STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G022	A. BUILDING _____ B. WING _____	03/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALPH SCOTT LIFESERVICES, INC/POPULAR STREET	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 033	Methods for Sharing Information CFR(s): 483.475(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This STANDARD is not met as evidenced by:	E 033	E033 By 4/8/21, the Director of ICF will review and discuss with QIDP the EP updates required annually for the EP plan. The Dir. of ICF will train the QIDP to update the individuals contact information in the EP manual. The director will further establish an EP plan review date to occur twice a year. The 1st review dates for this year will be 3/29/21 and the next review date will be 9/20/2021. The QIDP will make necessary updates to the emergency plan as needed A copy of the training will be filed in employee personnel records. A copy of the updated manual will be forwarded to the Poplar group home and all other ICF group homes as trainings are completed.	4/23/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Belinda K. Gudger, Dir of ICF		3/25/2021

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 033	Continued From page 1 Based on document review and interview, the facility failed to ensure an emergency preparedness (EP) communication plan was developed and maintained in compliance with Federal, State and local laws. The finding is: Review on 3/8/21 of the facility's EP plan had the wrong contact information. Further review revealed the face sheets had the contact information for two clients who were deceased. Additional review revealed a client who was admitted on 1/4/21 information was not included. During an interview on 3/9/21, the qualified intellectual disabilities professional (QIDP) confirmed the face sheets for the facility contained the incorrect information.	E 033		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) 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 its next required	E 039	N/A	

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E 039	Continued From page 2 community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion 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 Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full	E 039	N/A N/A	

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E 039	Continued From page 3 scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the	E 039		

4

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E 039	Continued From page 4 following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion 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 hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the	E 039	N/A	

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E 039	Continued From page 5 following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following:	E 039	N/A	

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E 039	Continued From page 6 (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, 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 [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or	E 039	E039 By 4/8/21, the Director of ICF will review and discuss with the QIDP the EP exercises required to test the emergency plan at least twice per year for the EP plan. The Dir. of ICF will train the QIDP to: • Perform a community or functional exercise annually unless the group home facility experiences an actual natural or man-made emergency that requires activation of the EP plan. • During the course of the same year, a 2nd exercise/and or mock disaster drill/and or tabletop exercise will take place. The Dir. Of ICF will further establish an EP plan review date to occur twice a year. The 1st review dates for this year will be 3/29/21 and the next review date will be 9/20/2021. The current pandemic has resulted in the implementation of emergency plan procedures, so an exercise for the group home is covered. The QP and a Dir. of ICF will process a tabletop exercise for	4/23/21

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E 039	Continued From page 7 (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the 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 interviews, the facility failed to ensure facility/community-based or tabletop exercises to test their Emergency Preparedness (EP) plan were conducted. This potentially affected clients #1, #2, #3, #4 and #5.	E 039	Poplar group home. The QP will make necessary updates to the emergency plan as needed. A copy of the training will be filed in employee personnel records. A copy of the updated manual will be forwarded to the Poplar group home and all other ICF group homes as trainings are completed.	

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E 039	Continued From page 8 The finding is: Review on 3/8/21 of the facility's EP plan dated January 2021, did not include a full-scale community-based or tabletop exercise for 2020. During an interview on 3/9/21, the qualified intellectual disabilities professional (QIDP) revealed the facility did not perform a tabletop exercise for 2020.	E 039	*W195 By 4/8/21, The Dir. Of ICF will re-train QIDP on various active treatment requirements that must be maintained in the ICF/IDD program. The director will re-train on required steps for client new admissions with review of the new Client admission form. The director will re-train on filing/processing necessary documentation such as: IPP, IDT Evaluations, client goals and guidelines in a timely manner. Furthermore the director will review/train: • W213- acquisition of assessments that identify developmental strengths • W196/W226- the individual program plan (IPP) to be prepared within 30 days of admission • W227- goals/objectives are developed that are necessary to meet the client's needs • W252- ensure that data collection on goals are maintained, documented and measurable • W255- Q IDP to review/revise	
W 195	ACTIVE TREATMENT SERVICES CFR(s): 483.440 The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: The team failed to: ensure that each client received a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training and treatment directed towards the acquisition of assessments that identifies developmental strengths (W213); ensure the individual program plan (IPP) is prepared within 30 days of admission (W196 and W226); ensure objectives are developed necessary to meet the client's needs (W227); ensure data relative to the accomplishment of the criteria specified in the clients' individual program plan and ensure objectives are documented in measurable terms (W252); ensure the qualified intellectual disabilites professional (QIDP) reviews/revises objectives as needed (255); and ensure clients comprehensive functional assessments are reviewed annually (W259).	W 195		4/20/21

