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

PRINTED: 01/09/2020
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
	34G047	A. BUILDING _____ B. WING _____	R 12/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILL CREATIONS OF CLINTON	223 FOREST TRAIL CLINTON, NC 28328

(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 000	INITIAL COMMENTS A revisit was conducted on 12/23/19 for all previous deficiencies cited on 9/24/19. The following deficiencies have been corrected, W186, W216, W249, W368 and W436 with W369 remaining out of compliance. In addition, new noncompliance was found. The facility is out of compliance.	W 000		
W 325	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(iii) The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure lab work was obtained as ordered by the physician for 1 of 4 audit clients (#15). The finding is: Lab work for client #15 was not obtained as ordered. Review on 12/23/19 of client #15's current physician's order dated 10/29/19 revealed the following: "CBC with Didd, Ferritin... in 1 to 2 weeks." Additional review of client #15's current record revealed the client had been admitted to hospital for loss of blood from unknown source. During an interview on 12/23/19, the qualified intellectual disabilities professional (QIDP) confirmed client #15's record did not indicate any labs drawn lab after the order was written. Further	W 325	In the future client # 15 and all clients will have lab work completed as ordered and determine necessary by the physician. The RN Team Lead will monitor physician's orders monthly and address any physician's orders that has not been completed, provide oversight with getting lab work scheduled as ordered by the physician to assure completion of lab work and all physician's ordered are completed within a timely manner.	2-21-2020

RECEIVED
By DHSR- Mental Health Licensing at 9:51 am, Jan 13, 2020

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

Chief Operations Officer 1-10-2020

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 325	Continued From page 1 interview with the facility's nurse via the phone revealed the physician's order was current and the lab draw was not completed as ordered.	W 325		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that staff passing medications, were competent in their duties. This had the potential to affect all clients. The findings are: Staff contributed to medication errors, unsecured medication room, did not utilize pharmacy services to refill medication. During morning observations in the home on 12/23/19 at 9:13 am, Staff C had already pre-punched the morning meds for clients #7 and #15, without either client being present. During interview with Staff C on 12/23/19, she did not offer an explanation for why the medication was prepared in advance of clients. During interview with the qualified intellectual disabilities professional (QIDP) on 12/23/19, she shared that staff handling medications have been trained on what to do. The QIDP commented that the issues witnessed today might be the result of	W 340	All medications monitor will receive 2-21-2020 additional training by the Chief Nursing Officer and/or RN Team Lead on Nursing Policy 206-1 Medication administration procedures with special emphasis on # 2 letters c,d and p to ensure that staff are competent in their duties as medications monitors with a focus on decreasing the likelihood of medication errors, the medication room is secured and utlization of pharmacy service to refill medication. Training will also focus on training clients and team members on appropriate protective and preventive health measures that include appropriate health and hygiene methods. The RN Team lead will monitor at least monthly and the Director will monitor weekly.	

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W 340	Continued From page 2 bad habits by staff.	W 340		
{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. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to administer medications for 1 of 4 audit clients (#5) without error. Client #5 did not receive prescribed dose of medication. During morning observations in the home on 12/23/19 at 7:53 am, client #5 did not receive her dose of Levonor as ordered by the physician. During the interview with Staff C on 12/23/19, she acknowledged that yesterday was the last time the dose of Levonor was given to client #5 and the medication had not been restocked. During the interview with the qualified intellectual disabilities professional (QIDP) on 12/23/19, stated that she was informed this morning by Staff C that she was unable to give a medication to client #5 during medication administration.	{W 369}	All Nurses and medication monitors will receive additional training on Medication Administration Policy # 206-1 letter f regarding medication administration to prevent possible medication errors and p regarding checking all medications to assure an adequate supply is on hand. In the future client #5 will receive her Levonor as prescribed by the physician. All clients will receive all medications as ordered. The RN Team Lead will monitor at least monthly.	1-22-2020
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration.	W 382	All drugs and biological will be stored/locked in the medication room except when medications are being administered.	1-22-2020

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W 382	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to ensure that the medication room remained lock, when not in use. The finding is: The medication room was unsecured and unsupervised. During morning observations in the home on 12/23/19 at 9:21 am, Staff C left the medication room, pulling the door behind her, to get client #7 to come take his medication. When Staff C and client #7 arrived at the medication room, Staff C opened the door without using her key. On the counter was a tray of pre-pulled medications for client #7. During the interview with Staff C on 12/23/19, she acknowledged that she forgot to lock the medication room door and apologized. During an interview with the qualified intellectual disabilities professional (QIDP) on 12/23/19, she commented that medications should be locked up.	W 382	Additional training will be provided to all medication monitors to assure that the medication room is lock at all time except when medications are being prepared and administered. The Director will monitor weekly and the RN Team Lead will monitor monthly.	
W 392	DRUG LABELING CFR(s): 483.460(m)(3) Drugs and biologicals packaged in containers designated for a particular client must be immediately removed from the client's current medication supply if discontinued by the physician. This STANDARD is not met as evidenced by:	W 392	In the future, all drugs and biologicals desiginated for a particular client will immediately be removed at the time of a client's discharge and medication has been discontinued by the physician. The LPN and/or RN Team Lead will utilize the MAR as a check and balance to assure that all medications are immediately removed from all clients current supply if discontinued by	2-21-2020

