PRINTED: 03/12/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G022	B. WING			03/	09/2021
	PROVIDER OR SUPPLIER	S, INC/POPULAR STREET		32	TREET ADDRESS, CITY, STATE, ZIP CODE 28 POPLAR STREET RAHAM, NC 27253		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 033	CFR(s): 483.475(c)  [(c) The [facility] must emergency prepare that complies with Fand must be review 2 years (annually for plan must include at (4) A method for she documentation for pare, as necessary maintain the continut (5) A means, in the release patient information (5) A means, in the release patient information (5) [(4) or (5)] A means about the general continut (6) [(4) or (5)] A means about the general continut (6) [(4) or (5)] A means about the general continut (6) [(4) or (5)] A means about the general continut (6) [(4) or (5)] A means about the general continut (6) [(4) or (5)] A means about the general continut (6) [(5)] A means about the general continut (6) [(6)] [(	ist develop and maintain an adness communication plan rederal, State and local laws red and updated at least every or LTC).] The communication II of the following:  aring information and medical patients under the [facility's] with other health providers to uity of care.  event of an evacuation, to rmation as permitted under 45 (ii). [This provision is not under §484.102(c), CORFs  ans of providing information ondition and location of facility's] care as permitted 510(b)(4).  03.748(c):] (4) A method for and care documentation for RNHCI's care, as necessary, to maintain the continuity of written election statement	EO	33			

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	NG		E SURVEY PLETED
		34G022	B. WING		03/	09/2021
	PROVIDER OR SUPPLIER	S, INC/POPULAR STREET		STREET ADDRESS, CITY, STATE, ZIP CODE 328 POPLAR STREET GRAHAM, NC 27253		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 039	Based on document facility failed to ensipreparedness (EP) developed and main Federal, State and Review on 3/8/21 of wrong contact information for two Additional review readmitted on 1/4/21.  During an interview intellectual disabilitic confirmed the face contained the income EP Testing Require CFR(s): 483.475(d).  *[For RNCHI at §40.4 HHAs at §484.102, "Organizations" und §485.920, RHC/FQ Facilities at §494.62.  (2) Testing. The [fact to test the emergen must do all of the face (i) Participate in community-based en (A) When a not accessible, con exercise every 2  (B) If the [fantural or man-maca activation of the emergen must do all or the face (B) If the [fantural or man-maca activation of the emergen must do all or the face (B) If the [fantural or man-maca activation of the emergen must do all or the face (B) If the [fantural or man-maca activation of the emergen maca activation of the emergen macalled the face (B) If the [fantural or man-maca activation of the emergen macalled the face (B) If the [fantural or man-macalled the face (B) If the [fantural or man-	or treview and interview, the sure an emergency communication plan was intained in compliance with local laws. The finding is:  If the facility's EP plan had the mation. Further review heets had the contact clients who were deceased. Evealed a client who was information was not included.  On 3/9/21, the qualified es professional (QIDP) sheets for the facility rect information.  ments  I(2)  I3.748, ASCs at §416.54, CORFs at §485.68, OPO, der §485.727, CMHC at HC at §491.12, ESRD [2]:  Icility] must conduct exercises acy plan annually. The [facility] ollowing:  In a full-scale exercise that is every 2 years; or a community-based functional years; or acility] experiences an actual de emergency that requires	EO			

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	NT OF DEFICIENCIES N OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  (X3) DATE S  COMPL		E SURVEY IPLETED			
		34G022	B. WING		03/	09/2021
	PROVIDER OR SUPPLIER	S, INC/POPULAR STREET		STREET ADDRESS, CITY, STATE, ZIP CODE 328 POPLAR STREET GRAHAM, NC 27253	, ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
E 039	functional of the actual event.  (ii) Conduct an every 2 years, opportunctional exercise this section is conduct imited to the form (A) A second community-based of functional exercise (B) A mock (C) A table is led by a facilitate discussion using a clinically-relevance of problem state prepared questions emergency plan.  (iii) Analyze maintain document exercises, and emergency the [facility's]	per individual, facility-based exercise following the onset of additional exercise at least posite the year the full-scale or under paragraph (d)(2)(i) of ucted, that may include, but is llowing: and full-scale exercise that is per individual, facility-based or individual, fa	E 039			
	patient's home. The exercises to test the annually. The hosping of the exercises to test the annually. The hosping of the emergency participate in the exercises to test the exercise the exercises the exercises the exercises the exercise the exercises the exerc	a community based exercise is duct an individual facility kercise every 2 years; or ospice experiences a natural gency that requires activation				

