STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G071	A. BUILDING _____ B. WING _____	11/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILL CREATIONS OF TARBORO	811 WESTERN BOULEVARD TARBORO, NC 27886

(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
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039	039 A full scale community based exercise, individual facility based exercise or table top exercise will be completed to test the emergency plans. The facility response will be documented to analyze continued effectiveness of the emergency plan that promotes best practice in the event of a disaster or emergency. Any identified needed revisions will be completed and changes implemented to maximize effectiveness of the emergency plan. The Director, Executive Director, and QM department will monitor every 6 months to ensure the table top exercise or full scale community based exercise is completed annually or more often as needed. DHSR-Mental Health DEC 01 2020 Lic. & Cert. Section	1-9-2021

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

Jessie Rashton | Chief Operations Officer | 11/23/2020

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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E 039	Continued From page 1 (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		

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E 039	Continued From page 2 (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]	E 039		

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E 039	Continued From page 3 (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to	E 039		

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E 039	Continued From page 4 test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises	E 039		

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E 039	Continued From page 5 to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise	E 039		

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E 039	Continued From page 6 is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on document review and interviews, the facility failed to ensure facility/community-based or tabletop exercises to test their Emergency Preparedness (EP) plan were conducted. This potentially affected all clients in the home. The finding is: The facility's EP plan did not include completion of facility/community-based or tabletop exercises. Review on 11/9/20 of the facility's EP plan dated 1/17/20, did not include a full-scale community-based or tabletop exercise for 2020. Further review revealed the last tabletop exercise was conducted on 5/14/19. During an interview on 11/9/20, the qualified intellectual disabilities professional (QIDP) revealed the facility did not perform a tabletop exercise for 2020; due to COVID-19.	E 039		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)	W 249		

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W 249	Continued From page 7 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 ensure each client received a continuous active treatment program consisting of needed interventions and services identified in the individual program plan (IPP) in the area of adaptive dining equipment for 2 of 7 audit clients (#1 and #2) and in fall preventions for 1 of 7 audit clients (#8). The findings are: A. Clients #1 and #2 were not prompted to use their adaptive dining equipment. 1. During lunch observations in the home on 11/9/20 at 11:40am, client #1 was observed wearing a wrist weight on his left wrist. Further observations revealed no other adaptive dining equipment being used by client #1. Additional observations revealed client #1's right hand was trembling while he ate. 2. During breakfast observations in the home on 11/10/20 at 8:23am, client #1 was not observed wearing his wrist weight. Further observations revealed no other adaptive dining equipment being used by client #1. Additional observations revealed both of client #1's hands were trembling while he ate.	W 249	Client #1 and #2 will utilize adaptive dining equipment at all mealtimes. Client #8 will have fall precautions implemented as written. All staff will receive training in: 1- ICF-IID Level of Care Basics and Active Treatment 2- Clients #1 and # 2 adaptive dining equipment. 3- All clients adaptive dining equipment 4- Client #8's fall precautions and monitoring guidelines 5- All clients fall precautions and monitoring guidelines The Director or PC will monitor mealtime and early morning programs twice weekly. The RQP will monitor programs twice monthly. The Executive Director (Corporate Office) will monitor programs once monthly. All monitoring will be documented. Any concerns will be followed up on.	

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W 249	Continued From page 8 Review on 11/9/20 of client #1's IPP dated 1/21/20 revealed, "He uses...a dycem to reduce spillage...wrist weights to stabilize his hands when trembling." Further review revealed client #1's adaptive equipment includes, "dycem and wrist weight." During an interview on 11/10/20, the home manager (HM) revealed client #1 uses his dycem mat at each each meal, to help keep his plate stable while he eats and it is the staffs' responsibility to ensure he uses it. The HM stated client #1 uses the wrist weights due to his tremors and it is staffs' responsibility to ensure he uses them. 3. During lunch observations in the home on 11/9/20 at 11:42am, client #2 was observed using a high sided plate, built up spoon, clothing protector and sippy cup. Client was not wearing wrist weights on her hands and spilled her food as she fed herself. Further observations revealed no other adaptive dining equipment being used by client #2. 4. During breakfast observations in the home on 11/10/20 at 8:22am, client #2 was not observed wearing her wrist weights. Further observations revealed no other adaptive dining equipment being used by client #2. Review on 11/10/20 of client #2's IPP dated 1/21/20 revealed wrist weights and a dycem mat to be used at meals. During an interview on 11/10/20, the qualified intellectual disabilities professional (QIDP) revealed clients #1 and #2 used their wrist weights due to tremors and dycem mats to help	W 249		