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W 195	Continued From page 9 The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated active treatment services to the clients.	W 195	client goals as needed • W259- client comprehensive functional assessment/ADLSE to be reviewed, at least, annually	
W 196	ACTIVE TREATMENT CFR(s): 483.440(a)(1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observations, record review and confirmed by interviews with staff, the facility failed to provide an aggressive implementation of specialized treatment to 4 of 5 audit clients (#1, #2, #4, #5) in the areas of dining, communication, leisure and choice making. The findings include: 1. Cross reference W213. The facility failed to ensure that each client received a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training and treatment directed towards the acquisition of assessments that identifies developmental strengths for 1 of 5 audit clients (#1).	W 196	The QIDP will ensure that the retrained categories are addressed and all updates/filings are implemented for all individuals of the Poplar Street group home. A copy of the training will be filed in employee(s) personnel records. Prior to 45 days of 3/9/21 (Survey exit), an internal record review (on or about 4/19/21) for all clients at Poplar group home will be processed verifying active treatment services are in place. Members of the coordinating staff will monitor for goal documentation/revision weekly, then observations will take place biweekly, and fade to monthly monitoring as appropriate. A copy of the documentation/observations will be forwarded to the QIDP and Dir. of ICF for review.	

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W 196	Continued From page 10 2. Cross reference W226. The facility failed to ensure the individual program plan (IPP) is prepared within 30 days of admission for 1 of 5 audit clients (#1). 3. Cross reference W227. The facility failed ensure objectives are developed necessary to meet the needs for 2 of 5 audit clients (#1 and #4). 4. Cross reference W252. The facility failed to ensure ensure data relative to the accomplishment of the criteria specified in the clients' individual program plan and ensure objectives are documented in measurable terms for 3 of 5 audit clients (#3, #4, and #5). 5. Cross reference W255. The qualified intellectual disabilities professional (QIDP) failed to ensure objectives were reviewed/revised as needed for 3 of 5 audit clients (#3, #4, and #5). 6. Cross reference W259. The facility failed to ensure comprehensive functional assessments are reviewed annually for 2 of 5 audit clients (#3 and #4).	W 196	W196 The Dir. Of ICF will re-train QIDP on maintaining a continuous active treatment for clients in the ICF/IDD program. The Director will train specifically on: IDT Evals, client IPP within 30 days, client goals, accomplishments of goal criteria are reflected an IPP, review and revise goals as needed, and process comprehensive functional assessments (ADLSE) at least annually. A copy of the training will be filed in employee(s) personnel records. The QP will make corrections to client records as follows: 1. By 4/16/21, the QP will ensure that client #1 has all Evals that Identify the client's specific developmental strengths (W213). An internal record review (on or about 4/19/21) for client #1 and all Individuals at Poplar group home will be processed verifying that IDT Evals are in place. Members of the coordinating staff will monitor quarterly, then fade to annual monitoring as appropriate. A copy	4/23/2
W 213	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(ii) The comprehensive functional assessment must identify the client's specific developmental strengths. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 5 audit clients (#1) comprehensive functional assessment (CFA) was	W 213		