Facility ID: 922412

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING  A. BUILDING		(X3) DATE SURVEY COMPLETED				
		34G022	B. WING			03/	09/2021
	PROVIDER OR SUPPLIER	ES, INC/POPULAR STREET		3	TREET ADDRESS, CITY, STATE, ZIP CODE 28 POPLAR STREET GRAHAM, NC 27253	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 039	facility- based the onset of the en (ii) Conduct at years, opposite the functional exercise this section is conduct in the section is conducted in the section is conducted exercise; or (B) A mode (C) A table is led by a facilitate discussion using a clinically-relevance of problem states of problem	assed exercise or individual functional exercise following hergency event. In additional exercise every 2 eyear the full-scale or under paragraph (d) (2)(i) of ducted, that may include, but is following: In a facility based functional exercise that is for a facility based functional exercise or workshop that for and includes a group narrated, ant emergency scenario, and a fements, directed messages, or a designed to challenge an emergency plan twice per must do the following: in an annual full-scale exercise based; or a community-based exercise is induct an annual individual ional exercise; or ospice experiences a natural regency that requires activation plan, the hospice is ging in its next required ity based or facility-based exercise following the onset	EC	039			

Facility ID: 922412

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G022	B. WING		03/	/09/2021	
	PROVIDER OR SUPPLIER	S, INC/POPULAR STREET		STREET ADDRESS, CITY, STATE 328 POPLAR STREET GRAHAM, NC 27253			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
E 039	community-based of exercise; or  (B) A moclo (C) A table by a facilitator that it using a narrated, emergency scenaristatements, directe questions desemergency plan.  (iii) Analyze the maintain document exercises, and emergency exercises, and emergency before the hospice's emergency exercises and emergency exercises and emergency exercises and emergency exercises and exercises are twice per year. The dothe following:  (i) Participate it that is community-before (A) When a not accessible, confacility-based functional exercise emergency plan, the engaging in its next based or functional exercise emergency event.  (ii) Conduct an	and full-scale exercise that is or a facility based functional of disaster drill; or stop exercise or workshop led includes a group discussion clinically-relevant or, and a set of problem disagned to challenge an endeation of all drills, tabletop ergency events and revise gency plan, as needed.  1.184(d), Hospitals at eat §485.625(d):] RTF, Hospital, CAH] must content the emergency plan endeation of all drill-scale exercise exased; or a community-based exercise is duct an annual individual, onal exercise; or exercise; or exercise; or exercise, content and exercise; or exercise is duct an annual or man-made	EO	039			

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G022	B. WING		03/	09/2021
	PROVIDER OR SUPPLIER	S, INC/POPULAR STREET		STREET ADDRESS, CITY, STATE, ZIP CODE 328 POPLAR STREET GRAHAM, NC 27253		
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E 039	community-based of functional exercises (B) A mock (C) A table is led by a facilitate discussion, using a clinically-releval set of problem state prepared questions emergency plan.  (iii) Analyze the maintain document exercises, and emergency plan.  (iii) Analyze the maintain document exercises, and emergency proceded [For LTC Facilities (2) The [LTC facility test the emergency including unannour emergency proceded [CF/IID] must do the (i) Participate in that is community-beased function (B) If the [Lan actual natural or requires activation the LTC facility is erequired a full-scale individual, facility following the onset (ii) Conduct are	and full-scale exercise that is or individual, a facility-based or a disaster drill; or top exercise or workshop that and includes a group narrated, and ements, directed messages, or designed to challenge an effacility's] response to and ation of all drills, tabletop ergency events—and revise gency plan, as needed.  at §483.73(d):]  at §483.73(d):]  at §483.73(d):]  at gency events—and revise gency plan, as needed.  at §483.73(d):]  at gency events—and revise gency plan, as needed.  at §483.73(d):]  at gency events—and revise gency plan at least twice per year, need staff drills using the cures. The [LTC facility, e following: an annual full-scale exercise pased; or a community-based exercise is duct an annual individual, onal—exercise.  TC facility] facility experiences man-made emergency that	E 039			