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W 392	Continued From page 4 Based on observations, record review and interview, the facility failed to assure all medications packaged in containers designated for a particular client was immediately removed from the client's current medication supply when the client was discharged to another facility. This affected 1 of 2 discharged clients. The finding is: One of the discharge client medication were not removed immediately from medication room and handed over to the guardian. During the medication administration observations in the home 12/23/19 at 10:30am, One of the two transfered client medication were in the medication cabinet. "Trazadone 50mg." Review on 12/23/19 of facility's discharge summary dated 7/1/19 revealed, The client was discharge on 7/1/19 to another facility and his medication given to the guardian During an interview on 12/20/19, the nurse revealed (Via Phone) the medication should have been removed given to the client's guardian during discharge.	W 392	the physician as well as being discharged to another facility. The RN Team Lead will monitor monthly.	
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, record review and staff interviews, the facility failed to ensure the proper consistency of liquid for 1 of 6 (#15) audited	W 460	A core meeting will be held to outline strategies to utilize in all settings including medication administrations regarding client #15 proper/appropriate liquid consistency. All staff will receive training on estabilished procedures. All clients nutrition needs will be reassessed to ensure that all clients receives a nourishing well balanced diet including modified and specially-	2-21-2020

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W 460	Continued From page 5 clients. The findings is: Client #15 was able to drink thinned liquids during medication administration. During morning observations in the home on 12/23/19 at 9:13 am, client #15 came to the medication room and sat on a chair in the hall, outside the door. Next to the small table, were a pitcher of water and apple juice (thinned liquids). Staff C left client #15 in the hall, as she gathered his medication and removed a thickened container of water from the refrigerator, inside of the medication room. While Staff C was busy, client #15 helped himself to a cup left on the table and poured a cup of apple juice, and then quickly drunk it. During the interview with Staff C on 12/23/19, she indicated that she didn't see client #15 take a drink from the pitcher of thinned apple juice on the hall table. She mentioned that client #15 was supposed to have thickened liquids which is why she had removed the container from the refrigerator to offer to client #15. During the interview with the nurse on 12/23/19, she mentioned that client #15 needed thickened liquids to avoid coughing. The nurse further communicated that they'll need to come up with a plan to remove pitchers of thinned liquids from the hall, so that client #15 wouldn't be tempted.	W 460	prescribed diets in all settings. All staff will receive training on all changes identified for all clients. The Director will monitor at least 2 times weekly and the nurse will monitor weekly.	

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: 1/10/2020

Here is the Plan of Correction for:

Skill Creations of Clinton
Provider Number 34G047, MHL082-003

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

January 10, 2020

Ms. Fontaine Swinson, Chief Operations Officer
Skilled Creations Inc.
P.O. Box 1636
Goldsboro, NC 27533

Re: Follow-up Survey Completed 12/23/2019
Skill Creations of Clinton, 223 Forest Trail Drive, Clinton, NC 28328
Provider Number 34G047
MHL# 082-003
E-mail Address: Fontaine.swinson@skillscreations.com

Dear Ms. Swinson:

Thank you for the cooperation and courtesy extended during the follow-up survey completed on December 23, 2019.

As a result of the follow-up survey, it was determined that some of the deficiencies have not been corrected, which is reflected on the enclosed CMS-2567. Additional deficient practices were identified and cited during the survey, which is reflected on the enclosed CMS-2567.

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

- Re-cited standard level deficiency during this follow-up survey.
- Standard level deficiencies were newly cited during this follow-up survey.

Time Frames for Compliance

- Re-cited standard level deficiency must be ***corrected*** within 30 days from the exit of the survey, which is January 22, 2020.
- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is February 21, 2020.

What to include in the Plan of Correction

January 10, 2020
Ms. Fontaine Swinson
Skilled Creations of Clinton

- 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

A follow up visit will be conducted to verify all deficient practices have been corrected. If we can be of further assistance, please call Esther Moore at 919-612-8832.

Sincerely,

esther moore

Esther Moore, BSW, QIDP
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

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