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W 196	Continued From page 10 2. Cross reference W226. The facility failed to ensure the individual program plan (IPP) is prepared within 30 days of admission for 1 of 5 audit clients (#1). 3. Cross reference W227. The facility failed ensure objectives are developed necessary to meet the needs for 2 of 5 audit clients (#1 and #4). 4. Cross reference W252. The facility failed to ensure ensure data relative to the accomplishment of the criteria specified in the clients' individual program plan and ensure objectives are documented in measurable terms for 3 of 5 audit clients (#3, #4, and #5). 5. Cross reference W255. The qualified intellectual disabilities professional (QIDP) failed to ensure objectives were reviewed/revised as needed for 3 of 5 audit clients (#3, #4, and #5). 6. Cross reference W259. The facility failed to ensure comprehensive functional assessments are reviewed annually for 2 of 5 audit clients (#3 and #4).	W 196	of the documentation/observations will be forwarded to the QIDP and Dir. of ICF for review. 2. By 4/16/21, the QP will ensure that client #1 has IPP established (W226). An internal record review (on or about 4/19/21) for client #1 and all Individuals at Poplar group home will be processed verifying that IPP is in place. Members of the coordinating staff will monitor quarterly, then fade to annual monitoring as appropriate. A copy of the documentation/observations will be forwarded to the QIDP and Dir. of ICF for review. 3. By 4/16/21, the QP will ensure that client #1 & #4 has specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment (W227). An internal record review (on or about 4/19/21) for client #1 & #4 and all Individuals at Poplar group home will be processed verifying that client(s) goals are updated/reviewed and in place. Members of the coordinating staff will monitor weekly, then	
W 213	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(ii) The comprehensive functional assessment must identify the client's specific developmental strengths. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 5 audit clients (#1) comprehensive functional assessment (CFA) was	W 213		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G022	A. BUILDING _____ B. WING _____	03/09/2021

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W 196	Continued From page 10 2. Cross reference W226. The facility failed to ensure the individual program plan (IPP) is prepared within 30 days of admission for 1 of 5 audit clients (#1). 3. Cross reference W227. The facility failed ensure objectives are developed necessary to meet the needs for 2 of 5 audit clients (#1 and #4). 4. Cross reference W252. The facility failed to ensure ensure data relative to the accomplishment of the criteria specified in the clients' individual program plan and ensure objectives are documented in measurable terms for 3 of 5 audit clients (#3, #4, and #5). 5. Cross reference W255. The qualified intellectual disabilities professional (QIDP) failed to ensure objectives were reviewed/revised as needed for 3 of 5 audit clients (#3, #4, and #5). 6. Cross reference W259. The facility failed to ensure comprehensive functional assessments are reviewed annually for 2 of 5 audit clients (#3 and #4).	W 196	observations will take place biweekly, and fade to monthly monitoring as appropriate. A copy of the documentation/observations will be forwarded to the QIDP and Dir. of ICF for review. 4. By 4/16/21, the QP will ensure that client #3, #4 & #5 have Data relative to accomplishment of the criteria specified (goals) in the client(s) individual program plan objectives are documented and measurable (W252). An internal record review (on or about 4/19/21) for client #3, #4 & #5 and all Individuals at Poplar group home will be processed verifying that client data is documented & measurable. Members of the coordinating staff will monitor weekly, then observations will take place biweekly, and fade to monthly monitoring as appropriate. A copy of the documentation/observations will be forwarded to the QIDP and Dir. of ICF for review. 5. By 4/16/21, the QP will ensure that client #3, #4 & #5 goals and	
W 213	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(ii) The comprehensive functional assessment must identify the client's specific developmental strengths. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 5 audit clients (#1) comprehensive functional assessment (CFA) was	W 213		