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
E 039	community-based of functional exercises (B) A moc (C) A table is led by a facilitato using a narrated, emergency scenaristatements, directed questions defended by a facilitation of the emergency plan.  (iii) Analyze the response to and madrills, tabletop exercite events, and revised emergency plan, as *[For ICF/IIDs at §4 (2) Testing. The ICI to test the emergency plan, as (i) Participate in that is community-be (a) When a not accessible, confacility-based function (B) If the ICI natural or man-madrication of the emergency endits of the emergency endits (ii) Conduct an may include, but is (A) A second	and full-scale exercise that is or an individual, facility based or a community-based exercises an annual full-scale exercise is duct an annual individual, onal exercise; or a community-based exercise is duct an annual individual, onal exercise; or a community-based exercise is duct an annual individual, onal exercise; or a community-based exercise is duct an annual individual, onal exercise; or a community-based exercise is duct an annual individual, onal exercise; or a community-based exercise is duct an annual individual, onal exercise; or a community-based exercise is duct an annual individual, onal exercise; or a community-based exercise is duct an annual individual, onal exercise; or a community-based exercise is duct an annual individual, onal exercise; or a community-based exercise is duct an annual exercise; or a community-based exercise is duct an annual individual, facility-based or individual, facility-based or individual, facility-based or individual, facility-based individual, facility-based full-scale exercise that is or an individual, facility-based	E 03	9		

Facility ID: 922412

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		34G022	B. WING _		03	/09/2021
	PROVIDER OR SUPPLIER	S, INC/POPULAR STREET		STREET ADDRESS, CITY, STATE, ZIP 328 POPLAR STREET GRAHAM, NC 27253		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE
E 039	(B) A mock (C) A table is led by a facilitate discussion, using a clinically-relevance of problem stat prepared questions emergency plan.  (iii) Analyze the maintain document exercises, and emergency exercises, and emergency in the ICF/IID's emergency following:  (i) Conduct a por workshop at leasing led by a facilitate discussion, using a emergency scenar statements, dir questions designed plan. If the OPO exor man-made emergency plan. If the OPO exor man-made emergency pengaging in its nexten following the onset (ii) Analyze the maintain document and emergency evand OPO's] emergency evand OPO's] emergency evand opological emergency experience exper	d disaster drill; or top exercise or workshop that or and includes a group an arrated, ant emergency scenario, and a ements, directed messages, or designed to challenge an eliCF/IID's response to and tation of all drills, tabletop ergency events, and revise gency plan, as needed.  6.360]  OPO must conduct exercises ancy plan. The OPO must do the aper-based, tabletop exercise st annually. A tabletop exercise	E 03	9		

	EMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED		
		34G022	B. WING		03/09/2021	
	PROVIDER OR SUPPLIER	S, INC/POPULAR STREET		STREET ADDRESS, CITY, STATE, ZIP CODE 328 POPLAR STREET GRAHAM, NC 27253	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE
E 039 W 195	January 2021, did r community-based of During an interview intellectual disabiliti	f the facility's EP plan dated not include a full-scale or tabletop exercise for 2020.  on 3/9/21, the qualified les professional (QIDP) or did not perform a tabletop	E 0			
	This CONDITION The team failed to received a continuous which includes agg implementation of a generic training and the acquisition of a developmental streindividual program 30 days of admission objectives are developmental streindividual program 30 days of admission objectives are developmental streindividual program 30 days of admission objectives are developmental streindividual program 30 days of admission objectives are documental individual program objectives a	a program of specialized and ditreatment directed towards assessments that identifies ingths (W213); ensure the plan (IPP) is prepared within on (W196 and W226); ensure eloped necessary to meet the 27); ensure data relative to the the criteria specified in the rogram plan and ensure imented in measurable terms equalified intellectual onal (QIDP) reviews/revises ed (255); and ensure clients ctional assessments are				

