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

PRINTED: 08/19/2019
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
	34G084	A. BUILDING _____ B. WING _____	08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILL CREATIONS OF GREENVILLE	2701 W 5TH STREET GREENVILLE, NC 27835

(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 record reviews, observations and interviews, the facility failed to ensure each client received a continuous active treatment plan consisting of needed interventions and services identified in the individual program plan (IPP) in the areas of active treatment and behavior management. This affected 2 of 5 audit clients (#1, #7). The findings are: 1. Client #1 was not provided with his assistive device as required. Review on 8/13/19 of Client #1's IPP dated 4/17/19 revealed that Client #1 wears palm rollers throughout the day to keep moisture from building up in his palms and skin breakdown due to his fingers being contracted. Further review of Client #1's record revealed guidelines for wearing palm rollers that should be worn throughout the day and taken off at night. During afternoon observations in the home on 8/13/19 from 3:45pm until 6:45pm, Client #1 was observed without his palm rollers.	W 249	All Employees will receive trining in ICF/IDD Level of Care Basics: * Active treatment * Encouraging Indepenndence * Teaching Cues * Client #1 assistive device * All client assistive devices * Guidelines for client #1 wearing palm rollers * Client #7 behavior support plan * All clients behavior support plans The Director will monitor these programs at least 3 times a week, document findings and follow up on any noted concerns with retraining as needed. The assigned Regional QP will monitor monthly and provide needed support to assure identified strategies continues to be appropriate as written. Core meetings will be held to assure best practice with noted revisions as deemed appropriate by the team. All staff will be inserviced on any revisions and/or changes to assure continuous active treatment identified for all clients. RECEIVED AUG 27 2019 DHSR-MH Licensure Sect	10-11-19

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

[signature] Chief Operations Office 8-26-19

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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SKILL CREATIONS OF GREENVILLE	2701 W 5TH STREET GREENVILLE, NC 27835

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W 249	Continued From page 1 Interview on 8/14/19 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that the palm rollers should be worn throughout the day and the guidelines in Client #1's record are current. 2. Staff did not consistently implement client #7's behavior support plan (BSP) as written. During afternoon observations in the home on 8/13/19 at 3:56pm, Client #7 was observed slapping himself in the head for a total of 5 times, taking his shirt off and biting his hand. Staff were observed to ignore the behavior. Client #7 then came into the other dayroom at 3:59pm and continued hitting his head. His face was red and puffy on the side he hit. Further observations at 4:01pm while Client #1 was waiting for his medication, he was observed slapping his head for a total of 3 times and stomping his feet. Review on 8/13/19 of client #7's BSP implemented on 4/5/18 and revised on 10/30/18 noted that his target behaviors include self-injury. This plan noted client #7 should immediately be interrupted if he engages in self-injury. According to the plan, this interruption should begin with a verbal prompt and work through to physical prompts as needed. Interview on 8/13/19 with the QIDP of the facility confirmed the plan is current and should have been consistently implemented as written.	W 249		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3)	W 288	Training will be provided that focus on techniques to manage client's inappropriate behavior with an emphasis on techniques can never be used as a substitute for active	10-11-19

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W 288	Continued From page 2 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: Based on record review and confirmed with interview, the facility failed to assure all techniques to manage behavior were incorporated into an active treatment program. This affected 1 of 5 audit clients (#6). The finding is: Client #6's use of Melatonin to aid in sleep was not incorporated into an active treatment plan. Review on 8/14/19 of client #6's physician's orders dated 6/27/19 revealed he is prescribed Melatonin for sleep. Review on 8/14/19 of Client #6's active treatment plan revealed a behavior support plan (BSP) implemented 2/20/18. Further reviewed of the BSP revealed no mention of Melatonin for sleep. Interview on 8/14/19 with the qualified intellectual disabilities professional (QIDP) confirmed client #6 receives Melatonin to help him sleep and she revealed there is a new program out for consent that probably has the Melatonin in the program.	W 288	treatment programs for the RN/LPN staff responsibile for physician's orders. A core meeting will be held to discuss client #6 use of Melatonia for sleep. A determination will be made on ways to support good sleep hygiene for client #6. A revision of his behavior plan will out-line techniques for the use of Melatonin as determined appropriate by the team that assures the active treatent process. In the future, the use of Melatonin and any other medications to address sleep hygiene for client #6 and all clients will be incorporated as part of an an active treatmment plan. All satff wil receive training on the revised plan. The Regional QP will monitor at least quarterly and the assigned Executive Director will monitor monthly to assure that medication to manage behaviors are incorporated into all clients active treatment programs.	
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.	W 369	In the future client #1 will receive his miralax as ordered/correct dosage. Client #5 will also receive the correct dosage of her depakene. All nurses and Medication Monitors will be re-trained in SCI procedures for medication administration as well as SCI procedures for medication administration without error-policy	10-11-19