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W 196	Continued From page 10 2. Cross reference W226. The facility failed to ensure the individual program plan (IPP) is prepared within 30 days of admission for 1 of 5 audit clients (#1). 3. Cross reference W227. The facility failed ensure objectives are developed necessary to meet the needs for 2 of 5 audit clients (#1 and #4). 4. Cross reference W252. The facility failed to ensure ensure data relative to the accomplishment of the criteria specified in the clients' individual program plan and ensure objectives are documented in measurable terms for 3 of 5 audit clients (#3, #4, and #5). 5. Cross reference W255. The qualified intellectual disabilities professional (QIDP) failed to ensure objectives were reviewed/revised as needed for 3 of 5 audit clients (#3, #4, and #5). 6. Cross reference W259. The facility failed to ensure comprehensive functional assessments are reviewed annually for 2 of 5 audit clients (#3 and #4).	W 196	program have been modified or changed in response to the client's specific accomplishments or need for new program (W255). An internal record review (on or about 4/19/21) for client #3, #4 & #5 and all Individuals at Poplar group home will be processed verifying that client need for new program. Members of the coordinating staff will monitor weekly, then the observations will take place biweekly, and fade to monthly monitoring as appropriate. A copy of the documentation/observations will be forwarded to the QIDP and Dir. of ICF for review. 6. By 4/16/21, the QP will ensure that client #3 & # 4 have their comprehensive functional assessment (ADLSE) for each client be reviewed by the interdisciplinary team for relevancy and updated as needed (W259). An internal record review (on or about 4/19/21) for client #3 & # 4 and all Individuals at Poplar group home will be processed verifying that ADLSE is in place. Members of the coordinating staff will monitor quarterly, then fade to annual	
W 213	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(ii) The comprehensive functional assessment must identify the client's specific developmental strengths. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 5 audit clients (#1) comprehensive functional assessment (CFA) was	W 213		

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W 196	Continued From page 10 2. Cross reference W226. The facility failed to ensure the individual program plan (IPP) is prepared within 30 days of admission for 1 of 5 audit clients (#1). 3. Cross reference W227. The facility failed ensure objectives are developed necessary to meet the needs for 2 of 5 audit clients (#1 and #4). 4. Cross reference W252. The facility failed to ensure ensure data relative to the accomplishment of the criteria specified in the clients' individual program plan and ensure objectives are documented in measurable terms for 3 of 5 audit clients (#3, #4, and #5). 5. Cross reference W255. The qualified intellectual disabilities professional (QIDP) failed to ensure objectives were reviewed/revised as needed for 3 of 5 audit clients (#3, #4, and #5). 6. Cross reference W259. The facility failed to ensure comprehensive functional assessments are reviewed annually for 2 of 5 audit clients (#3 and #4).	W 196	monitoring as appropriate. A copy of the documentation/observations will be forwarded to the QIDP and Dir. of ICF for review.	
W 213	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(ii) The comprehensive functional assessment must identify the client's specific developmental strengths. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 5 audit clients (#1) comprehensive functional assessment (CFA) was	W 213		

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W 213	Continued From page 11 completed. The finding is: Review on 3/8/21 of client #1's record revealed he was admitted to the facility on 1/4/21. Further review revealed client #1 does not have a CFA. During an interview on 3/9/21, the qualified intellectual disabilities professional confirmed client #1 did not have a CFA completed. Further interview revealed the QIDP is the responsible person who ensure CFA's are completed.	W 213	W213 The Dir. Of ICF will re-train QIDP & IDT that we should process and Identify the client's specific developmental strengths (EVALS: identify developmental strengths, preferences, methods of coping/compensation, community use and awareness, friendships and positive attributes and capabilities are clearly described in functional terms in the assessments.) for the IPP review. A copy of the training will be filed in employee(s) personnel records. By 4/16/21, the QP will ensure that client #1 has all Evals that Identify the client's specific developmental strengths. An internal record review (on or about 4/19/21) for client #1 at Poplar group home will be processed verifying that IDT Evals are in place. Members of the coordinating staff will monitor quarterly, then fade to annual monitoring as appropriate. A copy of the documentation/observations will be forwarded to the QIDP and Dir. of ICF.	4/23/21
W 226	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure each client received an individual program plan (IPP) within thirty days after admission,. This affected 1 of 5 audit clients (#1). The finding is: Record review on 3/8/21 of client #1's record revealed he was admitted to the home on 1/4/21. Further review revealed client #1 did not have an IPP completed. During an interview in 12/8/20, the qualified intellectual disabilities professional (QIDP) confirmed client #1 does not have an IPP completed. Further interview revealed the QIDP is the responsible person who ensure IPP's are completed.	W 226		