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W 249	Continued From page 9 keep their plates in place while they ate. B. Staff did not sit outside client #8's door, while in bed, to prevent falls. During morning observations in the home on 11/10/20 from 6:45-7:30am, client #8 remained in bed, with the door opened to his room, watching television. He had full padded siderails on his bed, in the upright position. Outside of his door, was an empty chair, with a sign taped to the wall, stating "Monitoring Station." Review on 11/10/20 of client #8's IPP revealed that he was ambulatory, used a walker and needed cues to slow down. Client #8 had a history of falls and had a falls protocol in place which required staff to sit in front of his bedroom at night. During an interview on 11/10/20 with the QIDP indicated that as long as client #8 was still in bed, staff should sit outside of his door monitoring him. She added that she expected someone to have been in the chair this morning.	W 249		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) 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 observations, record review and staff interviews, the facility failed to ensure all staff were able to demonstrate skills needed to	W 288		

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W 288	Continued From page 10 implement interventions necessary to manage inappropriate behaviors for 1 of 7 audit clients (#11). The findings are: Client #11's behavioral strategies were not implemented as written. During observations in the home on 11/9/20 at 11:50am during lunch, client #11 was seated in a wheelchair, in a high position, with tilt back and head rest. Client #11's wheelchair was positioned next to the table. Staff G stood behind client #11's right shoulder, held his plate and fed him. Client #11 had to turn his neck sharply to his right side, in order to be fed. He was fed in this position the entire meal and was not observed to spit at anyone as well as remained calm. During observations in the home on 11/9/20 at 6:05pm during dinner, client #11 was seated in his wheelchair, at the table. Staff J stood behind client #11's left shoulder, holding his plate and began to feed him. Client #11 had to turn his neck sharply, in order to be fed. Client #11 was not observed to spit at anyone and had a calm demeanor. After several minutes, staff J sat down in a chair, in front of client #11 and finished feeding him. During observations in the home on 11/10/20 at 8:22am, client #11 was sitting in his wheelchair at the table. Staff K stood behind his right shoulder, holding a plate of food and fed him, standing up. Client #11 had to turn his neck sharply, in order to be fed. Client #11 was not observed to spit at anyone and remained calm. Review on 11/10/20 of client #11's behavioral strategies for meal guidelines, there was no	W 288	W288 Client #11 will be fed all meals according to his behavioral plan and behavioral strategies for mealtimes. All staff will receive training on: 1- Client #11's behavior management plan and behavioral strategies for mealtimes 2- All client behavior management plans The Director or PC will monitor mealtime and behavioral programs twice weekly. The RQP will monitor programs twice monthly. The Executive Director (Corporate Office) will monitor programs once monthly. All monitoring will be documented. Any concerns will be followed up on as needed.	

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W 288	Continued From page 11 language about standing behind him, while feeding. On the behavior data form for client #11, it mentioned that he had a history of head butting, therefore staff should stand back from the headrest of the chair, as much as possible, to prevent any attempts by him to head butt. Staff also monitored client #11 for spitting and were advised to show no emotion, if he spat and to ignore the behavior. During an interview on 11/10/20 with Staff H, she stated that client #11 had a history of spitting but sometimes, his spitting was not intentional. She mentioned that sometimes client #11 accidentally spit when he talked. Staff H acknowledged that staff stood behind client #11 while feeding him so that he could not spit on them. She further said, that staff were told to sit in front of client #11 while feeding him, and that if he started spitting, staff should walk away and give him three minutes to calm down. During an interview on 11/10/20 with the director revealed that she had seen staff stand while feeding client #11 and had advised them to get a chair to feed him. Staff had been trained that if client #11 spat on them, to ignore the spitting, wait 3 minutes and continue to feed him.	W 288		
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.	W 340		

