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 _____	01/19/2022

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
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and 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	E 039	039 A full scale community based exercise or 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. This will be conducted now, and annually each year. Additionally, the facility Director will maintain documentation of the table top exercise and those that participated at the facility. 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 FEB 04 2022 Lic. & Cert. Section	03/19/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Leslie Rogers	Chief Operations Officer- Eastern Region	1-31-2022

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 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 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	E 039		

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E 039	Continued From page 2 a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (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.	E 039		

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E 039	Continued From page 3 *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (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 PACE at §460.84(d):]	E 039		

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E 039	Continued From page 4 (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization 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 PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE 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 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 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 PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE'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 5 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 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	E 039		

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E 039	Continued From page 6 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 HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a 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 every 2 years; or.	E 039		

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E 039	Continued From page 7 (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA 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 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 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 HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA'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 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	E 039		

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E 039	Continued From page 8 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. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure a facility/community-based exercise was conducted to test their emergency plan (EP). The finding is: During record review of the Emergency Preparedness Manual, with revision date of 1/12/22, there were no evidence of table top training activities for the past two years. Interview on 1/19/22 with the director revealed that she could not find a copy of their table top	E 039		

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E 039	Continued From page 9 training or attendance sheet. Interview on 1/19/22 with the executive director (ED) revealed table top exercises were supposed to be performed to update staff on how to handle disasters and they conducted them every year.	E 039		
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to maintain the privacy of 1 of 6 audit clients (#4) of medical information. The finding is: During observations in the home on 1/18/22 at 12:40 PM, a sign was posted outside the medication room door, facing the hall revealing client #4's name and new medication. The sign read: "[Client #4] now has a new medication ordered. She is back on 8 PM med pass, it is very important that she does not miss any doses of her Eliquis/Apixaban 5 mg tablet twice daily." The sign was undated and had the electronic signature of the nurse. An additional observation in the home on 1/18/22 at 3:00 PM revealed the identical sign regarding client #4's new medication was posted on the exterior guest/staff bathroom door in the main lobby. This signed remained on the bathroom door during another observation on 1/19/22 at	W 125	W125 All staff will receive re- training in client rights, specifically protecting the rights of clients regarding posting information in the facility. All staff and nurses will receive training in the SCI procedure for communicating medication changes, which is to note changes in the Medication Monitor Communication Log inside the Medication room. The Director or PC will monitor to assure client rights are protected once weekly. The Regional Nursing Director (RND) and the RN Clinical Director will monitor to assure rights are protected and the communication of medication changes twice monthly. The Executive Director (Corporate Office) will monitor the protection of client rights and communication once monthly. All monitoring will be documented. Any concerns will be followed up on.	03/19/2022

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W 125	Continued From page 10 8:30 AM. Record review on 1/18/22 of client #4's physician order revealed a new order for Eliquis 5 mg was issued on 1/5/22. Interview on 1/19/22 with the supervisor revealed that last week, she received a call from the nurse instructing her to hang a sign in visible places to inform the staff of client #4's new medication. Interview on 1/19/21 with the nurse revealed that when she started her medication administration today on 1st shift, she removed the sign regarding client #4 from the medication room door and hung on the medication cabinet instead. The nurse stated that the sign should not have hung on the outside door. The nurse acknowledged that she had asked the supervisor to post the signs for her. Interview on 1/19/22 with the executive director revealed the facility has to maintain client's privacy.	W 125		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) 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.	W 249		

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W 249	Continued From page 11 This STANDARD is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to ensure 2 of 6 audit clients (#8 and #14) received a continuous active treatment program consisting of needed interventions as identified in the individual program plan (IPP) in the areas of dining guidance and domestic skills. The findings are: A. During observations on 1/18/22 at 5:35 PM, client #14 sat at dinner table while Staff H stood to set up the meal for client #5. Staff H had her back to client #14 while feeding client #5. Client #14 independently opened two juice packs of thickened liquids and poured them into his cup until it reached the brim. The cup was clear and had a black line on it at the 2 ounce mark. Client #14 picked up his cup and hurriedly drunk all of the contents and coughed twice afterwards. Staff H was later seen clearing some items on the table and picked up two empty juice containers belonging to client #14 and threw them in trash. Staff H poured 2 ounces of a milk supplement into the cup of client #14 and refilled the cup to the mark, until the container was empty. Client #14 was not observed to cough, when his beverage consumption was paced and monitored. Review on 1/18/22 of client #14's IPP revealed meal guidelines dated 11/8/19, due to client #14's history of rapid consumption. It revealed: "[Client #14] tends to drink all that is in his glass at one time. To avoid choking and possible reflux, staff should only pour liquid to the fill line on [client #14's] cup. Once [client #14] drinks the drink in his cup, you may pour more back to the line indicated. Be sure to encourage [client #14] to drink slowly."	W 249	W249 All staff will be trained in: • Active Treatment Basics • Encouraging Independence • Providing the least amount of assistance necessary • Client #14's mealtime guidelines. • Client #8's training goals • All Clients dining and mealtime guidelines and services. • All clients training goals The Director or Program Coordinator (PC) will monitor mealtimes and goal training twice weekly The Regional QP (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.	03/19/2022