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W 213	Continued From page 11 completed. The finding is: Review on 3/8/21 of client #1's record revealed he was admitted to the facility on 1/4/21. Further review revealed client #1 does not have a CFA. During an interview on 3/9/21, the qualified intellectual disabilities professional confirmed client #1 did not have a CFA completed. Further interview revealed the QIDP is the responsible person who ensure CFA's are completed.	W 213		
W 226	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure each client received an individual program plan (IPP) within thirty days after admission,. This affected 1 of 5 audit clients (#1). The finding is: Record review on 3/8/21 of client #1's record revealed he was admitted to the home on 1/4/21. Further review revealed client #1 did not have an IPP completed. During an interview in 12/8/20, the qualified intellectual disabilities professional (QIDP) confirmed client #1 does not have an IPP completed. Further interview revealed the QIDP is the responsible person who ensure IPP's are completed.	W 226	W226 The Dir. of ICF will re-train the QIDP on completing IPP within the initial 30 days for clients in the ICF/IDD program. A copy of the training will be filed in employee(s) personnel records. By 4/16/21, the QP will ensure that client #1 has an IPP established. An internal record review (on or about 4/19/21) for client #1 at Poplar group home will be processed verifying that IPP is in place. Members of the coordinating staff will monitor quarterly, then fade to annual monitoring as appropriate. A copy of the documentation/observations will be forwarded to the QIDP and Dir. of ICF for review.	4/23/21

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W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure the individual program plan (IPP) included training to address identified needs relative to self-help skills for 2 of 5 audit clients (#1 and #4). The findings are: A. During observations in the home on 3/8/21 at 5:32pm, client #4 was observed in the bathroom, sitting on the toilet with the door wide open. At 5:44pm, client #4 was observed leaving the bathroom. Further observations revealed another client walking by the open bathroom door while client #4 was still there. At no time was client #4 prompted to close the bathroom door for privacy. Review on 3/8/21 of client #4's record revealed there is no mention on how client #4 is prompted for closing a door for privacy. During an immediate interview, the day manager stated client #4 needs a verbal prompts to shut the bathroom door for privacy. B. During observations in the home on 3/8/21, client #1 was observed being transferred from his bed to his wheelchair with staff using a electronic lift. Further observations revealed client #1 was able to follow verbal prompts to use a bar that is attached to his bed, to pull himself up. Additional	W 227	W227 The Dir. of ICF will re-train the QIDP on completing specific objectives (goals) necessary to meet the client's needs, as identified by the comprehensive assessment for clients in the ICF/IDD program. A copy of the training will be filed in employee(s) personnel records. A. By 4/16/21, the QP will ensure that client #4 goal on Privacy is established. Members of the coordinating staff will monitor weekly, then observations will take place biweekly, and fade to monthly monitoring as appropriate. A copy of the documentation/observations will be forwarded to the QIDP and Dir. of ICF for review. B. By 4/16/21, the QP will ensure that client #1 SLO on: 1. using grab bar as directed & 2. attempt to feed self 3x during meals will be established (and in IPP). Members of the coordinating staff will monitor weekly, then observations	4/23/21

