STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G304	A. BUILDING _____ B. WING _____	09/03/2025

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RALPH SCOTT LIFESERVICES, INC/VETERANS DRIVE	**500 VETERANS DRIVE ELON COLLEGE, NC 27244**

(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 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E 004		

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 004	Continued From page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Emergency Preparedness (EP) plan was reviewed and/or updated as needed. The finding is: Review on 9/2/25 of the facility's current EP plan did not include recent changes in management and direct care staff. Interview on 9/3/25 with the Director of Residential Services (DRS) acknowledged several changes had been made in management staff which was not included in the EP plan. The DRS noted the EP plan should be updated as needed with current personnel information.	E 004		
E 036	EP Training and Testing CFR(s): 483.475(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under	E 036		

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E 036	Continued From page 2 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).	E 036		

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E 036	Continued From page 3 *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This STANDARD is not met as evidenced by: Based on interview and review of the facility's Emergency Preparedness (EP) plan, the facility failed to ensure all staff were trained on the EP plan. The finding is: Review on 9/2/25 of the facility's EP plan training documentation revealed not all staff had received training on the EP plan. Interview on 9/3/25 with the Director of Residential Services (DRS) indicated training on the facility's Emergency Preparedness Plan for all new and existing staff was not available for review.	E 036		
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 record review and interview, the facility failed to ensure client #2's Individual Program	W 227		

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W 227	Continued From page 4 Plan (IPP) included objectives to meet her needs. This affected 1 of 5 audit clients. The finding is: Review on 9/2/25 of client #2's Behavior Support Plan (BSP) dated 7/17/25 addressed target behaviors of confusion and cooperation. Additional review of the plan did not include a specific objective to address her behavioral needs. Interview on 9/3/25 with the Director of Residential Services (DRS) confirmed client #2 continues to have behavioral needs and should have an objective in place to support her needs.	W 227		
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 each client received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of adaptive dining equipment use. This affected 3 of 5 audit clients (#1, #3 and #6). The findings are:	W 249		

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W 249	Continued From page 5 During lunch observations at the day program on 9/2/25 from 11:37am - 12:14pm, client #3 consumed her meal using a sectioned plate, curved built-up handled spoon and clothing protector. No other adaptive dining equipment was noted. During this time, client #6 consumed her food using a scoop plate with guard and clothing protector. No other adaptive dining equipment was utilized. Client #1 was observed in a different area of the day program while consuming her lunch. The client utilized a scoop plate with plate guard, a cup with lid and clothing protector. No other adaptive dining equipment was noted to be used with client #1 at the lunch meal. Interview on 9/3/25 with Staff A and Staff D revealed client #1, client #3 and client #6 all utilize scoop plates with a plate guard at meals. Additional interview indicated they all use a dycem mat/non-skid mat as well. Review on 9/2/25 of client #1's IPP dated IPP dated 3/4/25 and a diet list (posted in the kitchen of the home) revealed she is able to feed herself using a scoop plate with plate guard, a cup with a lid, clothing cover and a non-skid mat at meals. Review on 9/3/25 of client #3's IPP dated 8/19/25 and a diet list (posted in the kitchen of the home) indicated she uses a angled weighted spoon, non-skid mat, clothing cover and non-skid mat at meals. Review on 9/3/25 of client #6's IPP dated 4/3/25 and a diet list (posted in the kitchen of the home) noted she utilizes a scoop plate with guard, clothing cover and non-skid mat at meals.	W 249		

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W 249	Continued From page 6 Interview on 9/3/25 with the Director of Residential Services (DRS) and Qualified Intellectual Disabilities Professional (QIDP) confined the diet list posted in the kitchen was correct and should be followed.	W 249		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure written informed consent was obtained for client #2's restrictive Behavior Support Plan (BSP). This affected 1 of 5 audit clients. The finding is: Review on 9/2/25 of client #2's BSP dated 7/17/25 addressed target behaviors of confusion and cooperation. The plan included the use of Clozaril, Risperdal, Cogentin and Namenda. Additional review of the record did not include a current written informed consent for the BSP. Interview on 9/3/25 with the Qualified Intellectual Disabilities Professional (QIDP) indicated client #2's written informed consent for her BSP had not been obtained and was not available for review.	W 263		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by:	W 288		