	OF DEFICIENCIES OF CORRECTION	( )			(X3) DATE SURVEY COMPLETED	
		34G022	B. WING		03	/09/2021
	PROVIDER OR SUPPLIER	S, INC/POPULAR STREET		STREET ADDRESS, CITY, STATE, 328 POPLAR STREET GRAHAM, NC 27253	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN O  X (EACH CORRECTIVE AC  CROSS-REFERENCED TO  DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
W 195	Continued From pa	ge 9	W 1	95		
W 196	resulted in the facili		W 1	96		
	treatment program, consistent impleme specialized and ger services and related subpart, that is dire (i) The acquisition the client to function determination and i (ii) The prevention	of the behaviors necessary for				
	Based on observat confirmed by intervi failed to provide an specialized treatme #2, #4, #5) in the ar leisure and choice r	s not met as evidenced by: ions, record review and iews with staff, the facility aggressive implementation of nt to 4 of 5 audit clients (#1, reas of dining, communication, making. The findings include:				
	ensure that each cli active treatment pro aggressive, consist program of specialist treatment directed to	W213. The facility failed to ient received a continuous ogram, which includes ent implementation of a zed and generic training and towards the acquisition of dentifies developmental audit clients (#1).				

				OATE SURVEY OMPLETED		
		34G022	B. WING _		03/	09/2021
	PROVIDER OR SUPPLIER	S, INC/POPULAR STREET		STREET ADDRESS, CITY, STATE, ZIP CODE 328 POPLAR STREET GRAHAM, NC 27253	, ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
W 196	ensure the individual prepared within 30 audit clients (#1).  3. Cross reference ensure objectives at meet the needs for #4).  4. Cross reference ensure data accomplishment of clients' individual probjectives are docuted for 3 of 5 audit clients.	W226. The facility failed to all program plan (IPP) is days of admission for 1 of 5  W227. The facility failed are developed necessary to 2 of 5 audit clients (#1 and w252. The facility failed to a relative to the the criteria specified in the togram plan and ensure amented in measurable terms arts (#3, #4, and #5).  W255. The qualified	W 19	6		
W 213	to ensure objective needed for 3 of 5 at 6. Cross reference ensure comprehens are reviewed annual and #4). INDIVIDUAL PROCCFR(s): 483.440(c) The comprehensive identify the client's strengths.  This STANDARD is Based on record refailed to ensure 1 of 5 at 5 a		W 21	3		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION  NG	` '	E SURVEY IPLETED
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	PROVIDER OR SUPPLIER	S, INC/POPULAR STREET		STREET ADDRESS, CITY, STATE, ZIP CODE 328 POPLAR STREET GRAHAM, NC 27253	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRICE OF THE	LD BE	(X5) COMPLETION DATE
W 213	he was admitted to review revealed clie During an interview intellectual disabiliti	_	W 2	13		
W 226	person who ensure INDIVIDUAL PROC CFR(s): 483.440(c) Within 30 days afte	r admission, the m must prepare, for each	W 2	26		
	Based on record refailed to ensure each program plan (IPP) admission,. This at The finding is:	s not met as evidenced by: eview and interview, the facility ch client received an individual within thirty days after ffected 1 of 5 audit clients (#1).				
	revealed he was ac	Imitted to the home on 1/4/21.				
	intellectual disabiliti confirmed client #1 completed. Furthe	es professional (QIDP) does not have an IPP er interview revealed the QIDP derson who ensure IPP's are				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER  SCOTT LIFESERVICE	S, INC/POPULAR STREET		STREET ADDRESS, CITY, STATE, ZIP 328 POPLAR STREET GRAHAM, NC 27253		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
W 227	objectives necessa as identified by the		W 22	7		
	Based on observarinterview, the facility program plan (IPP) identified needs rel	s not met as evidenced by: tions, record review and y failed to ensure the individual included training to address ative to self-help skills for 2 of and #4). The findings are:				
	5:32pm, client #4 w sitting on the toilet of 5:44pm, client #4 w bathroom. Further client walking by the client #4 was still the	tions in the home on 3/8/21 at vas observed in the bathroom, with the door wide open. At vas observed leaving the observations revealed another e open bathroom door while here. At no time was client #4 the bathroom door for privacy.				
		of client #4's record revealed on how client #4 is prompted or privacy.				
		te interview, the day manager eds a verbal prompts to shut for privacy.				
	client #1 was obser bed to his wheelcha lift. Further observable to follow verba	tions in the home on 3/8/21, rved being transferred from his air with staff using a electronic ations revealed client #1 was all prompts to use a bar that is , to pull himself up. Additional				