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W 227	Continued From page 13 observations revealed staff handing client #1 eyeglasses to put on. During lunch observations in the home on 3/8/21, client #1 used a long handle spoon to eat his lunch; which was pureed by staff. Client #1 was able to scoop his food a few times before he then began to ask the staff sitting beside him for assisting with scooping. Client #1 used a cup with a straw to assistance him with drinking; staff had to lift up the cup for him to drink out of it. Further observations revealed staff fed client #1 the remainder of his meal. During dinner observations in the home on 3/9/21, client #1 was able to do hand over hand to pour his liquids. Further observations revealed client #1 using a long handle spoon. Client #1 fed himself one time and then asked the staff sitting next to him to feed him the rest of his pureed meal. Review on 3/8/21 of client #1's record revealed he did not have an individual program plan (IPP) or an adult daily living skills evaluation. Further review of client #1's record revealed he was admitted to the facility on 1/4/21. During an interview on 3/9/21, the qualified intellectual disabilites professional (QIDP) confirmed client #1 record did not have an IPP or a adult daily living skills evaluation. Further interview revealed the QIDP is the responsible person who is responsible to ensure client #1 had a IPP completed.	W 227	will take place biweekly, and fade to monthly monitoring as appropriate. A copy of the documentation/observations will be forwarded to the QIDP and Dir. of ICF for review.	
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1)	W 252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 252	Continued From page 14 Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on documentation review and interviews, the facility failed to ensure data was documented correctly. This affected 3 of 5 audit clients (#3, #4 and #5). The findings are: A. Review on 3/8/21 of client #3's record revealed missing data for the following goals: answer questions correctly, last time data was collected was on 11/13/20; walking exercise, last time data was collected was on 1/5/21; and use tablet, last time data was collected was on 1/8/21. B. Review on 3/8/21 of client #4's record revealed missing data for the following goals: name sort pictures from fast food restaurants, last time data was collected was on 11/12/20; give staff requested items, last time data was collected was on 7/31/20; bring clothing to laundry room, last time data was collected was on 10/20 and hang up shirts, last time data was collected was on 10/20. C. Review on 3/9/21 of client #5's record revealed missing data for the following goals: identify coins and dollar bill; last time data was collected was on 11/13/20; count items, last time data was collected was on 10/21/20; identify coins, last time data was collected was on 11/12/20 and answer questions about a recipe for dinner, last time data was collected was on 3/7/20.	W 252	W252 The Dir. of ICF will re-train the QIDP on direct care staff documenting Data relative to accomplishment of the criteria (goals) specified in clients IPP. The QP will retrain the direct care staff to consistently document client measurable goal data as required by state regulations. A copy of the trainings will be filed in employee(s) personnel records. A. By 4/16/21, the QP will ensure that client #3 goals are established & measurable data are consistently documented by staff. Members of the coordinating staff will monitor weekly, then observations will take place biweekly, and fade to monthly monitoring as appropriate. A copy of the documentation/observations will be forwarded to the QIDP and Dir. of ICF for review. B. By 4/16/21, the QP will ensure that client #4 goals are established & measurable data are consistently	4/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 252	Continued From page 15 During an interview on 3/9/21, the qualified intellectual disabilities professional (QIDP) revealed staff have been trained to collect data on goals. Further interview revealed the QIDP is the responsible person to ensure data is being collected.	W 252	documented by staff. Members of the coordinating staff will monitor weekly, then observations will take place biweekly, and fade to monthly monitoring as appropriate. A copy of the documentation/observations will be forwarded to the QIDP and Dir. of ICF for review. C. By 4/16/21, the QP will ensure that client #5 goals are established & measurable data are consistently documented by staff. Members of the coordinating staff will monitor weekly, then observations will take place biweekly, and fade to monthly monitoring as appropriate. A copy of the documentation/observations will be forwarded to the QIDP and Dir. of ICF for review.	
W 255	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 the goals have not been reviewed or revised. C. Review on 3/9/21 of the following goals for	W 255		

