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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 037	EP Training Program CFR(s): 483.475(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.	E 037		

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 037	Continued From page 1 (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness	E 037		

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E 037	Continued From page 2 policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.	E 037		

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E 037	Continued From page 3 (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.	E 037		

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E 037	Continued From page 4 *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: Based on document review and interviews, the facility failed to ensure direct care staff were adequately trained on the facility's emergency preparedness (EP) plan. The finding is: Review on 6/16/25 of the facility's EP plan dated 2025, did not include any information regarding training of staff. During an interview on 6/17/25, management staff confirmed staff have not been trained in regards to the EP plan.	E 037		
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure client #1 had the right to dignity related to the use of incontinence padding. This affected 1 of 5 audit clients (#1). The finding is:	W 125		

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W 125	Continued From page 5 During observations during the survey on 6/16 - 17/25, client #1 had a incontinence pad placed in the seat of his wheelchair. Further observations revealed client #1 was observed sitting on the incontinence pad while the wheelchair is being propelled around the house. During an interview on 6/17/25, management staff confirmed client #1 should not have had a incontinence pad on his wheelchair.	W 125		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 4 of 5 audit clients (#2, #3, #4 and #5) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of medication administration and adaptive dining equipment. The findings are: A. During mealtime observations in the home on 6/16 - 17/25, clients #2 and #5 were not provided with their dycem mats. At no time did staff	W 249		

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W 249	Continued From page 6 provide clients #2 and #5 with their dycem mats. Review on 6/16/25 of client #2's IPP dated 5/13/25 revealed he uses a dycem mat during meals. Review on 6/16/25 of client #5's IPP dated 3/20/25 revealed he uses a dycem mat during meals. During an interview on 6/17/25, management staff confirmed clients #2 and #5 should use a dycem mat during meals. Further interview revealed the dycem mats for both client #2 and #5 help with preventing their plates from sliding around on the table while they are eating. B. During medication administration in the home on 6/17/25, client #3 used a disposable cup during his medication administration. Review of client #3's IPP dated 2/20/25 revealed he uses a modified sippy cup to help with the amount of fluid he can drink at a time. During an interview on 6/17/25, Staff A revealed client #3 should have used his sippy, which prevents him from gulping his fluids. During an interview on 6/17/25, management staff confirmed client #3 should have used his sippy cup during medication administration. During medication administration in the home on 6/17/25 at 7:29am, Staff A punched all of client #3 pills; poured his water and spoon fed him his medications. At no time was client #3 allowed to participate in his own medication administration.	W 249		

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W 249	Continued From page 7 During an interview on 6/17/25, Staff A confirmed he should have allowed client #3 assist with his own medication administration. Review on 6/17/25 of client #3's medication administration skill assessment (no date) revealed he can make choices of liquid; needs full staff assistance with pouring; needs full assistance with punching out his medications and can spoon his medication into his mouth with full staff assistance. C. During medication administration in the home on 6/17/25 at 6:30am, Staff A punched all of client #4 pills; poured his water and spoon fed him his medications. At no time was client #4 allowed to participate in his own medication administration. During an interview on 6/17/25, Staff A confirmed he should have allowed client #4 assist with his own medication administration. Review on 6/17/25 of client #4's medication administration skill assessment (no date) revealed he can make choices of liquid; can pour his own liquid; can punch out his medications with minor assistance and can spoon his medication into his mouth without assistance. D. During medication administration in the home on 6/17/25 at 6:41am, Staff A punched all of client #2 pills; poured his water and spoon fed him his medications. At no time was client #2 allowed to participate in his own medication administration. During an interview on 6/17/25, Staff A confirmed he should have allowed client #2 assist with his own medication administration.	W 249		

