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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G047 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 06/04/2020 |
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| NAME OF PROVIDER OR SUPPLIER SKILL CREATIONS OF CLINTON | STREET ADDRESS, CITY, STATE, ZIP CODE 223 FOREST TRAIL CLINTON, NC 28328 |
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| (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 |
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| W 000 | INITIAL COMMENTS | W 000 | | |
| W 420 | <p>CLIENT BEDROOMS CFR(s): 483.470(b)(4)(iv)</p> <p>The facility must provide each client with functional furniture, appropriate to the clients needs.</p> <p>This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure client #2 was provided with functional furniture to support his needs. This affected 1 of 2 audit clients (#2). The finding is:</p> <p>Client #2 did not have equipment/furniture to support his stature.</p> <p>Review on 6/3/2020 of a document dated 6/3/2020 provided by the extermination company confirmed the facility had been treated for bed bugs on 5/25/2020 and on 6/3/2020.</p> <p>Interview on 6/3/2020 with staff B revealed clients #1 and #2 were removed from bedroom #6 because the facility had recently been treated for bed bugs in bedroom #6. Further review with staff B explained client #1 was sleeping on a air mattress in the activity room and that client #2 was sleeping on a physical therapy table in the front dayroom area,</p> <p>Interview on 6/3/2020 and 6/4/2020 with the</p> | W 420 | | |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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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: 06/05/2020
FORM APPROVED
OMB NO. 0938-0391

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| W 420 | <p>Continued From page 1</p> <p>Director revealed the facility had recently been treated for bedbugs. Further interview revealed during this time from 5/25/2020 until the present, clients #1 and #2 had been removed from bedroom #6 and relocated until the Extermination company returned. The Director confirmed client #1 was temporarily sleeping on an air mattress in the activity room and client #2 was sleeping on a physical therapy table with a leatherlike pad in the front dayroom.</p> <p>Interview with the Maintenance Supervisor on 6/4/2020 confirmed the mattresses and bed frames for #1 and #2 are available but have not been placed in bedroom #6 until the extermination company returns to the facility for a follow up visit in two weeks.</p> <p>Additional interview on 6/4/2020 with the Director confirmed no other alternatives other than the physical therapy table were provided as a bed for client #2 to sleep.</p> | W 420 | | | |