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W 252	Continued From page 15 During an interview on 3/9/21, the qualified intellectual disabilities professional (QIDP) revealed staff have been trained to collect data on goals. Further interview revealed the QIDP is the responsible person to ensure data is being collected.	W 252	W255 The Dir. of ICF will re-train the QIDP is to ensure that programs/goals will be modified or changed in response to the client's specific accomplishments or need for new program are realized. A copy of the training will be filed in employee(s) personnel records. By 4/16/21, the QP will ensure that client #5 goals and program have been modified or changed in response to the client's specific accomplishments or need for new program (W255). An internal record review (on or about 4/19/21) for client #5 at Poplar group home will be processed verifying that client need for new program. Members of the coordinating staff will monitor weekly, then the observations will take place biweekly, and fade to monthly monitoring as appropriate. A copy of the documentation/observations will be forwarded to the QIDP and Dir. of ICF for review.	4/23/21
W 255	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 the goals have not been reviewed or revised. C. Review on 3/9/21 of the following goals for	W 255		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALPH SCOTT LIFESERVICES, INC/POPULAR STREET	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 255	Continued From page 16 client #5 revealed they all have a completion date of 8/21/19: independently identify coins and dollar bills; count items; and identify correct colors. Further review revealed the goals have not been reviewed or revised. During an interview on 3/9/21, the qualified intellectual disabilities professional (QIDP) revealed all the goals for clients #3, #4 and #5 have not been reviewed or revised. Further interview revealed the QIDP is the responsible person who ensures the goals for the clients are reviewed and revised as needed.	W 255	W259 The Dir. of ICF will re-train the QIDP is to ensure that the comprehensive functional assessment (ADLSE) for each client must be filed/ processed and reviewed by the IDT for relevancy and updated as needed annually. A copy of the training will be filed in employee personnel records.	4/23/21
W 259	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure comprehensive functional assessments (CFA) were updated as needed. This affected 2 of 5 audit clients (#3 and #4). The findings are: Review on 3/8/21 of client #3's CFA revealed it has not been updated since February 2020. Further review of client #4's CFA revealed it has not been updated since February 2020. During an interview on 3/9/21, the qualified intellectual disabilities professional confirmed both of clients #3 and #4 CFA's have not been reviewed or updated since February 2020. Further interview revealed the QIDP is the	W 259	1. By 4/16/21, the QP will ensure that client #3 have their comprehensive functional assessment (ADLSE) for each client be reviewed by the interdisciplinary team for relevancy and updated as needed (W259). An internal record review (on or about 4/19/21) for client #3 at Poplar group home will be processed verifying that ADLSE is in place. Members of the coordinating staff will monitor quarterly, then fade to annual monitoring as appropriate. A copy of the documentation/observations will be forwarded to the QIDP and Dir. of ICF for review.	

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W 259	Continued From page 17 responsible person to ensure CFA's are reviewed and updated as needed.	W 259	2. By 4/16/21, the QP will ensure that client # 4 have their comprehensive functional assessment (ADLSE) for each client be reviewed by the interdisciplinary team for relevancy and updated as needed (W259). An internal record review (on or about 4/19/21) for client # 4 at Poplar group home will be processed verifying that ADLSE is in place. Members of the coordinating staff will monitor quarterly, then fade to annual monitoring as appropriate. A copy of the documentation/observations will be forwarded to the QIDP and Dir. of ICF for review.	
W 323	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(i) The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by: Based on record review and interviews the facility failed to ensure client #1 received his annual physical examination. This affected 1 of 5 audit clients (#3). The finding is: Review on 3/8/21 of client #3's current record revealed there was no current annual physical examination. Further review revealed there was no information on when client #1 had his last physical. During an interview on 3/9/21, the qualified intellectual disabilities professional (QIDP) confirmed client #3's annual physical examination has not occurred. Further interview revealed the QIDP was unsure why client #3's annual examination did not occur.	W 323		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.	W 340		

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W 259	Continued From page 17 responsible person to ensure CFA's are reviewed and updated as needed.	W 259		
W 323	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(i) The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by: Based on record review and interviews the facility failed to ensure client #1 received his annual physical examination. This affected 1 of 5 audit clients (#3). The finding is: Review on 3/8/21 of client #3's current record revealed there was no current annual physical examination. Further review revealed there was no information on when client #1 had his last physical. During an interview on 3/9/21, the qualified intellectual disabilities professional (QIDP) confirmed client #3's annual physical examination has not occurred. Further interview revealed the QIDP was unsure why client #3's annual examination did not occur.	W 323	W323 The Dir. of ICF will retrain QIDP & RN that the Evaluations of vision and hearing are required for ICF programming and obtained during client Physicals. Furthermore, documentation of appointment changes must be recorded. A copy of the training will be filed in employee(s) personnel records By 4/16/21, RN consultant will successfully notate the physical appointment status for client # 1 and client #3. An internal record review (on or about 4/28/21) for client # 1 & #3 at Poplar group home will be processed verifying that the annual physical appointments are recorded. Members of the coordinating staff will monitor quarterly, then fade to annual monitoring as appropriate. A copy of the documentation/observations will be forwarded to the QIDP and Dir. of ICF for review.	4/23/21
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.	W 340		

