STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G063	A. BUILDING _____ B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILL CREATIONS OF KINSTON	901 DOCTORS DRIVE KINSTON, NC 28503

(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 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to furnish client #3 with sport goggles and foot stool. this affected 1 of 4 audit clients. The finding is: During observations in the home on 8/26-27/24, client #3 did not wear sports goggles or was she offered to wear any. Client #3 also, did not use her foot stool while at the dinner and breakfast table. Review on 8/26/24 of client #3 Individual Program Plan (IPP), dated 1/16/24 revealed she has a diagnosis of nearsightedness. She utilizes sports frames daily. Further review revealed current adaptive equipment foot stool. Interview on 8/27/24 with Staff A revealed she was unsure of when client #3 should use the foot stool. Staff A was unsure of where client #3 glasses were located. Interview on 8/27/24 with the program director and qualified intellectual disabilities professional confirmed that the glasses were not available at the facility. Program director confirmed the foot stool has been in place for a long time however could not find any guidelines for the use of the foot stool.	W 436		

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.