DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G079	A. BUILDING ______ B. WING ______	C 10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILL CREATIONS OF WILSON	**2000 MARTIN LUTHER KING JR PARKWAY WILSON, NC 27893**

(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 A complaint survey was conducted on 10/29/24 intake #NC00223277. The complaint was substantiated. A deficiency was cited in relation to the complaint.	W 000		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 4 audit clients (#1) was provided nursing services in accordance with his needs regarding timely and appropriate medical intervention following an injury. The finding is: Review on 10/29/24 of the North Carolina Incident Response Improvement System (IRIS) report, dated 3/6/24 revealed an incident involving Client #1 on 3/2/24 in which he suffered an unwitnessed fall resulting in a fracture of the outer tip of his shoulder bone. The facility contacted the guardian, DSS, and provided in-person medical care on 3/4/24. On 3/2/24, client #1 reported pain in his right shoulder. The on-call nurse was notified by phone and Tylenol was prescribed. On 3/3/24, the physician was notified over the phone and Tylenol was prescribed with x-rays ordered for the following day. On 3/4/24, client #1 received an x-ray with results showing a fracture to his right shoulder. He was transferred to the emergency department for further investigation. The facility immediately started an internal investigation on 3/4/24 due to the unknown cause of the injury. On 3/6/24, the cause of the injury was determined to be likely from a fall during the	W 331		

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 331	Continued From page 1 time he was in his bedroom. Client #1 has a history of falls and has alarms in place to notify staff when he gets up. He is active and rocks in his chair in his bedroom. He is able to be left alone in his bedroom in his chair, which has an alarm with transmitter to notify staff if he gets up so they can assist in ambulation. He also has a bed alarm and takes the alarm with him when he gets up. It was determined that his chair alarm was not working efficiently. Further review of the IRIS report revealed the facility purchased new chair alarms and implemented a system for the charge person and on each shift to ensure alarms are working properly at the beginning of each shift. In addition, client #1 is provided with a 1:1 staff to ensure his safety. This is to be documented in the 24 hour communication log. Staff were inserviced on his ambulation guidelines. Review on 10/29/24 of an incident report dated 3/2/24 at 6:30pm revealed Staff A observed client #1 grabbing his right shoulder and observed a bruise on right shoulder area. Staff A stated client #1's shoulder appeared to be dislocated. The on-call nurse was notified and advised to ice the area and give Tylenol. The cause of injury was not witnessed. On 3/4/24, the administrator reported the incident was unseen, nurses were notified, and Tylenol was given. The physician ordered an x-ray and investigation was started into the incident by administration. No reference to an in-person nursing visit or video conference was noted. Review on 10/29/24 of hospital physician documentation, dated 3/4/24, revealed client #1 was seen for a collarbone fracture and scalp	W 331		

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W 331	Continued From page 2 contusion (bruises) from a fall. He was given a sling to wear for comfort and ice was applied to the area 3 - 4 times daily. Review on 10/29/24 of client #1's Individual Program Plan (IPP), dated 1/20/24, revealed he has epilepsy and is a risk for falls. His adaptive equipment includes a gait belt, bed and chair alarms, a shower chair, and wheelchair for long distances. Client #1's retirement schedule revealed he should be within visual eye of staff at all times. If he leaves the room, staff should follow behind him to assure his safety. He may have private time alone in his room with staff sitting outside his door and alarms on due to his ambulation guidelines as he tends to jump up quickly. Review on 10/29/24 of client #1's physical therapy evaluation, dated 8/12/24, revealed he has epilepsy and early onset Alzheimer ' s, as well as seizure disorder. He has a history of falls and was flagged for falls risk during this evaluation. He often refuses to wear a gait belt, but a bed and chair alarm are in place in his room. Recommendation is to continue to provide stand by staff assistance/supervision for ambulation to reduce the risk for falls. Review on 10/29/24 of client #1's ambulation guidelines, dated 3/10/20, revealed he is a risk for falls and a gait belt should be used during ambulation in addition to staff assistance. He should sit in regular chair with arm rests which assist him with pushing up and transferring independently. He will use inserts in his shoes to help him with weight bearing, as well as bed and chair alarms to help staff make their way to him quickly to avoid falls.	W 331		

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Review on 10/29/24 of client #1's staff badge and monitoring guidelines, implemented on 10/16/24, revealed his supervision is 1:1 from 7am - 11:30pm with assigned staff to rotate during the day. Assigned staff must assure bed and chair alarms are on when assuming responsibility and log that alarms are working. If an assigned staff must leave for a break, the badge for monitoring must be given to another staff to assume responsibility. If client #1 is napping, staff will assure the alarm is working and may sit outside of his door.