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER  RALPH SCOTT LIFESERVICES, INC/POPULAR STREET				STREET ADDRESS, CITY, STATE, ZIP COI 328 POPLAR STREET 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 CORR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
W 252	eyeglasses to put or During lunch observation #1 used a lon lunch; which was pure able to scoop his for began to ask the strassisting with scoop with a straw to assist had to lift up the cup Further observation the remainder of his During dinner observation the remainder of his During a lor himself one time an next to him to feed meal.  Review on 3/8/21 or he did not have an itor an adult daily living review of client #1's admitted to the facil During an interview intellectual disabilities confirmed client #1 a adult daily living sinterview revealed to	led staff handing client #1 n.  vations in the home on 3/8/21, g handle spoon to eat his ureed by staff. Client #1 was od a few times before he then aff sitting beside him for bing. Client #1 used a cup stance him with drinking; staff p for him to drink out of it. is revealed staff fed client #1 is meal.  rvations in the home on s able to do hand over hand to urther observations revealed ing handle spoon. Client #1 fed id then asked the staff sitting him the rest of his pureed  if client #1's record revealed individual program plan (IPP) ing skills evaluation. Further is record revealed he was lity on 1/4/21.  on 3/9/21, the qualified es professional (QIDP) record did not have an IPP or kills evaluation. Further he QIDP is the responsible bonsible to ensure client #1 had  MENTATION	W 2				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	34G022			B. WING			09/2021
NAME OF PROVIDER OR SUPPLIER  RALPH SCOTT LIFESERVICES, INC/POPULAR STREET				3	TREET ADDRESS, CITY, STATE, ZIP CODE 28 POPLAR STREET GRAHAM, NC 27253		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 252	Data relative to acc specified in client in	ge 14 omplishment of the criteria dividual program plan documented in measurable	W 2	252			
	Based on docume the facility failed to	s not met as evidenced by: ntation review and interviews, ensure data was documented ted 3 of 5 audit clients (#3, #4 gs are:					
	revealed missing da answer questions of collected was on 11 time data was colle	1 of client #3's record ata for the following goals: orrectly, last time data was /13/20; walking exercise, last cted was on 1/5/21; and use a was collected was on 1/8/21.					
	revealed missing daname sort pictures last time data was or give staff requested collected was on 7/laundry room, last t	21 of client #4's record ata for the following goals: from fast food restaurants, collected was on 11/12/20; I items, last time data was 31/20; bring clothing to ime data was collected was on shirts, last time data was 0/20.					
	revealed missing data identify coins and data was collected coins, last time data 11/12/20 and answer	21 of client #5's record ata for the following goals: ollar bill; last time data was /13/20; count items, last time was on 10/21/20; identify a was collected was on er questions about a recipe for ta was collected was on					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′			(X3) DATE SURVEY COMPLETED	
	34G022	B. WING		03	/09/2021	
NAME OF PROVIDER OR SUPPLIER  RALPH SCOTT LIFESERVICES, INC/POPULAR STREET			STREET ADDRESS, CITY, STATE, ZIP CODE 328 POPLAR STREET GRAHAM, NC 27253	-		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG	X (EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE	
During an interview ntellectual disabilitie evealed staff have on goals. Further in the responsible pers	on 3/9/21, the qualified es professional (QIDP) been trained to collect data nterview revealed the QIDP is	W 2	252			
the responsible person to ensure data is being collected.  PROGRAM MONITORING & CHANGE  CFR(s): 483.440(f)(1)(i)  The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan.  This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 3 of 5 clients' (#3, #4 and #5) objectives were reviewed and/or revised as needed including when the target date has passed. The findings are:  A. Review on 3/8/21 of the following goals for client #3 revealed they all have a completion date of 8/21/19: a walking exercise, sweeping; use his tablet with staff assistance; and sort/order colors. Further review revealed the goals have not been reviewed or revised.  B. Review on 3/8/21 of the following goals for client #4 revealed they all have a completion date of 8/21/19: give staff requested items; bring his clothing to the laundry room; and assist staff with hanging up his clothing. Further review revealed		W 2	255			