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W 340	Continued From page 12 This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure staff were sufficiently trained in wearing face masks. This potentially effected all the clients residing in the home. The findings are: Staff were not adequately trained in wearing face masks. a. During observations in the home on 11/9/20 from 3:56pm until 7pm, Staff A was observed wearing a face mask. Further observations revealed the face mask covered his mouth, but Staff A's nose was never covered. Additional observations revealed Staff A assisting various clients with setting their place settings, pouring their drinks and serving their dinner. At no time did Staff A pull the face mask over his nose. b. During observations in the home on 11/9/20 at 6:25pm, Staff B completely took off her face mask. Further observations revealed Staff B holding the day room door while a client went by her. Staff B put her face mask on at 6:26pm. c. During observations in the home on 11/10/20 at 8:05am, Staff C was observed wearing a face mask. Further observations revealed the face mask covered his mouth, but Staff C's nose was never covered. Further observations revealed Staff C leaving the day room and when he returned at 8:09am, the face mask was covering his nose. During an interview on 11/10/20, Staff D stated the face masks are suppose to cover "our nose and mouth and we are to wear them all the time	W 340	W340 All staff will receive training by the RN team leader in the proper usage of disposable masks. This will include wearing a disposable mask to cover the nose and mouth and wearing them at all times while on duty. The Director or PC will monitor the appropriate usage of masks twice weekly. The RN will monitor the appropriate usage of masks once monthly. All monitoring will be documented. Any concerns will be followed up on as needed.	

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W 340	Continued From page 13 while we are working." d. During observations in the home on 11/9/20 from 3:58pm until 6:08pm, Staff F was observed wearing a face mask, that hung beneath her nose. Within this period of time, Staff F was observed sitting within a foot of client #2 at the dining table in order to assist her. Staff F made not attempts to adjust her mask. Review on 11/10/20 of the facility's face mask guidelines (no date) states, "Cover mouth and nose with mask...." During an interview with the home manager (HM) on 11/10/20, she indicated that staff had been trained on how to pinch the face mask at the nose, for a better fit.	W 340		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the system of administrating medications as ordered was implemented. This affected 2 of 7 audit clients (#2 and #3) The findings are: A. Client #2 did not receive her Clearlax as ordered. During morning medication administration in the home on 11/10/20 at 7:14am, Staff E poured	W 368		

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W 368	Continued From page 14 Clearlax powder into a medication cup up to the 1/2 teaspoon line. Further observations revealed client #2 consumed the Clearlax powder after it was dissolved in a glass of water. During an interview on 11/10/20, Staff E stated the Clearlax powder gets poured to the 1/2 teaspoon line in the medication cup. Review on 11/10/20 of client #2's physician orders signed on 10/28/20 revealed, "GS Clearlax Powder Miralax Powder Mix with 1/2 capful (8.5 Grams) on 8oz of beverage of choice. During an interview on 11/10/20, the qualified intellectual disabilities professional (QIDP) revealed client #2's Clearlax powder should have been poured into the cap (which comes with the bottle) up to the 1/2 line. B. Client #2 did not receive her Pravastatin as ordered. During evening medication administration in the home on 11/9/20 at 4:59pm, Staff J placed one tablet of Pravastatin 10mg into a medicine cup of apple sauce and fed it to client #2. Further observations revealed that client #2 received her dinner meal at 6:05 pm on 11/9/20. Review on 11/9/20 of client #2's physician orders, signed 10/28/20 revealed Pravastatin 10mg every day with supper at 6 pm. During an interview on 11/10/20 with the QIDP she indicated that if the physician orders called for a medication to be taken with a meal then it should be given right before the client gets ready to eat.	W 368	W368 In the future client # 2, #3 and all clients will receive medication as ordered by the physician. The team will meet to discuss Client #3's food preferences with the physician. All nurses and med monitors will receive training on nursing policy 206-1 –assuring that clients receive medication as prescribed without error. The Director will monitor medication administration once weekly. The RN will monitor medication administration twice monthly. All monitoring will be documented. Any concerns will be followed up on as needed.	

