STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G054	A. BUILDING _____ B. WING _____	C 07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILL CREATIONS OF SANFORD	1751 HAWKINS AVENUE SANFORD, NC 27330

(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 On July 9, 2021, a complaint survey was completed for intakes #NC00178825 and #NC00178830. The complaints were unsubstantiated. However, an unrelated deficiency was cited.	W 000		
W 116	CLIENT RECORDS CFR(s): 483.410(c)(6) The facility must provide each identified residential living unit with appropriate aspects of each client's record. This STANDARD is not met as evidenced by: Based on observations and interviews, facility staff were not provided with the Individual program plans (IPPs). This potentially affects all 12 clients residing in the facility. The findings are: Upon entrance to the facility on 7/9/2021, the door to the records was observed to be locked and the staff were asked if they could provide information such as active treatment plans including an IPP for two individuals residing in the facility. Interviews with all staff on duty (A, B and C) confirmed they did not have access to any client information such as the IPP. They indicated client information such as evaluations, individual plans, medical treatment and health risks as well as other emergency and medical information was located in a locked office for which nobody there had a key. Interview with the Director on 7/9/2021 confirmed that no direct support staff had a key to client	W 116		

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

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 116	Continued From page 1 information but that she had not been aware of this until today.	W 116		