	SUMMARY STATE (EACH DEFICIENCY REGULATORY OR LS)  Continued From particular disabilities evealed staff have on goals. Further in the responsible persocial p	OVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 15  During an interview on 3/9/21, the qualified intellectual disabilities professional (QIDP) evealed staff have been trained to collect data on goals. Further interview revealed the QIDP is the responsible person to ensure data is being collected.  PROGRAM MONITORING & CHANGE  CFR(s): 483.440(f)(1)(i)  The individual program plan must be reviewed at east by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has elected in the individual program plan.  This STANDARD is not met as evidenced by: Based on record review and interview, the facility alled to ensure 3 of 5 clients' (#3, #4 and #5) objectives were reviewed and/or revised as needed including when the target date has bassed. The findings are:  A. Review on 3/8/21 of the following goals for client #3 revealed they all have a completion date of 8/21/19: a walking exercise, sweeping; use his ablet with staff assistance; and sort/order colors. Further review revealed the goals have not been eviewed or revised.  B. Review on 3/8/21 of the following goals for client #4 revealed they all have a completion date of 8/21/19: give staff requested items; bring his clothing to the laundry room; and assist staff with	OVIDER OR SUPPLIER  OTT LIFESERVICES, INC/POPULAR STREET  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 15  Ouring an interview on 3/9/21, the qualified antellectual disabilities professional (QIDP) evealed staff have been trained to collect data on goals. Further interview revealed the QIDP is the responsible person to ensure data is being collected.  PROGRAM MONITORING & CHANGE  CFR(s): 483.440(f)(1)(i)  The individual program plan must be reviewed at east by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives dentified in the individual program plan.  This STANDARD is not met as evidenced by: Based on record review and interview, the facility ailed to ensure 3 of 5 clients' (#3, #4 and #5) objectives were reviewed and/or revised as neceded including when the target date has bassed. The findings are:  A. Review on 3/8/21 of the following goals for client #3 revealed they all have a completion date of selection of the goals have not been eviewed or revised.  B. Review on 3/8/21 of the following goals for client #4 revealed they all have a completion date of 8/21/19: give staff requested items; bring his clothing to the laundry room; and assist staff with langing up his clothing. Further review revealed the goals have not been reviewed or revised.	OVIDER OR SUPPLIER  34G022  STREET ADDRESS, CITY, STATE, ZIP CODE  328 POPLAR STREET  GRAHAM, NC 27253  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 15  Ouring an interview on 3/9/21, the qualified intellectual disabilities professional (QIDP) is he responsible person to ensure data is being collected.  PROGRAM MONITORING & CHANGE  CFR(s): 483.440(f)(1)(i)  The individual program plan must be reviewed at east by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives date to reviewe and interview, the facility alled to ensure 3 of 5 clients' (#3, #4 and #5) bijectives were reviewed and/or revised as needed including when the target date has bassed. The findings are:  A. Review on 3/8/21 of the following goals for client #3 revealed they all have a completion date of 8/2/11/9: a walking exercise, sweeping; use his ablet with staff assistance; and sortforder colors. Further review revealed the goals have not been eviewed or revised.  3. Review on 3/8/21 of the following goals for client #4 revealed they all have a completion date of 8/2/11/9: give staff requested items; bring his tothing to the laundry room; and assist staff with langing up his clothing. Further review revealed he goals have not been reviewed or revised.	A BUILDING  34G022  B WING  TREET ADDRESS, CITY, STATE, ZIP CODE  328 POPLAR STREET  SUMMARY STATEMENT OF DEFICIENCIES  GRAHAM, NC 27253  DPREVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  W 252  During an interview on 3/9/21, the qualified intellectual disabilities professional (QIDP) everaled staff have been trained to collect data in goals. Further interview revealed the QIDP is he responsible person to ensure data is being collected.  PROGRAM MONITORING & CHANGE  CFR(s): 483.440(f)(1)(i)  The individual program plan must be reviewed at east by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives dentified in the individual program plan.  This STANDARD is not met as evidenced by: Based on record review and interview, the facility alied to ensure 3 of 5 clients' (#3, #4 and #5) bijectives were reviewed and/or revised as leaded including when the target date has leased on record review and and/or revised as leaded including when the target date has leased on record review and and/or revised as leaded including when the target date has label with staff assistance; and sort/order colors, further review revealed the goals have not been eviewed or revised.  3. Review on 3/8/21 of the following goals for client #4 revealed they all have a completion date of 8/2/119: give staff requested items; bring his lothing to the laundry room; and assist staff with langing up his clothing. Further review revealed the goals have not been reviewed or revised.	

