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

PRINTED: 07/18/2019
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
	34G040	A. BUILDING _____ B. WING _____	07/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILL CREATIONS	2101 ROYALL AVE GOLDSBORO, NC 27534

(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) [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.] * [For hospitals at §482.15 and CAHs at §485.625(a):] 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. 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 annually. * [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 annually. 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 updated at least annually. The finding is: The facility's EP plan was not reviewed or updated annually.	E 004	The Emergency Preparedness Plan was reviewed and updated on June 11,2019. Please find attached with the POC evidence of the review of the emergency prepardeness plan that utilized an all hazards approach. In the future the Facility Director will make sure she is familiar with what is being requested and specific terminology utilized by DHHS Surveyors. The facility Director will be inserviced on the DHHS survey process.regarding the emergency prepardnes plan. The assigned Executive Director for the assigned facility will monitor at least quarterly and meet with the Director for any noted concerns regarding maintenance of the emergency preparedness program which is titled SCI All Hazard Plans. RECEIVED AUG 0 2 2019 DHSR-MH Licensure Sect	9-14-19

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

[signature] Chief Operations Officer 7-31-19

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 Review on 7/16/19 of the facility's EP plan revealed no date. Further review of the plan did not include evidence of an annual review or update. Interview on 7/17/19 with the Qualified Intellectual Disabilities Professional (QIDP) revealed she was not aware if the EP plan had been reviewed or updated.	E 004		
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 2 of 3 audit clients (#3, #6) received a continuous active treatment plan consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of objective implementation, adaptive equipment use and participation with medication administration. The findings are: 1. Client #3's medication administration guidelines were not implemented as written.	W 249	All staff will receive training in ICF/IDD level of care basics: * ActiveTreatment * Encouraging Independence * Teaching cues * Providing the least amount of assistance necessary * Client #3 medication administration guidelines-19-S * All clients' medication administration guidelines	9-14-19

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W 249	Continued From page 2 During morning observations of medication administration in the home on 7/17/19 at 7:35am, client #3 was given a choice of drinks. The nurse prepared the medications, fed them to the client and threw away trash. During an interview on 7/17/19, when asked how client #3 participates with the med pass and if she has any goals which are implemented at this time, the facility's nurse revealed the client "knows her medications" and they go over them with her. Additional interview indicated client #3 was not capable of performing any physical tasks due to contractures in her hands/arms. Review on 7/17/19 of client #3's IPP dated 2/5/19 revealed a service goal (19-S) for medication administration (revised 9/21/18). Additional review of the guidelines noted, "Med staff will review the names and purpose of her medication with her and she will repeat it..." Interview on 7/17/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #3's service goal was current and should have been implemented during the med pass. 2. Client #6's mealtime objectives were not implemented as written. During lunch observations in the home on 7/16/19 at 1:01pm, Staff B cleared client #6's dirty dishes without prompting or assisting her to participate with this task. During dinner observations in the home on 7/17/19 at 6:51pm, Staff I wiped client #6's mouth during the meal without prompting or assisting her to participate with this task.	W 249	* Client #6 mealtime guidelines * All clients' mealtime guidelines * Client #6 adaptive dining equipment * Adaptive dining equipment for all clients The Director will monitor these program at least two times per week and the QP will monitor at least quarterly, document their findngs and follow up on any concerns	

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W 249	Continued From page 3 Interview on 7/17/19 with Staff B revealed client #6 can put her items in a bin after meals, wipe her mouth and feed herself with assistance. Review on 7/17/19 of client #6's IPP dated 10/9/18 revealed objectives to put her cup in the bin with gestures for 14 consecutive months (implemented 10/31/18) and to wipe her mouth with prompts for 5 consecutive sessions (implemented 1/11/19). Interview on 7/17/19 with the QIDP confirmed the objectives were current and should be implemented as written. 3. Client #6's adaptive dining mat was not provided at dinner. During dinner observations in the home on 7/16/19 at 6:44pm, client #6 was assisted to consume her meal using a scoop plate, wide based cup, cloth napkin and built-up handle spoon. No dycem mat was utilized. Review on 7/16/19 of client #6's IPP dated 10/9/18 revealed she utilizes a scoop plate, built-up handle spoon, wide based cup, dycem mat and cloth napkin at meals. Interview on 7/17/19 with the QIDP confirmed client #6 should use a dycem mat at meals.	W 249		

Tabletop Exercise

Facility: Skill Creations of Goldsboro

On June 11, 2019, staff from Skill Creation of Goldsboro met in a work session for the purpose of participation in a tabletop exercise. The exercise was facilitated by the COO/ICF for Skill Creations Inc. The scenarios were presented in several modules that included a review of events that could impact SCI Goldsboro requiring immediate response from staff present at the facility. The conditions of the scenarios were not disclosed to participants prior to the tabletop exercise. An emphasis was placed on how preplanning for emergencies such as a natural disaster foster staff ability to work together as a team and cope with the crisis. The exercise began with a severe thunderstorm watch issued by the local weather services. The drill continued with the watch being upgraded to a warning with lighting striking the building resulting in a fire emergency. The focus was to inject the sense of unpredictability that could occur during a crisis. The exercise was internal based on response from staff at the facility during the crisis to evaluation the ability for staff to recognize the scope of the emergency and implement appropriate pre-existing components of their emergency plan. The scenario presented helped the participants understand and become engaged in the exercise. The facilitator kept the exercise on target and was sensitive to the group dynamics as they worked together with an identified group leader. The emergency plan was reviewed to assure best practice on how to respond to each potential crisis/emergency. Each participant was required to provide feedback regarding actions/decisions made during the exercise, recommended changes if any to the current emergency plan and what they learned that could better prepare them during a disaster. Three tabletop exercises were chosen from the following hazard or perils identified that could pose a risk to SCI Goldsboro.