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W 368	Continued From page 15 During an interview on 11/10/20 with the director, she indicated that if 6 pm was meal time, then client #2 should have received the medication on the way to the table or while sitting at the table. C. Client #3 did not receive his Omeprazole as ordered. During evening medication administration in the home on 11/9/20 at 5:01pm, Staff J removed a Omeprazole 20mg capsule from a bubble pack and opened it, emptying the contents into a small cup of water. Client #3 drunk all of the water out of the cup, but some of the medication remained in the cup. Staff J returned to the medication room and poured a flavored liquid into the cup, with the medication and presented the cup to client #3. Client #3 drunk all of the liquid, but again, some of the granules of the medication was stuck to the side and bottom of the cup. Staff J discarded the cup. Review on 11/9/20 of client #3's physician orders, signed 10/28/20 revealed an order for Omeprazole 20mg; take capsule. May open and put in applesauce. During an interview with Staff J on 11/9/20, she revealed that even though the order for Omeprazole read to take with applesauce, client #3 did not like applesauce and he would spit the medication out if she placed it in food. During an interview with the QIDP on 11/10/20, she indicated that if client #2 did not like applesauce, staff could have given in chocolate pudding, that he likes. The medication should not have been given in water.	W 368		

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W 368	Continued From page 16 During an interview with the home manager on 11/10/20, she indicated that if staff were aware that client #2 did not like applesauce, then the nurse should have been notified so that the order could be changed to give the medication in another format.	W 368		
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 staff interviews, the facility failed to ensure that 1 of 7 audit client (#3) received full dose of medication. The finding is: Client #3 received a partial dose of Omeprazole. During observation of the evening medication administration on 11/9/20 at 5:01pm, Staff J placed contents of Omeprazole 20mg capsule, into a small cup of water and gave it to client #3 to drink. Further observations revealed that client #3 drunk all of the fluid, but in the cup, small granules of the medication remained stuck to the cup. Review on 11/09/20 of client #3's physician orders, signed 10/28/20 revealed an order for Omeprazole 20mg; take capsule. May open and put in applesauce. During an interview with Staff J on 11/09/20, she revealed that even though the order for	W 369	W369 In the future client #3 and all clients will receive medication as ordered by the physician without error. The team will discuss client #3's food preferences with the physician. All nurses and med monitors will receive training on nursing policy 206-1 –assuring that clients receive medication as prescribed without error. The Director will monitor medication administration once weekly. The RN will monitor medication administration twice monthly. All monitoring will be documented. Any concerns will be followed up on as needed.	

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W 369	Continued From page 17 Omeprazole read to take with applesauce, client #3 would spit the medication out if she placed it in food. During an interview with the QIDP on 11/10/20, she indicated that the Omeprazole will not dissolve in liquids, so a partial dose was received.	W 369		
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. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all medications remained locked. The findings are: The medications were left unsecured and unsupervised. A. During observations in the home on 11/9/20 at 5:32pm, bottles of First Aid Antiseptic, Hydrogen Peroxide and Iodine were found in a unlocked cabinet which was located in a office where the surveyors were using. Further observations revealed the door was kept unlocked, so the surveyors could use it. Review on 11/10/20 of the facility's policy on medication storage stated, "All medications shall be stored: a. In a securely locked medication storage area...." During an interview on 11/9/20, the home manager (HM) revealed the bottles should have	W 382	W382 All drugs and biologicals will be stored / locked in the medication room. This will include first aid supplies such as antiseptic, iodine and hydrogen peroxide. In the future, when medication is discontinued by the physician it will locked in the medication room until it can be returned to the pharmacy. The RN Team leader will re-in-service all nurses and medication monitors on Nursing policy 206-10 regarding medication storage and disposal. The Director will monitor medication storage and disposal once monthly. The RN will monitor medication storage and disposal once monthly. All monitoring will be documented. Any concerns will be followed up on as needed.	

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W 382	Continued From page 18 been locked in the medication room. The HM stated the nurse is the responsible person who ensures all the medications are kept locked up. B. During observations in the home on 11/9/20 at 4:15pm, a clear plastic container with lid were found in the unlocked record room. The record room was located within the activity room, where clients were gathered. Inside of the container were 14 bubble packs of discontinued medications, that ranged from laxatives, anti-histamines, anti-inflammatory to opioids. The dates of the orders ranged from 9/10/19 to 8/14/20. A further observation on 11/10/20 at 7:15am, revealed that the container of medications were still left on the floor of the record room, which was unlocked with clients in the vicinity. Review on 11/10/20 of the facility's policy on medication storage stated, "All medications shall be stored: a. In a securely locked medication storage area...." During an interview with the HM on 11/10/20 revealed that she was unaware that the container of medication had been left out in the record room. She took the container of medications and placed it in a locked cabinet in the activity room. During an interview with the director on 11/10/20, she indicated that medications should be double locked.	W 382		
W 390	DRUG LABELING CFR(s): 483.460(m)(2)(i) The facility must remove from use outdated drugs.	W 390		

