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 _____	07/02/2024

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 030	Names and Contact Information CFR(s): 483.475(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(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 facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following:	E 030		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 030	Continued From page 1 (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following:	E 030		

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E 030	Continued From page 2 (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is not met as evidenced by: Based on interview and review of the facility's Emergency Preparedness Plan (EPP), the facility failed to ensure the plan included names and contact information for all staff. The finding is: Review on 7/1/24 of the facility's EPP (last reviewed on 2/27/24) revealed no names or contact information for any staff working in the home. Interview on 7/2/24 with the Assistant Director of ICF confirmed names and contact information for staff were not included in the EPP.	E 030		
E 031	Emergency Officials Contact Information CFR(s): 483.475(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.542(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(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 facilities]. The communication plan must include all of the	E 031		

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E 031	Continued From page 3 following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This STANDARD is not met as evidenced by: Based on review of the facility's the Emergency Preparedness Plan (EPP)and interviews, the facility failed to ensure the plan included contact information for local emergency prepardness staff and other sources of assistance. The finding is: Review on 7/1/24 of the facility's EPP (last reviewed on 2/27/24) did not include a list of contacts with their contact information for local emergency preparedness staff and other sources of assistance. Interview on 7/2/24 with the Director of ICF and the Assistant Director of ICF confirmed no comprehensive list of local emergency	E 031		

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E 031	Continued From page 4 preparedness entities and other sources of assistance was included as part of their EPP.	E 031		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure each client received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of dining. During lunch observations at the day program on 7/1/24 at 11:47am, client #1 was fed his entire meal by staff without any prompts to assist with feeding himself. At the meal, the staff utilized a plastic spoon, a tupperware container, and paper cup with a straw added. Client #1 was not afforded the opportunity to assist with feeding himself. Review on 7/1/24 of client #1's IPP dated 9/14/23 revealed he feeds himself left-handed using a lap board, long-neck spoon, sectional plate with a non-skid mat, clothing cover, and cup with a lid and straw. Additional review of the plan indicated	W 249		

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W 249	Continued From page 5 the client can feed himself and the staff should only feed him when he "grows tired of feeding himself". Interview on 7/2/24 with the Assistant Director of ICF confirmed client #1's adaptive dining equipment should be utilized at the day program and the client should be assisting with feeding himself as well.	W 249		
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. This STANDARD is not met as evidenced by: Based on observations, document review and interviews, the facility failed to ensure staff were sufficiently trained how to perform appropriate medication administration tasks. This potentially affected all clients residing in the home (#1, #2, #3, #4, #5, #6). The findings are: A. During observations of medication administration at the day program on 7/1/24 at 11:23am, the Medication Technician (MT) (Staff E) dropped a pill on the table while administering client #4's afternoon medications. The MT placed the dropped pill in a paper pill cup and threw it in a nearby trash can. Immediate interview with the MT revealed they had been trained to dispose of pills dropped on the table because it's dirty. Additional interview indicated she was also trained to discard a	W 340		

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W 340	Continued From page 6	W 340		

dropped pill in the trash can.

Review on 7/2/24 of the facility's Medication Administration Training course information (no date) revealed if a pill is dropped the medication is "wasted by crushing and putting in coffee grounds or sand (environmentally friendly technique)."

Interview on 7/2/24 with the Assistant Director of ICF (AD) confirmed crushing and putting medications in coffee grounds was the appropriate way to dispose of dropped medications.

B. During observations of medication administration in the home on 7/2/24 at 6:34am and 6:57am, the MT (Staff B) signed the Medication Administration Record (MAR) before pills were dispensed or ingested by client #1 and client #6.

Immediate interview with Staff B revealed they had been trained to place a dot on the MAR and then initial after clients have taken their medications.

Review on 7/2/24 of the facility's Medication Administration Training course revealed, "Once a medication or medicated treatments is administered to an individual, the staff member should immediately document (sign his/her initials) in the correct area of the Medication Administration Record (MAR). A staff member may never sign off on the (MAR) prior to administering the prescribed order."

Interview on 7/2/24 with the AD conformed the MT should not sign the MAR before clients

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W 340	Continued From page 7 consume their medication. C. During observations of medication administration in the home on 7/2/24 at 6:34am, the MT (Staff E) placed one drop of Artificial Tears in both of client #1's eyes. Immediate interview with the MT confirmed client #1 had received one drop of Artificial Tears in each eye. Review on 7/2/24 of client #1's physician's orders dated 6/9 - 9/7/24 revealed an order for Artificial Tears, "2 drops each eye" twice daily. Interview on 7/2/24 with the Assistant Director (AD) confirmed the orders were current and client #1 should have received two drops per eye as indicated. D. Upon arrival to the home on 7/2/24 at 6:00am, the MT (Staff B) informed the surveyor client #2 and client #4 had already been given their morning medications. When asked why the clients had been given their medications (ordered for 7:00am) so early, the staff indicated she didn't "want to run behind" with all they have to do in the morning. Review on 7/2/24 of client #2's physician's orders dated 6/9 - 9/7/24 and his July '24 MAR revealed at least fifteen medications to be administered at 7:00am. Review on 7/2/24 of client #4's physician's orders dated 6/9 - 9/7/24 and his July '24 MAR revealed at least eleven medications to be administered at 7:00am.	W 340		

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W 340	Continued From page 8 Review on 7/2/24 of the facility's Medication Administration Training course noted, "Medication may be given in a grace period of one hour before scheduled dosing time until one hour past dosing time." Interview on 7/2/24 with the AD confirmed the medications should not be given outside of the window for administration.	W 340		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all medications were administered in accordance with physician's orders. This affected 1 of 4 clients (#6) observed receiving medications. The finding is: During morning observations of medication administration in the home on 7/2/24 at 7:08am, client #6 ingested Protonix 40mg along with twelve other medications. At approximately 7:20am, client #6 began consuming his breakfast meal. Review on 7/2/24 of client #6's physician's orders dated 6/1 - 9/7/24 revealed an order for Protonix 40mg, by mouth BID. The order also noted the medication should be administered "1 hour prior to meals". Interview on 7/2/24 with the Assistant Director of	W 368		

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W 368	Continued From page 9 ICF confirmed the order was current as written and the medication should have been administered an hour before breakfast.	W 368		
W 488	DINING AREAS AND SERVICE CFR(s): 483.480(d)(4) The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure client #1 ate in a manner which was not stigmatizing. This affected 1 of 4 audit clients. The finding is: During breakfast observations in the home on 7/2//24 at 7:17am, client #1 consumed his food with the lower portion of his clothing cover spread across his lap tray in front of him and the upper portion secured around his neck. At the meal, client #1's plate was positioned on top of the lower portion of his clothing cover and a dycem mat was noted under his plate. Initially, the client fed himself a couple of spoonfuls of food before Staff C began feeding him the majority of the meal. At the end of the meal, a small amount of food was noted on the client's clothing cover. Interview on 7/2/24 with Staff C revealed they do whatever works for client #1 and the staff. Additional interview indicated the clothing cover positioned in this manner keeps food from getting on his clothes. Review on 7/1/24 of client #1's Individual Program Plan (IPP) dated 9/14/23 revealed he uses a clothing cover at meals and is a "slow and sometimes messy eater". Additional review of	W 488		

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W 488	Continued From page 10 the plan did not indicate his clothing cover should be utilized in the manner previously described. Interview on 7/2/24 with the Assistant Director of ICF confirmed client #1's clothing cover should not be positioned in the manner previously described.	W 488		