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

PRINTED: 08/08/2019
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 |
|---|---|---|---|
| | 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<br>CFR(s): 483.430(e)(1)<br><br>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.<br><br>This STANDARD is not met as evidenced by:<br>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:<br><br>Staff were not trained to recognize that client #6's helmet fit appropriately and notify management.<br><br>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.)<br><br>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.<br><br>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 | All employees will receive training to recognize the appropriate fitting for client #6 helmet and all of his equipment . Emphasis will focus on quick and immediate notification to the Director anytime employees recognize client #6 helmet /equipment does not fit appropriately. An additional helmet will be available to avoid any delay with having a helmet that fits appropriately. Training will also include appropriate fitting for all equipment for all clients and the urgency for notifying the administrators when recognizing ill fitting for any equipment which enables employees to perform their duties effectively, efficiently and competently.<br>The Director will monitor all clients' equipment at least 2 times a week and the assigned Facility Executive Director and the assigned QP will monitor at least monthly.<br><br>RECEIVED<br>AUG 15 2019<br>DHSR-MH Licensure Sect | 9-27-19 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Chief Operating Officer (X6) DATE: 8-15-19

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.

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

PRINTED: 08/08/2019
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 |
|---|---|---|---|
| | 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 | Continued From page 1<br>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."<br><br>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.<br><br>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<br>CFR(s): 483.440(d)(1)<br><br>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.<br><br>This STANDARD is not met as evidenced by:<br>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 | All staff will receive training in ICF/IID Level of Care Basics:<br><br>* Active Treatment<br>* Encouraging Independence<br>* Teaching Cues<br>* Providing the least assistance necessary<br>* A core team meeting will be held to discuss client #6 behavior program for continued appropriateness as written and/or a revision as deemed appropriate by the team to assure | 9-27-19 |

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

PRINTED: 08/08/2019
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 |
|---|---|---|---|
| | 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 249 | Continued From page 2<br>(#6). The finding is:<br><br>Client #6's behavior program was not consistently implemented.<br><br>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.)<br><br>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 | W 249 | Consistent/implementation of client #6 behavior plan as well as clarity.<br>* All staff will receive training on client #6 behavior plan<br>* All staff will receive training on all clients' behavior plans to assure consistent/accurate implementation<br><br>The Director will monitor at least 2 times a week and address any concerns with retraining staff as needed. The Regional QP will monitor monthly and conduct core team meetings to determine any needed changes to assure consistent implementation of behavior plans for all clients. | |

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

PRINTED: 08/08/2019
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 |
|---|---|---|---|
| | 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 249 | Continued From page 3<br>remain sufficiently close to [client #6] to intervene if he attempts SIB."<br><br>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 | | |

**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: 8/15/2019

Here is the Plan of Correction for:

Skill Creations of Wilson
Provider Number 34G079, MHL 098005

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 9, 2019

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

Re: Recertification conducted: 7/30/19
**Skill Creations Wilson, 2000 Martin Luther King, Jr. Parkway, Wilson, NC 27893**
Provider Number: 34G079
MHL:098005
E-mail Address: fontaine.swinson@skillcreations.com

Dear Ms. Swinson,

Thank you for the cooperation and courtesy extended during the recertification survey completed 7/30/19. 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 Sept. 27, 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.***

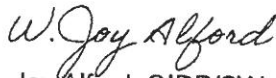
Send the original completed form to our office at the following address within 10 days of receipt of this letter.

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,



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