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W 249	Continued From page 12 Interview on 1/19/22 with the supervisor revealed client #14 cannot drink too much at meals to avoid aspiration. Client #14 needs supervision at meals. B. During observations in the home on 1/18/22 at 12:15 PM, client #8 remained in the dining room after consuming his lunch. After lunch, Staff J sprayed cleaning solution on the dining room tables and wiped the surface. Staff J did not ask client #8 to participate. An additional observation on 1/19/22 at 8:55 AM of client #8 eating breakfast in the dining room. Staff M asked client #8 to clear his dishes after his meal, but did not request that he wipe off the dining room table. Staff B came into the dining room at 9:15 AM, then took the cleaning solution and proceeded to wipe down the table, without asking client #8 to participate. Review on 1/18/22 of client #8's IPP revealed a training goal dated 10/4/21 to wipe the dining room table after verbal cues daily on 1st shift. Interview on 1/19/22 with the supervisor revealed, client #8 has to be prompted in order to get him to wipe the dining room table.	W 249		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure a restrictive Behavior	W 263		

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 _____	01/19/2022

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W 263	Continued From page 13 Support Plan (BSP) was conducted with the written consent of the guardian. This affected 2 of 6 audit clients (#2 and #9). The findings are: A. Review on 1/19/22 of client #2's BSP dated 8/6/21 revealed he was on behavioral medications: Risperidone, Abilify, Lexapro, Seroquel and Hydroxyzine HCL. Further review revealed an undated consent with both guardians initials and no information regarding the reason for his behavioral restrictions and treatment. The consent notes that it will expire in 6 months from the date of the signature. Interview on 1/19/22 with the director revealed that at admission, the facility met with the guardians and discussed a behavior plan for him. The director acknowledged that she could not locate a copy of the consent for client #2. Interview on 1/19/22 with the executive director (ED) revealed that at admission, she completes the information on the consent to have the guardians sign off, but she could not locate a copy of the form. B. During observations in the home, throughout the survey 1/18/22-1/19/22, client #9 wore a wide gait belt, with a personal alarm device attached. The device would alarm once she stood up from a seated position. Review on 1/18/22 of client #9's BSP consent signed by the guardian and dated 12/3/21, failed to list a restrictive device to monitor her movements. Interview on 1/19/22 with the ED revealed restrictive devices such as a chair alarm, should	W 263	W263 Written informed consent for client #2 and #9, as well as any other client's restrictive behavior plan will be obtained. The consent form will contain all needed information indicating what the restrictive technique is in the plan (including restrictive medication and alarms), the risks, benefits, alternatives, right to refuse and consequences. All Consent forms will be signed and dated and immediately scanned into the client Electronic Health Record. Additionally, the Executive Director (Corporate office) will conduct training with the Director and Regional QP on the requirements of consent for restrictive techniques (including medications and restrictive techniques such as alarms) to be included in a restrictive behavior plan and the need for informed written consent. The Director will assure that informed written guardian consent and Human rights consent is obtained for all clients that utilize restrictive techniques as a part of their behavior intervention program. The RQP will monitor for BIP consents at least quarterly. The Executive Director will monitor at least quarterly. All monitoring will be documented. Any concerns will be followed up on.	03/19/2022

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W 263	Continued From page 14 be listed on the BSP for the human rights committee to review and the guardian to consent.	W 263		03/19/2022
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 observation and interviews, the facility failed to ensure complete screening for COVID-19 symptoms and exposure, for all visitors. This had the potential to effect all clients (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14 and #15). The finding is: During observations at the home on 1/18/22 at 10:45 AM, Staff C answered the door, allowed the surveyor to enter and did not screen for COVID-19. Staff C left the lobby to get the Supervisor, who was unaware that screening was not done. At 11:30 AM, the supervisor met with the surveyor in the office and was informed that COVID-19 screening had not been done. The supervisor retrieved the thermometer to record the surveyor's body temperature and had the surveyor fill out a form with screening questions. Interview on 1/18/22 with the supervisor revealed, she expected whichever staff answering the door to the facility to screen visitors before allowing entry. Interview on 1/19/22 with the nurse revealed, she expected staff to screen all visitors immediately	W 340	W340 All staff will receive re- training on Infection, Prevention and Control Policy S- Covid Precautions by the RN Clinical Director. Specifically staff will be trained that daily screenings are required for all staff or visitors upon entry into the building including a questionnaire and temperature check. In the future all staff and visitors will be screened immediately upon entry. The Facility Director or Program Coordinator will monitor daily screenings twice weekly. The Regional Nursing Director (RND) will monitor daily screenings once weekly. The RN Clinical Director and Executive Director (Corporate Office employees) will monitor daily screenings once monthly.	

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W 340	Continued From page 15 for COVID-19 when entering the building. The nurse stated that she offered training on their screening procedure at the beginning of the pandemic and last week, when the facility was placed on quarantine for COVID-19 outbreak.	W 340		