AND PLAN C	D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		34G022	B. WING _		03/	09/2021	
NAME OF PROVIDER OR SUPPLIER  RALPH SCOTT LIFESERVICES, INC/POPULAR STREET				STREET ADDRESS, CITY, STATE, ZIP CODE 328 POPLAR STREET GRAHAM, NC 27253	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
W 255	of 8/21/19: independ dollar bills; count its colors. Further rev not been reviewed  During an interview intellectual disabilitis revealed all the goal have not been reviewed person who ensure reviewed and revise PROGRAM MONIT CFR(s): 483.440(f)  At least annually, the assessment of each the interdisciplinary updated as needed. This STANDARD is Based on record refacility failed to assessments (CFA This affected 2 of 5 findings are:  Review on 3/8/21 of has not been updated so the pupdated so the interdisciplinary updated as needed. This standard to assess assessments (CFA) this affected 2 of 5 findings are:  Review on 3/8/21 of has not been updated so the pupdated so the pupdate	hey all have a completion date indently identify coins and ems; and identify correct iew revealed the goals have or revised.  You on 3/9/21, the qualified ies professional (QIDP) als for clients #3, #4 and #5 ewed or revised. Further the QIDP is the responsible is the goals for the clients are ed as needed. FORING & CHANGE (2)  The comprehensive functional in client must be reviewed by the relevancy and interviews, the comprehensive functional in client must be reviewed by the reviews and interviews, the comprehensive functional in the reviews and interviews and interviews and interviews are reviewed by the reviewed by	W 25				
	intellectual disabiliti both of clients #3 a reviewed or update						