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1. **Bomb Threat**
2. **Mail or Internet Threat**
3. **Civil Unrest/Disturbance**
4. **Flood**
5. **Facility Fire**
6. **Hurricane**
7. **Missing Client**
8. **Severe Thunder Storm**
9. **Earthquake**
10. **Utility Failure**
11. **Hazardous Materials**
12. **Medical Emergency**
13. **Ice/Snow Emergency**
14. **Vehicle Emergency**
15. **Extreme Temperatures**
16. **Tornado**
17. **Railroad Incident**

Summary/Conclusion: Sever Thunder Storm:

It is sunny and pleasant outside, at 3:15 pm there is a flashing news weather update. Meteorologist, Greg Fisher reports a line of severe thunderstorms developing in Central North Carolina and rapidly moving east. Advisory was noted for the following counties- Durham, Wake, Johnston, Wayne, Sampson and Lenoir. The advisory for identified counties will remain in effect until 7:30 pm. He further noted that the identified counties should stay tune and be prepared for damaging winds up to 50 miles per hours. The administrator is not on site. The wind is blowing and it raining. The lights has blinked a couple times. A flash news

updated noted that the storm has been upgraded to a severe thunderstorm warning. It was noted that there were standing water in the parking lot; however did not pose a threat. What do you do?

Discussion:

Staff identified the disaster chief. The administrator was contacted for further instructions to determine if they would be relocating at this point. A decision was made that they would shelter in place. Staff agreed to preplan by checking the emergency food stock, getting out the generator, battery operated radio, flash lights, packing clothes for the clients and going to gas up the vans and get gas for the generator. They agreed that if the wind increased they would move the clients to the hall ways with activities provided in an effort to keep their routine as close to normal as possible. The administrator/disaster chief reported to the facility for further oversight in making further decision to assure the safety for clients and staff. The emergency management for the county would be notified to inform them that this is an ICF/IDD for further guidance and support.

Summary/Conclusion: Fire Emergency:

Scenario was presented that a fire has been detected in the facility following lighting striking the building. The alarm has been activated and the fire department is on their way. After recognizing that while rushing to evacuate everyone from the building the keys to the vehicles were left in the building. Open discussion- what do you do?

Summary: The identified the disaster chief immediately contacted the fire department due to the fire alarm not working at that time. All other staff immediately participated in the evacuation for all clients and staff. The disaster chief contacted the administrator to make them aware of the crisis. A head cunt was completed to assure that all clients and staff had been evacuated away from the building. Since it was raining the clients were placed on the vans. They agreed they would ask one of the fireman to get the keys since they could not re-enter the building. Everyone present appeared to have a good understanding of the emergency procedures and agreed that training staff to implement the emergency plan would definitely assist them with responding appropriately during a crisis.

_____

Facilitator Signature

Skill Creations, Inc.
Post Office Box 1636
Goldsboro, North Carolina 27533-1636
Telephone: (919)734-7398 Fax: (919)735-5064
"Creating Life Skills With Those We Serve"

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Fax Transmission

To: Ms. Lesa Williams
Mental Health Licensure and Certification Section
NC Division of Health Service Regulation

919-715-8078

From: Fontaine Swinson

Date: 7/31/2019

Here is the Plan of Correction for:

Skill Creations of Goldsboro
Provider Number 34G040, MHL 096-007

If you have any questions, do not hesitate to contact me. I can be reached via email or by telephone at : fontaine.swinson@skillcreations.com; phone number 919-920-4476

The original is being sent by US Mail.

Thank you,

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

July 19, 2019

Ms. Fontaine Swinson, COO
Skill Creations, Inc.
P.O. Box 1636
Goldsboro, NC 27533

Re: Recertification Survey Completed on July 16 - 17, 2019
Skill Creations, 2101 Royall Ave., Goldsboro, NC 27532
Provider Number: 34G040
MHL Number: MHL096-007
E-mail Address: fontaine.swinson@skillcreations.com

Dear Ms. Swinson:

Thank you for the cooperation and courtesy extended during the recertification survey completed July 17, 2019. This survey was required for continued participation in the Medicaid program.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form (CMS-2567). The purpose of the Statement of Deficiencies is to provide you with specific details of the practices that do not comply with regulations. You must develop one Plan of Correction that addresses each deficiency listed on the CMS-2567 form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance and what to include in the Plan of Correction.

Type of Deficiencies Found

- All tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is September 14, 2019.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.

- Sign and date the bottom of the first page of the CMS-2567 Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. **Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.**

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Please be advised that additional W tags may be cited during the Life Safety Code portion of the recertification survey.

A follow-up visit will be conducted to verify all deficient practices have been corrected. If we can be of further assistance, please call Wilma Worsley-Diggs at 919-612-5520.

Sincerely,

Wilma Worsley-Diggs

Wilma Worsley-Diggs, M.Ed., QIDP
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

Cc: DHSR@Alliancebhc.org
QM@partnersbhm.org
DHSRreports@eastpointe.net
Leza Wainwright, Director, Trillium Health Resources LME/MCO
Fonda Gonzales, Interim Quality Management Director, Trillium Health Resources LME/MCO
File