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

PRINTED: 06/26/2019
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
	34G054	A. BUILDING _____ B. WING _____	06/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILL CREATIONS OF SANFORD	1751 HAWKINS AVENUE SANFORD, NC 27330

(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 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, interviews and record reviews, the facility failed to assure a pattern of interactions supported the individual program plans (IPP) in the areas of collar use and adaptive dining equipment use. This affected 2 of 4 audit clients (#7 and #11). The findings are: 1. Client #7 was not assisted in using her rocker knife. During observations on 6/19/19 for breakfast, client #7 had 2 waffles. A rocker knife and fork were provided. Client #7 ate the waffles by pulling them apart using her spoon and fingers. She was not prompted to use the knife and fork. A review on 6/18/19 of client #7's IPP dated 12/6/18 revealed a comprehensive functional assessment/educational prevocational evaluation dated 11/20/18 revealed Client #7 can feed herself using a fork and can cut with a rocker knife. It further noted, she requires staff assistance to use the rocker knife. Interview with staff B on 6/19/19 revealed client	W 249	All staff will receive training in ICF/IID Basics: * Active Treatment * Encouraging Independence * Teaching Cue * Providing the least amout of assistance necessary * Client # 7 usage of a rocker knife * Client # 11 consistent application of cervical collar to support head drop * All clients adaptive equipment A core meeting wil be held to discuss a formal service and/or revision to foster consistent application of Client # 11 cervical collar as deemed appropriate by the team. All staff will be trained or retrained on the service The Director and Program Director will monitor at least 3 times a week and address any noted concerns with retraining staff as needed RECEIVED JUL 0 8 2019 DHSR-MH Licensure Sect	8-17-19

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

Chief Operations Officer 6-7-19

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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W 249	Continued From page 1 #7 needs reminders to use the rocker knife Further interview on the same date with the qualified intellectual disability professional (QIDP) confirmed client #7 should be provided assistance with the rocker knife. 2. Client #11 did not receive consistent application of a cervical collar, to support a head drop condition. a. During observations on 6/18/19 at 9:30 am, staff indicated that client #11 was not in group activity because she was on scheduled bed rest. At 11:35 am, client #11 arrived in the living room and was not wearing a cervical collar, and held her head low, with chin tucked. Client #11 continued to be observed through lunch, until 1:00 pm. The observation of client #11 resumed at 4:00 pm; she did not wear a cervical collar until Staff A placed it around her neck at 4:45 pm. Client #11 wore it for 30 minutes. When client #11 was transported to the dining room table at 6:30 pm, she was not wearing the cervical collar and her head hung low, until she began to feed herself, minutes later. b. During observations on 6/19/19 at 7:47 am, client #11 was dressed, in wheelchair and in the living room. She was not wearing a cervical collar; her chin was tucked. Review on 6/18/19 of client #11's IPP dated 5/30/19 revealed that client #11 had a diagnosis of profound hyphosis/head drop and needed to have a cervical collar applied three times daily.It was noted that client #11 tolerated the cervical collar without problems. Review on 6/19/19 of client #11's Documentation Adaptive Equipment Sheet, revealed that client	W 249		

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W 249	Continued From page 2 #11 should wear the cervical collar for 30 minutes, three times a day. The last sixty days of documentation was reviewed, which illustrated a pattern of incomplete daily application of the cervical collar. Interview with Staff B on 6/19/19 suggested that client #11 sometimes removed the strap to the cervical collar when applied by staff, but it was not recorded on the data sheet, as treatment refused. Staff B also acknowledged that staff might have forgot to apply the cervical collar on client #11. Interview with the nurse on 6/19/19 confirmed that staff were supposed to apply the cervical collar on client #11, three times a day. Interview with the qualified intellectual disabilities professional (QIDP) on 6/19/19 revealed that the occupational therapist (OT) visited the facility every Monday and was responsible for monitoring the the use of the cervical collar. The QIDP stated that the OT had not brought any concerns to her attention regarding client #11.	W 249		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure data was recorded for 1 of	W 252	The data collection system relative to the accomplishment of client # 11 applying the cervical collar will be reassessd by the team. This will be in conjunction with the core meeting held by the team to develop a formal service goal or revision. The data collection system will be defined in measurable terms with an individualized data sheet for Client # 11 wearing the cervical collar to ensure data is recorded as identified in the PCP.	8-17-19

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W 252	Continued From page 3 4 audit clients (#11). The finding is: Staff did not record thorough documentation of applying the cervical collar three times a day for client #11 on the Documentation Adaptive Equipment Sheet. Review on 6/18/19 of client #11's individual program plan (IPP) dated 5/30/19 revealed that client #11 had a diagnosis of profound hyphosis/head drop and needed to have a cervical collar applied three times daily. It was noted that client #11 tolerated the cervical collar without problems. Review on 6/19/19 of client #11's Documentation Adaptive Equipment Sheet, revealed that client #11 should wear the cervical collar for 30 minutes, three times a day. The purpose of the collar was to improve client #11's upright head position, as she tends to posture with head flexed forward throughout most of the day. The last sixty days of documentation was reviewed. The documentation was blank on the following dates: 4/19/19, 4/25/19, 5/6/19, 5/10/19, 5/21/19, 5/23/19, 6/4/19, 6/11/19-6/16/19 and 6/18/19. Interview with Staff B on 6/19/19 revealed that client #11 sometimes removed the strap to the cervical collar when applied by staff, but it was not recorded on the data sheet, as treatment refused. Staff B acknowledged that some of the blank data was because staff might have forgot to apply the cervical collar on client #11. Interview with the nurse on 6/19/19 confirmed that staff were supposed to apply the cervical collar on client #11, three times a day.	W 252	All clients data collection systems and documentation for adaptive equipment will be reassessed and revisions made as needed to ensure that consistent documentation of data as identified in their PCP. All staff will receive training on client # 11 and all clients data collection systems for adaptive equipment. The Director and the Program Director will monitor all data at least 3 times a week for appropriate documentation and address noted concerns with retraining as needed.	

