempts to re-acclimate client #2 to his walker, but he was uncomfortable and frightened to use it, due to a previous injury. During an interview on 12/3/19 with the home manager revealed that client #2 could scoot a short distance in his wheelchair or move the chair backwards, using his feet. He sometimes used the walker at the day program, otherwise staff pushed his wheelchair to transport him. During an interview on 12/3/19 with the assistant director, she revealed that client #2's wheelchair was replaced in 2015 and was not in disrepair.	W 260	Continued ...	Feb. 1st 2020
W 324	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(ii) The facility must provide or obtain annual physical examinations of each client that at a minimum includes immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics. This STANDARD is not met as evidenced by: Based on record review and interview, the facility	W 324	W324: By 1/10/20, The QP will follow up with the DSS representative as well as the healthcare provider to obtain immunization records for client #6. RN will review client#6 charts and then document the findings on an Adult Immunization form. Furthermore all IWS immunization records will be obtained if not already in place and updated on the Adult Immunization Form as well. Records along with the Adult Immunization Record form will be filed in each individual personnel records. Members of the coordinating staff will monitor and make sure all tetanus booster shots and immunizations are documented and up to date on the form as well. Observations will be weekly then fade to monthly monitoring as appropriate. Copies of documentation/observations will be forwarded to the QIDP and Director of ICF for review.	

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W 324	Continued From page 5 failed to ensure current immunization records were obtained for client #6. This affected 1 of 5 audit clients. The finding is: Client #6's record did not contain her current immunizations. Review on 12/2/19 of client #6's record revealed she had been admitted to the facility on 12/17/18. Additional review of the record did not include his current immunizations. Interview on 12/3/19 with the Qualified Intellectual Disabilities Professional (QIDP) and house manager revealed they have had difficulty obtaining proper records for client #6 including her current immunizations.	W 324	Continued.....	
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 observation, record review and staff interviews, the facility failed to ensure all drugs were administered in accordance with physician's orders. This affected 1 of 5 audit clients (#4). The finding is: Client #4 did not receive his medication in compliance with physician's orders. During observations at the day program on 12/3/19 at approximately 11:15 am, client #4 was eating his lunch with peers. Further observation	W 368	W368: By 1/15/20, The AD of the day program along with the RN will retrain staff on the importance of giving medications at the prescribed time for client #4 as well as all individuals. The RN will specifically discuss the purpose of the medications, administration procedure, guiding principle, count process, and integrity. A copy of trainings will be filed in personnel records. Members of the coordinating staff will monitor the execution of the administering of meds through weekly observations that will fade to monthly monitoring as appropriate. A copy of the documentation/observation will be forwarded to the QIDP and Director of ICF for review.	Feb. 1st 2020

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W 368	Continued From page 6 during medication administration at approximately 11:48am, client #4 received Gas X 80 mg by mouth. Review on 12/3/19 of client #4's physician's orders dated 10/1/19 revealed, "Gas X 80mg 1 tablet by mouth before each meal." During an interview on 12/3/19, the medication technician (MT) revealed client #4 received his medication after lunch. During an interview on 12/3/19, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4 should have received Gas X before meals as ordered.	W 368	Continued...	
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure all medications remained locked except when being administered. This potentially affected all clients in the home. The finding is: Medications were not kept locked. During observations of medication administration in the home on 12/2/19 at approximately 7:30m, the medication technician (MT) left the medication room opened , client #4 and the surveyor were in the room. As the MT left the	W 382	W382: By 1/10/20, The QP and RN will retrain staff on the importance of keeping the med room door locked when it is unoccupied. Training will review that only authorized persons may have access to the drug storage area, securing the area, focusing on medication administration and the dangers of individuals and unauthorized personnel having access to medications. A copy of trainings will be filed in personnel records. Members of the coordinating staff will monitor the execution of the administering of meds through weekly observations that will fade to monthly monitoring as appropriate. A copy of the documentation/observations will be forwarded to the QIDP and Directory of ICF for review.	Feb. 1st 2020

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W 382	Continued From page 7 room, the closet containing medications and the door to the medication room were unlocked and/or open and there were medication on the counter. Interview on 12/2/19 with the MT revealed they had been trained to ensure the door to the medication room "was closed" when leaving medications room. Interview on 12/3/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed medications should be kept locked if the MT needs to leave the area during medication administration.	W 382	Continued...	

RALPH SCOTT
LIFESERVICES, INC.
Serve · Support · Empower

FAX COVER SHEET

To: Esther Moore	**From:** Terrance R. Ward (336-227-1011 ext. 57)
Company: Mental Health Licensure and Certification Section	**Company:** RALPH Scott Lifeservices
Fax: 919-715-8078	**Pages:** 11
Phone: 919-855-3795	**Date:** 1/8/2020
Re:	**cc:**

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

• ***Comments:***

Attn: Esther Moore
Mental Health Licensure and Certification Section
NC Division of Health Service Regulation

Attached is a copy of the POC for the Townbranch Grouphome.
The original has been put in the mail as well.

Phone: 336-227-1011 Fax: 336-226-6465
408 W. Trade Street, Burlington, NC 27217
www.rsli.org

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

December 20, 2019

Ms. Jennifer Helton, CEO
Ralph Scott Lifeservices, Inc.
408 West Trade Street
Burlington, NC 27217

Re: Recertification Completed December 3, 2019
Ralph Scott Lifeservices, Inc. 710 Townbranch Rd, Graham, NC 27253
Provider Number 34G021
MHL 001-008
E-mail Address: jennifer@rsli.org

Dear Ms. Helton:

Thank you for the cooperation and courtesy extended during the recertification survey completed December 3, 2019. This survey was required for continued participation in the Medicaid program.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form (CMS-2567). The purpose of the Statement of Deficiencies is to provide you with specific details of the practice(s) that does/do not comply with regulations. You must develop one Plan of Correction that addresses each deficiency listed on the CMS-2567 form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance and what to include in the Plan of Correction.

Type of Deficiencies Found

- Standard level deficiencies were cited.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is February 1, 2020.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the CMS-2567 Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Please be advised that additional W tags may be cited during the Life Safety Code portion of the recertification survey.

A follow up visit will be conducted to verify all deficient practices have been corrected. If we can be of further assistance, please call Esther Moore at 919-612-8832.

Sincerely,

esther moore

Esther Moore, BSW, QIDP
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

Cc: qmemail@cardinalinnovations.org