IMENT OF HEALTH	AND HUMAN SERVICES					APPROVED	
RS FOR MEDICARE	& MEDICAID SERVICES			O	MB NO.	0938-0391	
					(X3) DATE SURVEY COMPLETED		
34G040		B. WING			C 01/14/2025		
PROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE			
REATIONS							
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	(X5) COMPLETION DATE			
INITIAL COMMENT	rs	W 0	00				
the recertification sintake #NC0022598 substantiated; how the complaint was of survey also resulted PROGRAM IMPLE CFR(s): 483.440(d) As soon as the inter formulated a client each client must re- treatment program interventions and so and frequency to su	urvey on 1/13 - 1/14/25 for 88. The allegation was not ever, a deficiency related to cited and the recertification d in cited deficiencies. MENTATION (1) rdisciplinary team has s individual program plan, ceive a continuous active consisting of needed ervices in sufficient number upport the achievement of the	W 2	49				
Based on observation interviews, the facilination received a continuous consisting of needed as identified in the line area of behave affected 1 of 5 audion During evening observations 1/13/25 from 4:00 perconsistently became teeth, screaming arwrist. Various staffibehavior by calling biting" or asking him	tions, record review and ity failed to ensure client #6 bus active treatment program ad interventions and services individual Program Plan (IPP) vior management. This t clients. The finding is: ervations in the home on m - 6:13pm, client #6 e agitated by grinding his nd biting his left and/or right in the area addressed the the client's name, saying, "No n what's wrong (without						
	RS FOR MEDICARE OF DEFICIENCIES DF CORRECTION PROVIDER OR SUPPLIER REATIONS SUMMARY STA (EACH DEFICIENCY REGULATORY OR L INITIAL COMMENT A complaint investi the recertification si intake #NC0022598 substantiated; howe the complaint was of survey also resulted PROGRAM IMPLE CFR(s): 483.440(d) As soon as the inter formulated a client survey also resulted PROGRAM IMPLE CFR(s): 483.440(d) As soon as the inter formulated a client interventions and si and frequency to su objectives identified plan. This STANDARD is Based on observati interviews, the facil received a continue consisting of needed as identified in the L in the area of behave affected 1 of 5 audi During evening obs 1/13/25 from 4:00p consistently becam teeth, screaming ar wrist. Various staff behavior by calling biting" or asking hir	DF CORRECTION IDENTIFICATION NUMBER: 34G040 PROVIDER OR SUPPLIER REATIONS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS A complaint investigation was conducted during the recertification survey on 1/13 - 1/14/25 for intake #NC00225988. The allegation was not substantiated; however, a deficiency related to the complaint was cited and the recertification survey also resulted in cited deficiencies. 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	RS FOR MEDICARE & MEDICAID SERVICES COF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILD Browing 34G040 B. WING PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIT INITIAL COMMENTS W 0 A complaint investigation was conducted during the recertification survey on 1/13 - 1/14/25 for intake #NC00225988. The allegation was not substantiated; however, a deficiency related to the complaint was cited and the recertification survey also resulted in cited deficiencies. W 2 PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) W 2 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 2 This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #6 received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of behavior management. This affected 1 of 5 audit clients. The finding is: During evening observations in the home on 1/13/25 from 4:00pm - 6:13pm, client #6 consistently became agitated by grinding his teeth, screaming and biting his left and/or right wrist. Various staff in the area addr	RS FOR MEDICARE & MEDICAID SERVICES C OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA A BUILDING A BUILDING SECORRECTION (X1) PROVIDER/SUPPLIER/CLIA A BOULDARE 34G040 PROVIDER OR SUPPLIER ST REATIONS 21 G SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG INITIAL COMMENTS W 000 A complaint investigation was conducted during the recertification survey on 1/13 - 1/14/25 for intake #NC00225988. The allegation was not substantiated; however, a deficiency related to the complaint was cited and the recertification survey also resulted in cited deficiencies. PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) W 249 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, record review and interviews, the facility failed to ensure client #6 received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of behavior management. This affected 1 of 5 audit clients. The finding is: During evening observations in the home on 1/1/	RS FOR MEDICARE & MEDICAID SERVICES OI COP DEFICIENCIES (X) PROVIDERSUPPLER/CLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 346040 B WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2101 ROYALL AVE GOLDSBORO, NC 27534 ID PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID INITIAL COMMENTS W 000 A complaint investigation was conducted during the recertification survey on 1/13 - 1/14/25 for intake #NC00225988. The allegation was not substantiated, however, a deficiency related to the complaint was cited and the recertification survey also resulted in cited deficiencies. PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) W 249 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 This STANDARD is not met as evidenced by: Based on observations, record review and interventions and services as identified in the Individual Program plan. ID This affected 1 of 5 audit clients. The finding is: During evening observations in the home on 1/13/25 for 4:00m - 6:13pm, client #6 consistently became agitated by grinding his teath, screaming and biting his left and/or right wrist. Various staff in the area addressed the behavior by calling the client's wrong (without<	RS FOR MEDICARE & MEDICAID SERVICES OMB NO. COP DEFICENCIES (X) PROVIDERSUPPLETCUA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING (X2) DUAL COM 34G040 B. WING (X2) MULTIPLE CONSTRUCTION A BUILDING (X2) DUAL COM PROVIDER OR SUPPLER 34G040 B. WING (X2) MULTIPLE CONSTRUCTION REATIONS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTFINING INFORMATION) INTEREST ADDRESS, CITY, STATE, ZIP CODE 2101 ROYALL AVE COLDSBORO, NC 27534 INITIAL COMMENTS W 000 (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCE) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCE) INITIAL COMMENTS W 000 (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCE) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCE) INITIAL COMMENTS W 000 V249 CROSS-REFERENCE) A complaint investigation was conducted during the recervice action was not substantiated; however, a deficience. PROGRAM IMPLEMENTATION CCR (S): 483.440(d)(1) W 249 As soon as the interdisciplinary team has formulated a client's individual program plan. W 249 This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #6 consistently became agitated by grinding his feeth, screaming and biting his left and/or right wist. Various staff in the area addressed the behavior by calling the client's name, saving. "No biting' or asking him wh	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 01/15/2025