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W 249	Continued From page 8 Review on 6/17/25 of client #2's medication administration skill assessment (no date) revealed he can make choices of liquid; can pour his own liquid; can punch out his medications without any assistance and can spoon his medication into his mouth without assistance. During an interview on 6/17/25, management staff confirmed clients #4, #2 and #3 should have been allowed to participate in their own medication administration to the best of their abilities.	W 249		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure medications remained locked except when being prepared for administration. The finding is: During morning medication observations in the home on 6/17/25 at 6:50am, Staff A exited the medication room. Further observations revealed the door to the medication room remained opened. Additional observations revealed Staff A exited the medication room and went into a clients' bedroom to let him know it was time to get his medication. Further observations revealed the cabinets that contained the medications were also open and the medications were visible. During an interview on 6/17/25, Staff A stated he had been trained not to leave the door to the medication room open when they are not in there.	W 382		

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W 382	Continued From page 9 During an interview on 6/17/25, management staff confirmed staff have been trained no to leave the door to the medication room open when they are not in there.	W 382		
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, record reviews and interviews, the facility failed to ensure recommended equipment specifically a wheelchair was maintained in good repair for 1 of 5 audit clients (#5). The finding is: During observations throughout the survey on 6/16 - 17/25 the armrests for client #5's wheelchair was worn down/torn and wrapped with black tape. Review on 6/16/25 of client #5's Individual Program Plan (IPP) dated 3/30/25 revealed his only form of transportion is his wheelchair. During an interview on 6/17/25, management staff confirmed client #5's wheelchair is in need of repair.	W 436		
W 442	EVACUATION DRILLS CFR(s): 483.470(i)(1)(i) The facility must hold evacuation drills to ensure that all personnel on all shifts are trained to	W 442		

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W 442	Continued From page 10 perform assigned tasks. This STANDARD is not met as evidenced by: Based on review of fire drill reports and interviews, the facility failed to show staff were sufficiently trained in conducting fire drills. This potentially affected all clients residing in the home (#1, #2, #3, #4 and #5). The finding is: Review on 6/16/25 of the facility's fire drills revealed there were fire drills missing for March 2025, November 2024 and August 2024. During an interview on 6/17/25, management staff revealed the staff working in the home during March 2025, November 2024 and August 2024 were not trained in conducting fire drills.	W 442		
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a sanitary environment was provided to avoid transmission of possible infection and prevent possible cross-contamination. This potentially affected 2 of 5 clients (#4 and #5) living in the home. The finding is: During dinner observations in the home on 6/16/25 at 6:20pm, Staff A and Staff B used the same knife to cut food on the plates on clients #4 and #5. Further observations revealed both clients had already ate off both of their plates. During an interview on 6/17/25, management	W 455		

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W 455	Continued From page 11 staff confirmed the same knife should not have been used between clients #4 and #5.	W 455		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure each client received a nourishing, well balanced diet including modified specially prescribed diet as prescribed. This affected 2 of 5 audit clients (#3 and #5). The findings are: A. During dinner observations in the home on 6/16/25, client #3 was observed eating a slice of bread which was sliced in half. Further observations revealed client #3 was eating whole grapes and whole pieces of watermelon chunks. Client #3 was observed putting 3 - 4 grapes into his mouth at one time. At no time was client #3's food cut into bite size pieces. Review on 6/16/24 of client #3's Individual Program Plan (IPP) dated 2/20/25 revealed his diet is bite sized. Review of 6/17/25 of client #3's Nutritional Evaluation dated 2/12/25 revealed his diet is bite sized. B. During dinner observations in the home on 6/16/25, client #5 was observed eating a slice of bread which was sliced in half. Further	W 460		

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W 460	Continued From page 12 observations revealed client #5 was eating whole pieces of watermelon chunks. At no time was client #5's food cut into bite size pieces. Review on 6/16/24 of client #5's IPP dated 3/30/25 revealed his diet is bite sized. Review of 6/17/25 of client #5's Nutritional Evaluation dated 3/18/25 revealed his diet is bite sized. During an interview on 6/17/25, management staff revealed bite size food should be the size of a pea. Management staff confirmed both clients #3 and #5 should be cut into bite size pieces.	W 460		