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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G079	A. BUILDING ______ B. WING ______	07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILL CREATIONS OF WILSON	**2000 MARTIN LUTHER KING JR PARKWAY WILSON, NC 27893**

(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 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 observations, record reviews and interviews, the facility failed to assure all staff were trained to recognize ill fitting equipment and to notify management if equipment did not fit appropriately. This affected 1 of 4 audit client (#6). The finding is: Staff were not trained to recognize that client #6's helmet fit appropriately and notify management. During observations on 7/29/19, client #6 had a helmet on and off throughout the day. Whenever he had the helmet off, there was a line indention in his forehead. Additionally, when he had the helmet on his head, it fit back (more on the crown of his head). It did not cover the bandaged wound (Previously caused by self-injurious behavior.) Note: The wound was bandaged and was routinely being monitored by a speciality hospital outpatient woundcare clinic. The helmet is to address Self-injurious behavior. Review on 7/29/19 of client #6's behavior support program, dated 2/26/19, revealed that to reduce his self-injurious behaviors, he should wear his foam helmet during waking hours and at bedtime when directed for medical necessity. It additionally noted, "The helmet and/or mittens are	W 189		

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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W 189	Continued From page 1 to be removed during meals and snacks....During these times staff are to remain sufficiently close to [client #6] to intervene if he attempts SIB." An interview on 7/29/19 with staff A, B, C and D all revealed that this is how client #6's helmet fits him. When asked about the wound, staff B stated the helmet used to fit over the wound but the helmet was washed and shrank. She also pointed out a number of holes in the helmet. All staff stated that the helmet was acceptable. Further interview on 7/29/19 with the qualified intellectuall disability professional (QIDP) and Director confirmed that staff should have notified them about the ill fitting helmet. The Director stated the helmet did not fit appropriately and immediately obtained another helmet and placed it on the client. It covered the wound.	W 189		
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 assure the behavior program was consistently and accurately implemented for 1 of 4 audit clients	W 249		

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W 249	Continued From page 2	W 249		

(#6). The finding is:

Client #6's behavior program was not consistently implemented.

During observations throughout the survey on 7/29 and 7/30/19, client #6 periodically wore his helmet and was periodically out of his helmet. There was no consistent timeframe which he was out of his helmet. During observations in the afternoon on 7/29/19, client #6 was released from his equipment and his arms were consistently blocked by physical contact for more than 10 seconds at a time by staff A. He was also seen on several occasions to be out of his helmet with several staff in the room but on the other side of the room from him. For example, on 7/29/19 at 6:15pm, staff A left client #6 sitting in front of his food while they went across the room and prepared other food. During this time, he was not wearing his helmet or mittens and he was observed hitting his head lightly directly on the covered wound. There was no staff intervention. At other times throughout the day on 7/29/19, he was also observed hitting his covered wound while wearing the helmet (which was ill fitting and did not cover the wound.)

Review on 7/29/19 of client #6's behavior support program, dated 2/26/19, revealed that to reduce his self-injurious behaviors, he should be physically blocked up to 10 seconds or less at a time. It noted blocks should not exceed 10 seconds of physical contact. It also noted, he should wear his foam helmet during waking hours and at bedtime when directed for medical necessity. It additionally noted, "The helmet and/or mittens are to be removed during meals and snacks....During these times staff are to

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W 249	Continued From page 3 remain sufficiently close to [client #6] to intervene if he attempts SIB." Interview with the qualified intellectual disabilities professional (QIDP) on 7/30/19, confirmed there was not a consistent implementation of the behavior program and confirmed the behavior program was confusing about the notes and the doctor's orders. She also confirmed there is a current doctor's order for helmet and mittens. With the order in place there were questions about whether he should remain in the restraints for 1 hour and 50 minutes consistently with only a ten minute break. She confirmed there was confusion to the restraints use being contingent or non-contingent.	W 249		