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.

		AND HUMAN SERVICES				FORM	01/15/2025 APPROVED 0938-0391	
STATEMENT	rement of deficiencies (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:		l` í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G040	B. WING			C 01/14/2025		
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
SKILL C	REATIONS				101 ROYALL AVE GOLDSBORO, NC 27534			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE	
W 249	was sporadically pr puzzle to look at or ball on one occasio 5:34pm, Staff C app client #6's left hand until 5:44pm. After 1 #6 continued to bite client displayed per no verbal praise or provided by staff. Interview on 1/13/23 sleeves are used for be worn for "10 - 15 Additional interview time and use of the behavior." Interview on 1/14/25 #6 has biting behav hand for "15 - 30 m The staff noted the address his behavior Review on 1/14/25 Intervention Plan (E objective to display behavior for fourtee review of the plan m 'actual or attempted typically involving h Further review of th reinforcements sho behaviors: "1. [Clien for complying with a defined targeted be receive verbal prais during his working h	esented with a picture or was assisted to hold a small on. On one occasion, at plied a protective sleeve to /wrist which remained in place removal of the sleeve, client a his left wrist. Although the iodic intervals of being calm, edible reinforcements were 5 with Staff C revelaed the or his biting behaviors and can 5 minute" increments. r indicated there was not set a sleeve is "based on his 5 with Staff B indicated client viors and uses a sleeve on his inutes" when biting occurs. y only use his sleeves to	W 2	249				