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W 288	Continued From page 7 Based on observation, record review and interviews, the facility failed to ensure techniques to manage client #5's inappropriate behaviors was included in a formal active treatment plan. This affected 1 of 5 audit clients. The finding is: During observations in the home throughout the survey on 9/2 - 9/3/25, a baby monitoring device was noted in the living of the home and in client #5's bedroom. Interview on 9/3/25 with Staff F revealed client #5 did not have any restrictive devices in her bedroom. Review on 9/2/25 of client #5's Behavior Support Plan (BSP) dated 4/1/25 revealed an objective to display one or fewer episodes of target behaviors per month for 8 consecutive months. Additional review of the BSP included target behaviors of aggression, crying, antagonizing others, elopement, making untrue statements and stealing. Further review of the record revealed various techniques used to address client #5's inappropriate behaviors include an audio monitor in her bedroom to be turned on anytime she is in her room, one bin in bedroom to store belongings, non-valuable items discarded weekly, limit of five coloring pages per day; once daily search of client's bedroom at home/area at day program, search of her bag before and after returning from day program and one-on-one staff during all community outings. Review of client #5's BSP did not incorporate the use of techniques previously described to address her inappropriate behaviors. Interview on 9/3/25 with the Director of Residential Services (DRS) confirmed the	W 288		

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W 288	Continued From page 8 techniques to address client #5's inappropriate behaviors were not included in the her current BSP.	W 288		
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 review and interviews, the facility failed to ensure client #2 was taught to use and make informed choices about the use of her eye glasses. This affected 1 of 5 audit clients. The finding is: During observations at the day program on 9/2/25, client #2 did not wear eye glasses. Additional observations in the home on 9/2 - 9/3/25, revealed client #2 wearing eye glasses while watching television. Interview on 9/3/25 with Staff E and Staff F revealed client #2 does not like to wear her eye glasses and has thrown them in the trash in the past. Additional interview indicated she requires prompting to wear her eye glasses. Review on 9/3/25 of client #2's IPP dated 7/17/25 revealed new eye glasses were ordered at her last vision appointment on 5/21/25. Additional review of the record did not include any training to teach the client to use her eye glasses appropriately and make informed choices about their use.	W 436		

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W 436	Continued From page 9 Interview on 9/3/25 with the Director of Residential Services (DRS) indicated client #2 may have had training regarding her eye glasses in the past; however, no recent training has be implemented.	W 436		
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 all clients received their modified and specially-prescribed diets as indicated. This affected 2 of 3 audit clients (#2 and #3). The findings are: During dinner observations in the home on 9/2/25 at 5:15pm, client #2 and client #3 were assisted to serve themselves moist and ground pork chops at the meal. The clients consumed the pork chops without difficulty. Interview on 9/2/25 with Staff D revealed client #2's food is chopped into pieces while client #3 consumes a pureed diet. Review on 9/2/25 of client #2's Individual Program Plan (IPP) dated 7/17/25 and a diet list (posted in the kitchen of the home) revealed her food should be soft and chopped. Review on 9/3/25 of client #3's IPP dated 8/19/25 and a diet list (posted in the kitchen of the home)	W 460		

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W 460	Continued From page 10 indicated her food should be pureed. Interview on 9/3/25 with the Director of Residential Services and the Director of Special Projects (DSP) confirmed client #2's diet should be chopped, not ground, while client #3 consumes a pureed diet which should be smooth.	W 460		
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 observations, record review and interviews, the facility failed to ensure client #6 ate in the least stigmatizing manner. This affected 1 of 5 audit clients. The finding is: During dinner observations in the home on 9/2/25 at 5:15pm, client #6 consumed her meal with a clothing protector secured around her neck. Closer observation of the clothing protector revealed the lower portion was spread across the table in front of the client and the client's plate was placed on top of it. Client #6 consumed her entire meal with her clothing protector applied in this manner. Interview on 9/2/25 wit Staff D revealed the client #6's clothing protector was applied in this manner to keep food from falling everywhere. Review on 9/2/25 of client #6's Individual Program Plan (IPP) dated 4/3/25 revealed she can feed herself and wears a cloth cover at meals. Additional review of the IPP did not indicate her clothing protector should be applied	W 488		

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W 488	Continued From page 11 in this manner. Interview on 9/3/25 with the Director of Residential Services (DRS) confirmed client #6's clothing protector should not have been worn in the manner previously described.	W 488		