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W 369	Continued From page 3 This STANDARD is not met as evidenced by: Based on observations and confirmed with record reviews and interviews, the facility failed to assure all medications were given as ordered. This affected 2 of 5 audit clients residing in the facility (#1 and #5). The findings are: 1. Client #1 did not receive the correct dose of Miralax. During observations on 8/14/19, client #1 received his medications at 9:00am. During the medication pass the nurse assisted him by preparing 17 grams of Miralax in 8 ounces of water. However, he refused to drink all but a couple of sips of this medication. Review on 8/14/19 of the physician's orders dated 6/26/19 confirmed client #1 should have received Miralax 17 grams in the morning. Interview on 8/14/19 with the Nurse and Acting Director confirmed client #1 should have received the dose as ordered. 2. Client #5 did not receive the correct does of her Depakene. During observations on 8/13/19 at 4:05pm, client #5 received her medications. The nurse assisted her by drawing up into a syringe Valporic Acid for Depakene. The measurement was 5 ml. However when she fed this to her in a small medicine cup and a large portion of it drained back out of her mouth. Review on 8/14/19 of the physician's orders dated 6/26/19 confirmed client #5 should have received the full 5 ml of medication.	W 369	206-1. The Director wil monitor medication administration at least weekly and the RN Team Lead will monitor at least quarterly.	

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W 369	Continued From page 4 Interview on 8/13/19 with the nurse confirmed there was medication that drained or drooled out of client #5's mouth. She did not know the amount. She indicated they will explore other ways of her taking her medications.	W 369		
W 447	EVACUATION DRILLS CFR(s): 483.470(i)(2)(iii) The facility must file a report and evaluation on each evacuation drill. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to esnure a report of each evacuation drill was completed. The finding is: Fire drill reports had not been completed. Review on 8/13/19 of the facility's fire drill evacuation book revealed no reports could be located for April 2019 - June 2019. Interview on 8/13/19 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that fire drills had been done for April 2019 - June 2019. However, no reports had been completed.	W 447	In the future reports and evaluations on each drill will be documented and filedwith a special emphasis on fire drills. A schedule for drills/fire drills will be posted as a visual reminder on the board in the Director's office. The assigned Executive Director will review all drills including fire drills monthly and address any noted concerns to assure drils/fire drills are being completed and follow up	10-11-19

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: 8/26/2019

Here is the Plan of Correction for:

Skill Creations of Greenville
Provider Number 34G084, MHL 074012

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

August 20, 2019

Mrs. Fontaine Swinson, Chief Operations Officer
Skill Creations, Inc.
P.O. Box 1636
Goldsboro, North Carolina 27533

Re: Recertification conducted: 8/14/19
Skill Creations Greenville, 2701 West Fifth St., Greenville, NC 27835
Provider Number: 34G084
MHL: 074012
E-mail Address: fontaine.swinson@skillcreations.com

Dear Ms. Swinson,

Thank you for the cooperation and courtesy extended during the recertification survey completed 8/14/19. 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 October 11, 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
DHSR@Alliancebhc.org
QM@partnersbhm.org
dhhs@vayahealth.com
DHSRreports@eastpointe.net