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W 252	Continued From page 4 Interview with the qualified intellectual disabilities professional (QIDP) on 6/19/19 revealed that the occupational therapist (OT) visited the facility every Monday and was responsible for monitoring the the use of the cervical collar and review if the data was completed. The QIDP shared that the OT had not brought any concerns to her attention regarding incomplete data documentation for client #11.	W 252		
W 260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure the individual program plan (IPP) was revised at least annually for 1 of 4 audit clients (#11). The finding is: The facility produced an exact duplication, in parts, of the 2018 IPP for client #11, evidenced by identical statements in 18 out of 19 sections of the record. Review on 6/18/19 of client #11's electronic record revealed an IPP dated 5/31/18. A partial review was conducted when the facility shared that the newest IPP had not been scanned into the computer, but could be printed for review. A copy of the IPP dated 5/30/19, was presented by management for review. The assessments from the previous year IPP were identical in wording, to the current plan, with the exception of an updated vision exam, updated body weight and errors with	W 260	In the futue client # 11 and all clients' Person Centered Plans will be revised at least annually . The QIDP will receive further training to assure that all Person Centered Plans (IPP) are revised annually. The assigned Executive Director from the corporate office will monitor all plans at least monthly to assure that the individual program plans are current. Any plans noted not to be current will be addressed and corrective action taken to implement needed changes to assure that plans are revised annually.	8-12-19

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W 260	Continued From page 5 the client's current age and admission date to the facility. Interview on 6/19/19 with the qualified intellectual disabilities professional (QIDP) revealed that the reason why the 2018 and 2019 reports appeared similar was because client #11 had chronic conditions that received the same treatments.	W 260		
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, interviews and record reviews, the facility failed to provide the correct diet for 1 of 4 audit clients (#11). The finding is: Staff did not omit starch or bread product at each meal for client #11. a. During a meal observation on 6/18/19 at 6:30 pm, client #11 received bite size pieces of cheeseburger on bun, french fries, green beans and diced peaches. Client #11 was able to feed herself independently and ate all of her food. b. During a meal observation on 6/19/19 at 8:35 am, client #11's plate was half full of bite sized pieces of blueberry waffles. There were about 20 pieces of waffles on her plate, along with scrambled eggs. Client #11 was observed feeding herself and ate all of her food. Staff C was present at the dining table.	W 460	All staff members who assist with serving food and assisting client #11 and all clients during their meals will receive training in serving all food according to their diets. This will include any modifications to assure that all clients receive a nourishing, well balanced diet that includes modified and special prescribed diets. Diet cards will be made available for staff to use as a reference when preparing food as well as assisting clients with their meal. The Director and Program Director will monitor mealtimes at least 3 times a week to assure that all clients are receiving the appropriate diets.	8-17-19

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W 460	Continued From page 6 Review on 6/18/19 of client #11's Individual Program Plan (IPP) dated 5/30/19, revealed that a 1200 calorie daily diet, finely chopped, high fiber with omission of one bread or starch at every meal, should be provided at meals. There was an identified medical need for client #11 to decrease her weight, which was recorded at 183 pounds. Interview with Staff C on 6/19/19 revealed that she was unaware that client #11 had dietary restrictions for bread and starch foods. An additional interview on 6/19/19 with the cook, revealed that she was aware of at least two clients (#12 and #14) who had dietary restrictions for breads and starches, due to diabetes. When following their diet, the cook stated that if there were more than one bread/starch served, then one dish would be eliminated. The cook would then substitute a non-starch food for the food item eliminated. The cook was unsure if waffles, served at breakfast today, should be eliminated as a bread or starch. Interview with the nurse on 6/19/19 revealed that client #11 should not have received both a hamburger bun and french fries at dinner, due to her dietary restrictions with breads/starch food.	W 460		

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"

6

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: 7/7/2019

Here is the Plan of Correction for:

Skill Creations of Sanford
Provider Number 34G054, MHL 053001

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,

Fontaine Swinson

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

6/27/19

Ms. Fontaine Swinson, CEO
Skill Creations, Inc.
1751 Hawkins Ave.
Sanford, NC 27330

Re: Recertification Completed 6/19/19
Skill Creations of Sanford, 1751 Hawkins Ave., Sanford, NC 27330
Provider Number:34G054
MHL#053001
E-mail Address: Ciara.stubbs@skillcreations.com, Fontaine.swinson@skillcreations.com

Dear Ms. Swinson:

Thank you for the cooperation and courtesy extended during the recertification survey completed 6/19/19. 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

- Standard level deficiencies were cited.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is August 17, 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 Joy Alford at 919-605-4336.

Sincerely,

W. Joy Alford

Joy Alford, QIDP/SW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

Cc: qmemail@cardinalinnovations.org
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DHSRreports@eastpointe.net
_DHSR_Letters@sandhillscenter.org
Leza Wainwright, Director, Trillium Health Resources LME/MCO
Fonda Gonzales, Interim Quality Management Director, Trillium Health Resources LME/MCO