DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G063	A. BUILDING _____ B. WING _____	01/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILL CREATIONS OF KINSTON	901 DOCTORS DRIVE KINSTON, NC 28503

(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 039	EP Testing Requirements CFR(s): 483.475(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. 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 a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, 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.	E 039	A full scale community based or individual facility based exercise or table top exercise will be completed to test the emergency plan. The facility response will be documented to analyze continued effectiveness of the emergency plan that promotes best practice in the event of a disaster/emergency. Any identified needed revisions will be completed and changes implemented to maximize effectiveness of the emergency plan during a true crisis. The Director and facility assigned Executive Director will monitor at least every 9 months To ensure the full scale or table top exercise Is completed annually or more often based On specific needs identified during an emergency drill. RECEIVED FEB 04 2019 DHSR-MH Licensure Sect	3-23-19

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

Chief Operations Officer 2-3-2019

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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SKILL CREATIONS OF KINSTON	901 DOCTORS DRIVE KINSTON, NC 28503

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E 039	Continued From page 1 *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and 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 interview, the facility failed to ensure a facility/community-based or tabletop exercise was conducted to test their emergency plan. The finding is: The facility's Emergency Preparedness (EP) plan did not include completion of facility/community-based exercise or tabletop exercise. Review on 1/22/19 of the facility's EP plan (dated 2018 Edition) did not include a full-scale community-based or individual facility-based exercise or a tabletop exercise to test their emergency plan. Interview on 1/23/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the facility has not conducted a full-scale facility/community-based exercise or a tabletop	E 039		

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E 039	Continued From page 2 exercise to test the effectiveness of their current emergency plan.	E 039		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff were sufficiently trained to prevent falls and the potential for falls involving clients in the home. This affected four clients (#1, #5, #6, #13). The findings are: Staff were not adequately trained to prevent client falls. Review of facility incident/accident reports (from August '18 - Present) revealed the following falls for 4 clients residing in the home: Client #1 10/02/18 - Client #1 fell getting a bath 11/12/18 - Client #1 fell trying to sit on the toilet Client #5 11/03/18 - Client #5 fell while trying to sit in recliner 01/09/19 - Client #5 stumbled against the Christmas tree in the foyer 01/17/19 - Client #5 was found face down on the floor on her right side	W 189	Core team meetings will be held to address the need for detailed guidelines to ensure safety and safe ambulation for client # 1, client # 5, client # 6, client # 13 as well as all clients. Goals and/or services will be developed according to needs identified by the team. All employees will receive training to ensure they take all necessary steps to prevent falls and the potential for falls for client #1, Client #5, client #6, client #13 and all clients. All employees will be receive training on all goals/services deemed appropriate by the team that are effective and efficient in assuring all clients' safety. Employees will be physically tested on carrying out these procedures. Incident reports will be reviewed weekly and any noted falls will be addressed immediately with noted changes identified by the team to prevent falls or the potential for falls with retraining for all employees. The Director or Program Director will monitor ongoingly and the assigned facility Executive Director will monitor monthly.	3-23-19

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W 189	Continued From page 3 Client #6 08/20/18 - Client #6 fell in bedroom sustaining a broken femur 10/08/18 - Client #6 fell getting up from her chair 12/15/18 - Client #6 fell getting up from her chair 12/16/18 - Client #6 stumbled and fell 12/28/18 - Client #6 misstepped and fell sideways to the ground 01/11/19 - Client #6 lost her balance attempting to sit on toilet Client #13 10/03/18 - Client #14 fell getting out of van 10/09/18 - Client #14 fell going to bathroom 10/28/18 - Client #14 fell going to med room 01/01/19 - Client #14 was found on the floor in the bathroom Staff interview on 1/23/19 revealed they had gotten some training after client #6 broke her hip but they could not recall any training since then. Interview on 1/23/19 with the Qualified Intellectual Disabilities Professional (QIDP) revealed incident reports are reviewed on a quarterly basis and acknowledged several falls have occurred. The QIDP indicated staff have not received training to address the frequency of falls over the past 6 months.	W 189		
W 203	ADMISSIONS, TRANSFERS, DISCHARGE CFR(s): 483.440(b)(5)(i) At the time of the discharge the facility must develop a final summary of the client's developmental, behavioral, social, health and	W 203		