Review on 10/29/24 of the facility investigation revealed an investigation was started on 3/4/24 to determine the cause of client #1's injury to his shoulder. X-ray results revealed a fracture to his right shoulder. All staff were interviewed that were on duty on the weekend of 3/2/24 and 3/3/24. First shift staff all stated they did not notice anything wrong with client #1 on 3/2/24. However, staff reported he was seen getting up and down from his chair with the alarm not sounding. During second shift change in the afternoon on 3/2/24, staff and clients were outside as client #1 was in his chair in his room alone. When staff walked down the hallway, client #1 walked toward them carrying his chair alarm. Staff noticed the alarm was not making any sound, but he was not witnessed to have fallen. The cause of the fall could not be determined, but a fall may have occurred due to the chair alarm not working.

Further review of staff statements revealed on 3/2/24, Staff E worked first shift and went to the door to notify second shift, outside some of the clients, that they were leaving and clients inside needed to be watched. Staff F reported she left

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work at 3:30pm and client #1 was rocking in his chair in his room with no issues noted. Staff G worked first shift and stated second shift took several clients, including client #1, outside when they came onto shift. Client #1 returned inside to his room. No staff was noted to accompany him. At 4:00pm, Staff G alerted second shift staff that she was leaving and supervision of clients inside needed to be covered. Staff H stated he was coming in to cover. Staff H worked second shift and stated client #1 did not go outside and was in his room during the afternoon. Staff did not maintain visual supervision of him during this time. Staff H noticed client #1 complaining about his shoulder after dinner and notified the nurse. On 3/3/24, Staff D woke client #1 for his bath and he told her his arm hurt. She called the nurse. Staff E noticed client #1 complaining about his shoulder. However, no bruise was evident at the time. The nurse was notified and she gave permission for Tylenol. Client #1 continued to complain about pain throughout the end of shift.

To prevent future incidents and ensure safety, the facility ordered new alarms for client 1's bed and chair. Client #1 is assigned a 1:1 staff which must keep him in visual sight. If the staff takes a break, the badge must pass to another staff for responsibility. Each shift lead must document that alarms are working daily in a log.

Interview on 10/29/24 with the administrator revealed the incident happened on the weekend and the on-call nurse was contacted instead of their regular nurse. She was unsure as to why the on-call nurse had not attended to client #1 in person, but stated she thought she had used photos to determine injury severity.

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W 331	Continued From page 5 Interview on 10/29/24 by phone with the on-call nurse revealed she was working on the weekend of the incident. When calls are made for falls or injuries, normally on-call nurses immediately send clients to the emergency department if they hit their head. If they do not hit their head and are mildly bruised, they given Tylenol, ice, and monitored. If the fall is unwitnessed, the nurse depends on staff to assess the client and relay medical indications, as well as using Facetime. However, the on-call nurse confirmed neither in-person assessment nor Facetime was completed for client #1 on 3/2/24 after the report of his pain and a fall. Instead, pictures were sent to her and staff were instructed to give him Tylenol and to ice the area. On 3/3/24, staff called again to report client #1 still seemed to be in pain. The on-call nurse notified the physician and an appointment was made for an x-ray to be completed on 3/4/24. No in-person consultation was completed. On 3/4/24, client #1 was x-rayed and treated in-person by the physician at the emergency department. Interview on 10/29/24 with the facility nurse revealed nurses should Facetime or video after a fall to determine the range of motion and possible injuries. If a fall is unwitnessed, on-call nurses rely on staff observations, but staff are not medically trained to assess possible broken bones or medical injuries.	W 331		