Facility ID: 922584

If continuation sheet Page 2 of 8

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES (X) PROVIDER DERSUPPLIER (X) PROVIDER DESUPPLIER (X)			AND HUMAN SERVICES					: 01/15/2025 APPROVED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING COMPLETED 34G040 B. WING C C NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2101 ROYALL AVE GOLDSBORO, NC 27534 (MAID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES RECOLATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION RECOLATORY OR LSC IDENTIFYING INFORMATION) PROVIDER OR SUPPLA COMPLETED COMPLETED W 249 Continued From page 2 appropriate social interaction with his peers. Verbal praise should be situation specific and may occasionally be paired with a small edible (low calorie edibles) such as '[Client #6], I like the way you are' No mention of self-injury should be made during this praise." W 249 Additional review of the BIP noted if self-injury cocurs, "Staff should prompt' [Client #6], I like the may occasionally be paired with [S], like the may occasionally be paired with [S], like the may should be made during this praise." W 249 Additional review of the BIP noted if self-injury cocurs, "Staff should prompt' [Client #6], nume himself" The plan indicated, "If [Client #6] attempts to bite his arms and cannot be redirected with immediate verbal and physical promptsProtective arm sleeves will be applied. These sleeves are to be worn over sixty consecutive minutes without being removed for at least ten minutes" W 252 W 252 PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) W 252 Data relative to accomplishment of the criteria specified in client individual program plan W 252	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	1			<u>ЭМВ NO</u>	. 0938-0391	
34G040 B. WING				` ´			COMPLETED		
2111 ROYALL AVE GOLDSBORO, NC 27534 Image: Colspan="2">Image: Colspan="2">2101 ROYALL AVE GOLDSBORO, NC 27534 Image: Colspan="2">Image: Colspan="2">PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY WILST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Image: Colspan="2">Image: Colspan="2">COMPLETION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE precedulation of the precedulation of the precedulat			34G040	B. WING	i				
SKILL CREATIONS GOLDSBORO, NC 27534 (P4) ID PREFIX TAG ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST REPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION WIST REPRECEDED 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) (w) DATE W 249 Continued From page 2 appropriate social interaction with his peers. Verbal praise should be situation specific and may occasionally be paired with a small edible (low calorie edibles) such as "Client #6], 1 like the way you are "Staff should prompt "[Client #6] verbally and with gestures to stop attempting to injure himseff." The plan indicated, "If [Client #6] attempts to bite his arms and cannot be redirected with immediate verbal and physical promptsProtective arm sleeves will be applied. These sleeves are to be worn own until [Client #6] displays ten consecutive minutes of calm (absence of all targeted behaviors). These sleeves are no to be worn own until (Client #6] displays ten consecutive minutes of calm (absence of all targeted behaviors). These sleeves are no to be worn own own with [Client #6] displays ten consecutive minutes of calm (absence of all targeted behaviors). These sleeves are no to be worn owner sixty consecutive minutes without being removed for at least ten minutes" W 252 W 252 PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) W 252 Data relative to accomplishment of the criteria specified in client individual program plan W 252	NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
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with the properties social interaction with his peers. Verbal praise should be situation specific and may occasionally be paired with a small edible (low calorie edibles) such as '[Client #6], 1 like the way you are' No mention of self-injury should be made during this praise." Additional review of the BIP noted if self-injury occurs, "Staff should prompt '[Client #6] verbally and with gestures to stop attempting to injure himself" The plan indicated, "If [Client #6] attempts to bite his arms and cannot be redirected with immediate verbal and physical promptsProtective arm sleeves will be applied. These sleeves are to be worn outril [Client #6] displays ten consecutive minutes of calm (absence of all targeted behaviors). These sleeves are not to be worn over sixty consecutive minutes without being removed for at least ten minutes" W 252 PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) W 252 Dract relative to accomplishment of the criteria specified in client individual program plan W 252	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC	D BE	COMPLETION	
This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure data relative to the accomplishment of identified objectives		appropriate social in Verbal praise shoul may occasionally be (low calorie edibles way you are	A metaction with his peers. d be situation specific and e paired with a small edible) such as '[Client #6], I like the ' No mention of self-injury ring this praise." f the BIP noted if self-injury d prompt '[Client #6] verbally o stop attempting to injure in indicated, "If [Client #6] arms and cannot be nediate verbal and physical e arm sleeves will be applied. to be worn until [Client #6] cutive minutes of calm eted behaviors). These be worn over sixty consecutive ng removed for at least ten 5 with the Director confirmed current and should be MENTATION (1) omplishment of the criteria adividual program plan documented in measurable s not met as evidenced by: tions, record review and y failed to ensure data relative			DEFICIENCY)			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/15/2025 APPROVED 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		` '			(X3) DATE COM	E SURVEY PLETED
		34G040	B. WING				C 14/2025
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
SKILL CI	REATIONS				2101 ROYALL AVE GOLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
W 252	affected 1 of 5 audit During evening obs 1/13/25 from 4:00pt consistently became teeth, screaming ar wrist. Various staff i behavior by calling to biting" or asking hin seeking a response was sporadically pro- puzzle to look at or ball on one occasio a protective sleeve which remained in p removal of the sleev his left wrist. During observations 7:49am - 8:33am, c was applied to his le self-injurious behav Interview on 1/13/28 sleeves are used fo be worn for "10 - 15 Additional interview time and use of the behavior." Additiona are documented ele	measurable terms. This t clients (#6). The finding is: ervations in the home on m - 6:13pm, client #6 e agitated by grinding his nd biting his left and/or right n the area addressed the the client's name, saying, "No n what's wrong (without esented with a picture or was assisted to hold a small n. At 5:34pm, Staff C applied to client #6's left hand/wrist blace until 5:44pm. After ve, client #6 continued to bite s in the home on 1/14/25 from lient #6's protective sleeve eft hand to address his iors. 5 with Staff C revelaed the r his biting behaviors and can 5 minute" increments. indicated there was not set sleeve is "based on his al interview noted behaviors	W 2	252			