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W 390	Continued From page 19 This STANDARD is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard outdated medication for 3 of 7 audit clients (#1, #3 and #8). The finding is: Facility had kept outdated bubble packs of medications for at least a year. During observations on 11/9/20 at 4:15pm, a small plastic container of medications were found under the desk in the records room. Inside of the container were 3 bubble packs of expired medications that had been prescribed to 3 clients. The medications included: 1 pack of Hydro 5-325mg that was dated for 9/10/19 1 pack of AllrerG 25mg that was dated for 10/15/19 1 pack of Acetaminophen that was dated for 10/31/19 During an interview with the home manager on 11/10/20, she revealed that she was unaware that there was outdated medication that had not been returned to the pharmacy. The home manager indicated that the nurse recently went on leave. During an interview with the director on 11/10/20, she indicated that outdated medication should have been returned to the pharmacy, within days of being pulled. She further added, that the pharmacy had recently been at the facility.	W 390	W390 In the future, the facility will remove from use all outdated drugs. Expired or outdated drugs will be stored locked in the medication room, until they can be returned to the pharmacy. The RN Team leader will re-in-service all nurses and medication monitors on Nursing policy 206-10 regarding medication storage and disposal. The Director will monitor medication storage and disposal once monthly. The RN will monitor medication storage and disposal once monthly. All monitoring will be documented. Any concerns will be followed up on as needed.	
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1)	W 460		

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W 460	Continued From page 20 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 reviews and staff interviews, the facility failed to ensure that dietary orders were followed for 3 of 7 audit clients (#2, #7 and #8). The findings are: A. Clients #2 and #8's meals were not prepared at a pureed consistency. 1. During observations in the home between 11/9/20-11/10/20 that included lunch, dinner and breakfast meals, the consistency of client #2's pureed meals were soupy and dripped off of her spoon. An additional observation on 11/09/20 at 6:05pm revealed that client #2 was served pureed taco salad, that had one fragment of a taco shell, in which she consumed. Review on 11/9/20 of the Monthly Dietary Roster dated 11/1/20 indicated that client #2 should receive a regular calorie pureed diet. 2. During observations in the homes between 11/9/20-11/10/20 that included lunch, dinner and breakfast meals, the consistency of client #8's pureed meals were soupy and dripped off of his spoon. Review on 11/9/20 of the individual program plan (IPP) dated 7/8/20 revealed that client #8 should receive a regular calorie pureed diet. During an interview on 11/10/20 with Staff H, she indicated that she prepared breakfast today. On	W 460	W460 Clients #2, #7, and #8 will receive all diets, portions and supplements as ordered by their physician, at the correct consistency. All staff will receive training on all clients' diet orders, diet modifications, portions and supplements. All staff will receive re-training on how to prepare the correct diet consistency to assure that all clients receive a nourishing, well balanced diet that includes modified or special prescribed diets. Diet rosters will be available for all staff to use when preparing meals or assisting clients with their meal in the dining room. The Director or PC will monitor mealtime programs twice weekly. The RQP will monitor mealtime programs twice monthly. The Executive Director (Corporate Office) will monitor mealtime programs once monthly. All monitoring will be documented. Any concerns will be followed up on as needed.	

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W 460	Continued From page 21 the menu was blueberry muffin, oatmeal and yogurt. When preparing the muffin and oatmeal for a pureed consistency, she stated that she added water and blended the food for 10 seconds. During an interview on 11/10/20 with the qualified intellectual disabilities professional (QIDP), she indicated that a pureed texture should be soft and smooth, like pudding. She acknowledged that the food, after processed should not drip, be soupy or runny. During an interview on 11/10/20 with the director, she indicated that she trained the staff how to prepare mechanically altered diets. She mentioned that if staff noticed that the diet was not followed then they should send the plate back to the kitchen. B. Clients #2, #7 and #8 did not receive their nutritional supplements with meals. 1. During observations in the home on 11/9/20 at 11:42am, client #2 did not receive a Boost pudding with lunch. An additional observation on 11/20/20 at 8:22am, client #2 did not receive a Boost pudding with breakfast. Review on 11/9/20 of the Monthly Dietary Roster dated 11/1/20 indicated that client #2 should receive Boost pudding with each meal. 2. During observations in the home on 11/9/20 at 6:30pm, client #7 did not receive a double portion of taco salad. An additional observation on 11/10/20 at 8:40 am, client #7 did not receive a double portion of yogurt.	W 460		