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W 203	Continued From page 4 nutritional status. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a final summary for 1 of 1 discharged clients was developed. The finding is: A discharge summary was not completed for 1 of 1 discharged clients. Review on 1/23/19 of the record for 1 of 1 discharged clients revealed the client had been admitted to the hospital after becoming sick in the home. The record did not indicate the client had been readmitted to the home after her admission to the hospital. Interview on 1/23/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the client had been discharged from the facility in August '18. Additional interview indicated no discharge summary had been completed for the client as of the date of this survey.	W 203	This Client's discharge summary will be completed. In the future, a discharge summary will be completed at the time of discharge to another facility for all clients. The Director and the assigned facility Executive Director will monitor each client's discharge and ensure a summary has been completed upon each discharge to another facility.	3-23-19
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.	W 249		

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W 249	Continued From page 5 This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 2 of 4 clients (#1, #6) received a continuous active treatment plan consisting of needed interventions and services as identified in the Individual Program Plan (IPP) while participating with the administration of their medications. The findings are: Clients (#1, #6) were not afforded the opportunity to participate with the administration of their medications to their maximum potential. a. During observations of medication administration in the home on 1/22/19 at 5:23pm, client #1 came to the area with prompting, pointed at her picture and sanitized her hands. The staff dispensed her pills into a pill cup, added applesauce, spooned the pills from the cup and fed them to the client, and threw away her trash. Review on 1/23/19 of client #1's IPP dated 10/23/18 revealed a service (85-S) for administering her medications (implemented 12/6/07). Service 85-S noted the client can come to the medication room when called, identify her picture on the MAR with prompts, spoon feed medications from a pill cup with applesauce or pudding added, stir Miralax and dispose of items in the trash with a prompt. The service also indicated client #1 will be as independent as possible in self-medication administration. b. During observations of medication administration in the home on 1/23/19 at 8:11am, client #6 came to the area with assistance, placed one chewable pill in her mouth, ingested her	W 249	All staff will receive training in: *ICF-IID Level of Care Basics:* • Active Treatment • Encouraging Independence • Teaching cues • Providing the least assistance necessary to maximize independence • Client #1's service goal 85-S medication administration guidelines • Client #6's service goal 1-S medication administration guidelines Medication administration guidelines for all clients The Director will monitor these programs at least three times per week, document findings and follow up on any concerns with the RN Team Lead. The RN Team Lead will monitor medication administration at least monthly.	3-23-19

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W 249	Continued From page 6 medications and drank water. The staff dispensed other pills into a pill cup, obtained a cup of water, added applesauce to the pill cup, fed the pills to the client and placed the cup into a nearby bin. Review on 1/23/19 of client #6's IPP dated 9/18/18 revealed a service (1-S) for administering her medications (implemented 2/27/17). Service (1-S) noted the client can come to the medication area when called, wash/sanitize her hands, identify her name or picture, put meds in her mouth and swallows, drink liquids and dispose of trash. The service also indicated client #6 will be as independent as possible in self-medication administration. Interview on 1/23/19 with the facility's nurse revealed all clients are prompted to be as independent as possible with the administration of their medications. Additional interview indicated all clients have been assessed for their skills and abilities in the area of medication administration.	W 249		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure all medications were administered without error. This affected 1 of 3 clients (#6) observed receiving medications. The finding is:	W 369	In this situation, the Physician had called in the order directly to the pharmacy to discontinue the medication Haldol for client #6. The nurse failed to assure that the appropriate documentation discontinuing the order was in the chart as required. In the future, medications for client #6 and all clients will not be discontinued without first assuring that the appropriate orders are on the physician's order in the client's chart. This will both assure accuracy of medications being administered and/or discontinued without error and all orders are present in all clients' charts. All nurses will be in- serviced on this procedure by the RN Team Lead. The RN Team Lead will monitor at least monthly.	3-23-19

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W 369	Continued From page 7 Client #6's Haldol was not administered as indicated on current written orders. During observations of medication administration in the home on 1/23/19 at 8:11am, client #6 did not receive Haldol. Review of client #6's current physician's orders (dated 11/4/18 - 2/4/19) revealed Haldol 1mg tablet, take 4 tablets (4mg) by mouth twice daily in the morning and at 6p. The Hadol was ordered for 7:30am and 6:00pm. Interveiw on 1/23/19 with the facility's nurse revealed there should have been an order to discontinue the Haldol from December '18; however, the order could not be located.	W 369		