DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G311	A. BUILDING ______ B. WING ______	02/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALPH SCOTT LIFESERVICES, INC/ROSEMONT STREET	304 ROSEMONT STREET GIBSONVILLE, NC 27217

(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 observations, record reviews and interviews, the facility failed to ensure 1 of 4 audit clients (#2) had the right to be treated with dignity regarding the use of plate being placed on top of clothing protector. The finding is: Client #2's dignity was not considered regarding the use of plate being placed on top of clothing protector. During meals observations at the day program, client #2 clothing protector was attached to client neck then placed on top of the client wheelchair padded board. During an interview on 2/4/2020, staff B revealed the clothing protector is placed on top of the board to prevent client #2's chair from getting dirty from spillage. Review on 2/4/2020 of client #2 individual program plans (IPPs) dated 11/08/19 revealed a right"...he continue to require a full assistance to understand and exercise right to dignity." During an interview on 2/5/2020, the Qualified Intellectual Disabilities Professional (QIDP) confirmed the clothing protector should be tucked instead of placing on the client board for his dignity during meal.	W 125	W125 By April 4, 2020 AD of the Day Program will review and re-train staff on client #2 rights and all the other client's right including the right to have dignity regarding the use of plate being placed on top of clothing protector. AD of Day Program will monitor during meal times to ensure client rights are being exercised. AD of Day Program will monitor bi weekly and fade to monthly. A copy of all trainings will be filed in staff records. RECEIVED FEB 28 2020 DHSR-MH Licensure Sect	4/5/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Belinda K. Gordon — TITLE: Dir of cl CF — (X6) DATE: 2/28/2020

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 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, record reviews and interviews, the facility failed to ensure 1 of 4 audit clients (#2) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of adaptive dining equipment use. The finding is: Clients (#2) was not given the adaptive cup. During medication adminstration observations at the day program On 2/4/2020 at approxiametly 1:25pm, client #2 received his medication and drank water with a regular foam cup. The client was not able to take all the liquids due to the sitting angle on his wheelchair. Review on 2/4/2020 of client #2's IPP dated 11/7/19 revealed client #2 use sippy cup as a daptive equipment including medication adminstatrion. Interview on 2/4/20 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #2 should use a sippy cup for all his liquid intake	W 249	W249 By April 4, 2020 AD of the Day Program will review and retrain staff on client # 2 and all additional client's IPP's and adaptive equipment needs form. The training will include the use of adaptive equipment especially in all environments including the med pass. AD of the Day Program will monitor during medication administration to ensure proper adaptive equipment is being used. AD of Day Program will monitor bi weekly and fade to monthly observations. A copy of all trainings will be filed in staff records.	4/5/2020

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W 249	Continued From page 2 including medication adminstration.	W 249		
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 failed to ensure current immunization records were obtained for client #6. This affected 1 of 4 audit clients. The finding is: Client #6's record did not contain his childhood immunizations. Review on 2/5/2020 of client #6's record revealed he had been admitted to the facility on 2018. Additional review of the record revealed he had Flu vaccine yearly and had Dtap on 2018. Further review the record did not include his childhood immunizations. Interview on 2/5/2020 with the Qualified Intellectual Disabilities Professional (QIDP) and facility's nurse revealed they have had difficulty obtaining proper records for client #6 including his childhood immunizations.	W 324	W324 By April 4, 2020 The QP and Nurse will review client # 6 and all the other client's charts to include childhood immunizations record. Client # 6 IPP will be reviewed and updated as needed. Director of ICF will re-train RN to ensure the charts are updated and each client has their childhood immunizations record. In addition to this QP will update record review form for ICF to ensure childhood immunizations is filed in Volume 1 and all training will be filed in POC book.	4/5/2020
W 325	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(iii) The facility must provide or obtain annual physical	W 325		