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W 460	Continued From page 22 Review on 11/9/20 of the Monthly Dietary Roster dated 11/1/20 indicated that client #7 should receive a regular calorie double meat/protein item at meals. 3. During observations in the home on 11/10/20 at 8:40am, revealed that client #8 did not receive a nutritional shake with his breakfast. Review on 11/9/20 of the individual program plan (IPP) dated 7/8/20 revealed that client #8 should receive an Ensure shake with breakfast. During an interview on 11/10/20 with the QIDP she reviewed the nutritional evaluations for clients #2, #7 and #7. The QIDP acknowledged that on 10/31/19 a dietician evaluation supported giving client #2 Boost pudding with each meal. In addition, a dietary evaluation completed on 5/21/20 for client #8, recommended that he receive Ensure shake for breakfast. Client #7 was supposed to still receive double meats and proteins at meals. The QIDP indicated that supplements were available in the kitchen and the dietary staff had a copy of the current diet. However, she noted that everyone was responsible for handing out the supplements and should know the clients dietary orders.	W 460		
W 485	DINING AREAS AND SERVICE CFR(s): 483.480(d)(4) The facility must supervise and staff dining rooms adequately. This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure sufficient	W 485		

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W 485	Continued From page 23 supervision in the dining room to assure 2 of 7 audit clients (#11 and #12) programs were implemented during meals. The findings are: Staffing was inadequate to provide individual assistance at meals for clients #11 and #12. A. During observations in the home on 11/9/20 at 11:42am, Staff G stood next to client #12 holding his plate, in mid-air as he scooped his food to eat. Client #2 was already seated at a table, receiving assistance from Staff F. Client #11 remained in his wheelchair and was not placed at a table since there were only two staff in the room. At 11:47am, client #11 could be heard stating that he was hungry. Staff G, stopped assisting client #12 and went to client #11 and took him to another table and began feeding him. Client #12 continued to scoop his food out of his high side plate, but had food spillage. Review on 11/10/20 of client #12's individual program plan (IPP) dated 11/6/19, indicated that client #12 could feed himself independently but required cueing from staff to slow down, not try to overload his spoon and to drink liquids between bites. B. During observations in the home on 11/9/20 at 6:05pm, client #12 sat alone at his table and was able to feed himself dinner. His drinks were out of reach on the table, so he consumed all of his food, without taking sips. At another table, client #2 fed herself and client #11 was being fed by Staff J. Staff J fed client #11 for 15 minutes, then went to client #12 and offered him his drinks. He had four glasses of beverages lined up on the table, with straws. Client #12 was observed quickly drinking all of the beverages and Staff J	W 485	485 Facility administration will assure adequate staffing patterns to allow for sufficient supervision in the dining room. The team will review mealtimes, and mealtime seating to allow for sufficient supervision in the dining room to implement dining programs. The Executive Director will assist with decision making as needed. The Director or Program Director will monitor mealtimes at least twice per week. The RQP will monitor mealtime programs twice monthly. The Executive Director (Corporate Office) will monitor mealtime programs once monthly. All monitoring will be documented. Any concerns will be followed up on as needed.	

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W 485	Continued From page 24 was heard saying to him, "You must be thirsty." Review on 11/10/20 of client #11's IPP dated 1/22/20, indicated that client #11 must be fed by staff, except finger foods. During an interview on 11/10/20 with the director, she indicated that there was supposed to be at least three staff in the room during meals. She acknowledged that this morning, they were short staff because Staff K had car trouble and came in later.	W 485		

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Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

November 23, 2020

RE: Recertification Survey November 9 – 10, 2020
Skill Creations of Tarboro, 811 Western Blvd., Tarboro, NC 27886
Provider Number 34G 071
MHL# 033-008

Please find enclosed the plan of correction for deficiencies received on 11-18-2020 for the annual recertification survey conducted on 11-9 and 11-10 -2020 at Skill Creations of Tarboro. Please contact me should you have any questions or need additional information.
Thank you,

Seslie Roughton

Seslie Roughton
Chief Operations Officer –Eastern Region
Skill Creations, Inc.
Seslie.roughton@skillcreaitons.com
252-908-1151