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		AND HUMAN SERVICES			FORM	01/15/2025 APPROVED 0938-0391	
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			PLE CONSTRUCTION G	(X3) DATE COMI	(X3) DATE SURVEY COMPLETED	
		34G040	B. WING			C 14/2025	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
SKILL C	REATIONS			2101 ROYALL AVE GOLDSBORO, NC 27534			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
W 252	Review on 1/14/25 Intervention Plan (B objective to display behavior for fourteer review of the facility system revealed no 1/14/25 and no doc protective sleeve for review of the BIP no "Episodes of tantrue computer data system monthly basis" Interview on 1/14/29 Disabilities Professi #6's behaviors shou indicated. The QIDF protective sleeve sh electronically. NURSING SERVIC CFR(s): 483.460(c) Nursing services m other members of the appropriate protect measures that inclu- training clients and health and hygiene This STANDARD is Based on observat interviews, the facili sufficiently trained r health/safety measu administration proce use of latex gloves. clients (#7 and #8).	of client #6's Behavior BIP) dated 5/21/24 revealed an no episodes of self-injurious en calendar months. Additional d's electronic data collection of documented behaviors for umentation of the client's or 1/13/25 and 1/14/25. Further oted under data collection, ms will be recorded on the em and reviewed at least on a 5 with the Qualified Intellectual ional (QIDP) confirmed client uld be documented as P also noted use of the client's nould also be documented ES ((5)(i) ust include implementing with he interdisciplinary team, ive and preventive health ude, but are not limited to staff as needed in appropriate methods. s not met as evidenced by: tions, document review and ity failed to ensure staff were regarding preventative ures, medication edures, and the appropriate This affected 2 of 5 audit	W 253				

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		AND HUMAN SERVICES				FORM	01/15/2025 APPROVED 0938-0391	
STATEMENT	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G040	B. WING				C 14/2025	
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
SKILL C	REATIONS				101 ROYALL AVE GOLDSBORO, NC 27534			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 340	revealed client #7 h left foot. The invest osteoporosis and is other bone injuries. unknown. Additionan noted the Physical to assess client #7 be taken. Further re- including a PT note recommendations re- wheelchair seating/ transfer guidelines. will be in serviced of requested." Interviews on 1/13/2 Staff G and Staff H of client #7's fracture it happened. Staff H thought it may have she moves around bed at times. All of not received any re- safety needs since foot. Interview on 1/14/2 Intellectual Disabilit Vice President of O by the PT was sche month; however, as staff training had be #7's injury after the B. During observati 3:45pm, the Medica noted pouring a wh containing a bevera	age 5 had sustained a fracture to her igation indicated the client has a susceptible to fractures and The cause of the injury was al review of the investigation Therapist (PT) was contacted to determine further actions to eview of the investigation, a dated 1/8/25, revealed regarding client #7's /positioning, repositioning and The PT note indicated, "Staff on positioning and transfers as 25 and 1/14/25 with Staff F, revealed they were all aware red foot but were not sure how H and Staff G indicated they e occurred in her bed since a lot and lifts herself up in the the staff indicated they had training regarding client #7's she sustained the injury to her 5 with the Director, Qualified ties Professional (QIDP) and Operations indicated retraining eduled to occur later this s of the date of the survey, no een initiated regarding client investigation was completed.	W 3	340				

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		AND HUMAN SERVICES				FORM	01/15/2025 APPROVED 0938-0391	
STATEMENT	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· ·		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G040	B. WING				C 14/2025	
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
SKILL C	REATIONS				101 ROYALL AVE GOLDSBORO, NC 27534			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
W 340	revealed client #8 w The client began co moving around the wheelchair. After gi left the area. At 3:44 bottle to the floor wi of drink remaining. by a staff, placed in kitchen. Client #8 d beverage. Interview on 1/13/25 had been trained to medications after th Review on 1/14/25 & Procedure: Medic 10/20/22) revealed Administration Proc medication is given observed to assure swallowed" Interview on 1/14/25 MT's should ensure medication during t policy and procedur C. During observati from 12:40pm - 1:0 their meals while we spits a lot. Review on 1/14/25 Control policy (Revi	vas given Miralax in the bottle. onsuming the drink while living/dining room in her ving the bottle to client, the MT 9pm, client #8 dropped the ith approximately 3 - 4 ounces The bottle was then picked up a bin and taken into the id not finish consuming the 5 with the MT indicated she of the facility's Nursing Policy cation Administration (Revised: under Medication cedure, "The client's prepared to him/her and the client is that the medication has been 5 with the Director confirmed e client's have ingested their he med pass as per nursing res.	W	340				

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		AND HUMAN SERVICES					FORM	01/15/2025 APPROVED 0938-0391	
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:				E CONSTRUCTION		(X3) DATE SURVEY COMPLETED C		
		34G040	B. WING	;				_ 14/2025	
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, Z	ZIP CODE			
SKILL C	REATIONS				101 ROYALL AVE SOLDSBORO, NC 27534				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD THE APPROPF	BE	(X5) COMPLETION DATE	
W 340	prevent the spread infection." Additona indicate latex glove feeding clients. Interview on 1/14/2 latex gloves are no	nge 7 of organisms and potential il review of the policy did not is should be worn while 5 with the Director confirmed t required or necessary to be any clients in the home.	W	340					

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