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W 340	Continued From page 18 This STANDARD is not met as evidenced by: Based on observations, record review and interview, the nursing services failed to ensure that staff were sufficiently trained in taking the temperature and the wearing of face masks in regards to COVID-19 protocol. This potentially effected clients #1, #2, #3, #4 and #5. The findings are: A. During morning observations in the home on 3/9/21 at 5:44am, the surveyor entered the home. Further observations revealed the day manager who opened the door did not take the temperature of the surveyor. During an interview on 3/9/21, the day manager revealed she should have taken the temperature of the surveyor once they had entered the home. Further interview revealed all visitors who enter the home should have their temperature taken. During an interview on 3/9/21, the qualified intellectual disabilities professional (QIDP) revealed even though there was no policy about how temperatures should be taken of visitors; temperatures should still be taken due to COVID-19. B. During observations in the home on 3/8/21 between 11:57am - 12:02pm, Staff A's face mask was below his nose while he was assisting a client with his lunch. At 2:41pm, Staff A was observed talking to management staff while his mask was pulled down around his chin. Further observations revealed clients were also in the area. Additional observations revealed at 5:02pm, Staff B was in the kitchen preparing dinner and her face mask was pulled down	W 340	W340 RN consultant will retrain staff in COVID protocols that were established at the onset of the pandemic. The nurse will train all direct care staff at Poplar group home. A copy of the training will be filed in employee(s) personnel records. A. By 4/16/21, the direct care staff will correctly take temperatures and confirm COVID-19 contact status of all visitors entering the group home. B. By 4/16/21, the direct care staff will properly wear PPE/face mask as trained for the protection of clients and all personnel in the group home.	4/23/21

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W 340	Continued From page 19 around her chin. Further observations revealed Staff B did not pull up her face mask to cover her face until 5:28pm. From 5:51pm until 6:01pm, the face mask on Staff B was not covering her nose. During observations in the home on 3/9/21 at 5:55am, Staff B entered the home and was not wearing a face mask. Further observations revealed Staff B did not put on a face mask until 6:09am. During an interview on 3/9/21, Staff B revealed staff are to wear a face mask at all times, while they are in the home. Further interview revealed the face mask is suppose to cover the nose of the person wearing it. During an interview on 3/9/21, the day manager stated staff are to wear face masks once they enter the home. Further interview revealed staff have been trained in the wearing of face masks.	W 340		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 1 of 5 audit clients (#4) individual program plan (IPP) included	W 436		

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W 436	Continued From page 20 specific information to address the usage of a rollator. The finding is: During observations in the home throughout the survey on 3/8 - 9/21, client #4 was observed using a rollator with staff assistance. Review on 3/8/21 of client #4's IPP dated 6/20 revealed there was no information in regards to the usage of a rollator. Further review revealed there was no information regarding the use of a rollator mentioned in client #4's physical therapy (PT) evaluation dated 6/22/20. During an interview on 3/9/21, the day manager revealed client #4 has been using the rollator since 2018, due to falls and unsteady balance. During an interview on 3/8/21, the qualified intellectual disabilities professional (QIDP) revealed the facility's nurse stated client #4's rollator was put into place after a hospital visit (date unknown). Further interview revealed the use of the rollator is not mentioned in any evaluations for client #4.	W 436	W436 The Dir. of ICF will retrain QIDP / RN & PT that the requirement for client items (such as Rollator, dentures, eyeglass etc.) are items that must be Furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of. Documentation for such items and how they are to be used properly must be recorded in IPP, nursing eval, PT eval (if related to ambulation). A copy of the training will be filed in employee(s) personnel records By 4/16/21, the IDT will resolve the Rollator issue pertaining to client #4. Client #4 is currently using a Rollator that currently has no information in regards to the use of the Rollator and there is some discrepancy as to where or how the Rollator was initiated. The Rollator for client #4 is not mentioned in physical therapy Eval, Nursing Eval nor the IPP.	4/23/21