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W 325	Continued From page 3 examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure lab work was obtained as ordered by the physician for 1 of 4 audit clients (#6). The finding is: Lab work for client #6 was not obtained as ordered. Review on 2/4/2020 of client #6's current physician's order revealed the following: labs annually as indicated. Additional review of client #6's current record revealed the most recent labs were dated 5/2/18. During an interview on 2/5/2020 with the facility's nurse via phone revealed clients #6's labs are supposed to be assessed annually not unless otherwise specified. During an interview on 2/5/2020, the qualified intellectual disabilities professional (QIDP) confirmed client #6's record did not have any more recent labs.	W 325	W325 By April 4, 2020 QP and Day Manager will obtain client # 6 lab work and all other clients' lab work and will file in volume 1. QP will add lab work to our record review form for ICF to ensure that lab work is filed in volume 1. Director of ICF will train QPs on the updated form. Director of ICF will train Day Manager to ensure she obtains the lab work results. A copy of all trainings will be filed in the POC book.	4/5/2020
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.	W 368		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2020
FORM APPROVED
OMB NO. 0938-0391

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W 368	Continued From page 4 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 4 audit clients (#4). The finding is: Client #4 did not receive his medication in compliance with physician's orders. During observations at the home on 2/4/2020 at approximately 5:20pm, client #4 was ingested calcium 600mg/Vit D with 3 more pills. Review on 2/4/2020 of client #4's physician's orders dated 11/29/19 revealed, "calcium 500mg, take 1 tab by mouth twice daily." During an interview on 2/4/2020, the medication technician (MT) revealed client #4 received her medication per medications administration record (MAR) and the available medication from the pharmacy. During an interview on 2/4/2020 with the facility's nurse revealed the physician order does not match the medication available. During an interview on 2/4/2020, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4's physician orders were not followed.	W 368	W368 By April 4, 2020 RN will go back and review Client #4 and all the other clients 90 day orders/MARs to see if any changes were made on 90 day orders by PCP. If any changes are made RN will update MARs. QP will denote change in order when sending to pharmacy. RN will recheck MARs against signed orders when returned. RN will sign after PCP returns 90 day order to reflect review of signed (MD/PCP/NP) orders. If changes are made in orders it is highlighted on orders to ensure PCP sees changes (current). RN will re-check MAR to make sure order changes are carried over to MAR for next month. Any changes made will have 2nd check to MAR and pill pack. Each month RN will compare old MARs to new MARs when preparing next month's MARs. RN will use the signed orders where changes noted for second check. Director of ICF will monitor RN services bi monthly and all trainings will be filed in the POC book.	4/5/2020
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.	W 369		

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W 369	Continued From page 5 This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure all medications were given as ordered. This affected 1 of 4 audit clients (#4). The finding is: One medication was not given at the dose it was ordered. During observations of the medication pass on 2/4/2020 at 5:50pm, client #4 was given calcium 600mg/D among other medications. Review of client #4's the physician's orders signed 11/28/19 revealed, "Calcium 500mg: take 1 tablet by mouth twice daily." Interview on 2/4/2020 with the nurse revealed that the current order was correct and the client received the wrong dose and was not able to tell for how wrong the dose was wrong. Interview on 2/4/2020 with the qualified intellectual disabilities professional (QIDP) confirmed there is no current order for calcium 600mg/D in the record.	W 369	W369 By April 4, 2020 RN will review current physician orders with comparisons to the MAR and medications in the home for client # 4 and all other clients of the home. RN will retrain house staff on ensuring that the medication is administered correctly as reflected on MAR and physician orders. QP and Nurse will monitor the administration of medication bi monthly and will fade monitoring as needed. A copy of trainings will be filed in POC book.	4/5/2020

RALPH SCOTT
LIFESERVICES, INC.
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Wambui Karanu

To:	State Surevayour	From:	Brittany Blount
Company:	NC dept. of health human services	Company:	Ralph Scott
Fax:		Pages:	
Phone:		Date:	
Re:		cc:	

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

• *Comments:*

Phone: 336-227-1010 Fax: 336-226-6465
408 W. Trade Street, Burlington, NC 27217

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

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

February 18, 2020

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

Re: Recertification Survey Completed February 4, 2020
Ralph Scott Lifeservices, Inc./Rosemont Street,
304 Rosemont Street, Gibsonville, NC 27217
Provider Number: 34G311
MHL Number: 001-031
E-mail Address: Jennifer@rsli.org

Dear Ms. Helton

Thank you for the cooperation and courtesy extended during the recertification survey completed 2/4/2020. 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 <deficiency/ deficiencies> must be ***corrected*** within 60 days from the exit of the survey, which is **4/5/2020.**

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.

MENTAL HEALTH LICENSURE & CERTIFICATION SECTION

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603
MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718
www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

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