	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G022	B. WING		03/	09/2021	
	PROVIDER OR SUPPLIER	S, INC/POPULAR STREET		STREET ADDRESS, CITY, STATE, ZIP CODE 328 POPLAR STREET GRAHAM, NC 27253			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE	
W 259 W 323	responsible person to ensure CFA's are reviewed and updated as needed.  3 PHYSICIAN SERVICES		W 2				
	examinations of ea	ovide or obtain annual physical ch client that at a minimum ion of vision and hearing.					
	Based on record re facility failed to ens	s not met as evidenced by: eview and interviews the ure client #1 received his amination. This affected 1 of 5 the finding is:					
	revealed there was examination. Furth	f client #3's current record no current annual physical er review revealed there was when client #1 had his last					
W 340	intellectual disabiliti confirmed client #3' has not occurred. I	ES	W 3	40			
	other members of t appropriate protect measures that inclu	ust include implementing with he interdisciplinary team, ive and preventive health ude, but are not limited to staff as needed in appropriate methods.					

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVI COMPLETED	
		34G022	B. WING			03/	09/2021
NAME OF PROVIDER OR SUPPLIER  RALPH SCOTT LIFESERVICES, INC/POPULAR STREET				3	TREET ADDRESS, CITY, STATE, ZIP CODE 28 POPLAR STREET BRAHAM, NC 27253		
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 340	Based on observa interview, the nursi that staff were suffit temperature and the regards to COVID-effected clients #1, findings are:  A. During morning 3/9/21 at 5:44am, the Further observation who opened the dottemperature of the During an interview revealed she should of the surveyor one Further interview rethe home should here the home should here interview intellectual disability revealed even thou how temperatures temperatures temperatures temperatures temperatures should COVID-19.  B. During observation between 11:57am was below his nose client with his lunch observed talking to mask was pulled do observations reveal area. Additional observational observational observations reveal area. Additional observations reveal area. Staff B was staff and the result of the	s not met as evidenced by: tions, record review and ng services failed to ensure ciently trained in taking the le wearing of face masks in 19 protocol. This potentially #2, #3, #4 and #5. The  observations in the home on the surveyor entered the home. This revealed the day manager and did not take the	W 3	340			

Event ID: 193711

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G022	B. WING			03/0	09/2021
	PROVIDER OR SUPPLIER	S, INC/POPULAR STREET		32	TREET ADDRESS, CITY, STATE, ZIP CODE 28 POPLAR STREET RAHAM, NC 27253		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
W 340	Staff B did not pull uface until 5:28pm. It has a face mask on Sonose.  During observations 5:55am, Staff B entwearing a face mask revealed Staff B did 6:09am.  During an interview staff are to wear a for they are in the home the face mask is superson wearing it.  During an interview stated staff are to we enter the home. Furthey are to we have been trained in SPACE AND EQUIFICER(s): 483.470(g)  The facility must fur and teach clients to choices about the unhearing and other cand other devices is interdisciplinary teal.	urther observations revealed up her face mask to cover her From 5:51pm until 6:01pm, taff B was not covering her in the home on 3/9/21 at ered the home and was not exist. Further observations in not put on a face mask until on 3/9/21, Staff B revealed ace mask at all times, while exist ered the home and was not exist. Further interview revealed prose to cover the nose of the on 3/9/21, the day manager rear face masks once they exist from the wearing of face masks. PMENT (2)  Thish, maintain in good repair, use and to make informed se of dentures, eyeglasses, ommunications aids, braces,	W 3				
	reviews, the facility	failed to ensure 1 of 5 audit al program plan (IPP) included					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G022	B. WING			03/09/2021	
	PROVIDER OR SUPPLIER	ES, INC/POPULAR STREET		328	EET ADDRESS, CITY, STATE, ZIP CODE POPLAR STREET AHAM, NC 27253	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)			(X5) COMPLETION DATE
W 436	During observation survey on 3/8 - 9/2 using a rollator with Review on 3/8/21 revealed there was the usage of a rollator mentioned (PT) evaluation daturing an interview revealed client #4 since 2018, due to During an interview intellectual disability revealed the facility rollator was put in (date unknown).	on to address the usage of a rig is:  Ins in the home throughout the 21, client #4 was observed the staff assistance.  Of client #4's IPP dated 6/20 is no information in regards to ator. Further review revealed mation regarding the use of a lin client #4's physical therapy ated 6/22/20.  When on 3/9/21, the day manager has been using the rollator of falls and unsteady balance.  When on 3/8/21, the qualified ties professional (QIDP) by's nurse stated client #4's to place after a hospital visit further interview revealed the is not mentioned in any	W	136			