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 _____	04/08/2025

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
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, documentation and interviews, the facility failed to ensure staff were sufficiently trained in the documentation of falls/seizures for 1 of 8 audit clients (#13). The finding is: During observations in the home on 4/7/25 at 4:08pm, client #13 fell during a seizure. Further observations revealed client #13 fell on her backside as soon as she dropped the bowling ball. Client #13 was helped off the floor by the Habilitation Specialist (HS) and Staff C and assisted to sit down in a chair in the day program. Review on 4/8/25 of the electronic documentation revealed staff did not document when client #13 fell during a seizure. During an interview on 4/8/25, the HS confirmed staff did not document when client #13 fell during a seizure.	W 189		
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		

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

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W 249	Continued From page 1 This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 1 of 8 audit clients (#8) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of medication administration. The finding is: During medication administration in the home on 4/8/25 at 8:21am, Staff A fed client #8 his medication in pudding. During meal time observations in the home, client #8 was observed feeding himself without any issues or spillage. During an interview on 4/8/25, Staff A stated that she was told client #8 is fed his pills during his medication administration. Review on 4/8/25 of client #8's IPP dated 10/28/24 revealed, "[Client #8] uses a spoon to eat his food". During an interview on 4/8/25, the HS confirmed client #8 can use a spoon to feed himself independently.	W 249		
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.	W 436		

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W 436	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure physical therapy recommendations were followed to replace a power wheelchair for 1 of 8 audit clients (#14). The finding is: Observations on 4/7/25 throughout 4/8/25, revealed client #15 in a power wheelchair, with a left side joystick to navigate the chair. Client #14 had a footrest and no trunk support devices to keep her sitting position upright, causing her to lean over the left side of the wheelchair. During dinner on 4/7/25 at 5:45pm, Staff C had to reposition client #14 upright during her meal several times. Record review on 4/8/25 of client #14's Physical Therapy Evaluation from 6/13/24 revealed her wheelchair showed "significant signs of wear and tear, has outgrown its useful life and unsafe to use...her wheelchair needs to be replaced to accommodate both her skeletal abnormalities and postural deviation, and prevent future development of pressure areas/skin breakdown, while providing her the necessary least restrictive mobility." There was no updated note from the physical therapist (PT) that the wheelchair for client #14 was successfully replaced. During an interview on 4/7/25 with client #14 revealed her stating she needed a new wheelchair but could not elaborate on the reasons. During an interview on 4/8/25 with the Quality Intellectual Disability Professional (QIDP) revealed she did not recall reading the recommendation of the PT and when he visited	W 436		

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W 436	Continued From page 3 their facility, he did not mention any follow-up requests for client #14's wheelchair. During an interview on 4/8/25 with the Executive Director, he reread the 6/13/24 PT recommendation for client #14 and acknowledged that they missed the recommendation.	W 436		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations, record review and interviews the facility failed to ensure proper infection control procedures were followed in order to promote client health/safety and prevent possible cross-contamination. This potentially affected clients 5 of 8 (#1, #6, #9, #14 and #15), The findings are: A. During afternoon observations in the home on 4/7/25 at 4:25pm, client #6 picked her nose five times. Further observations revealed client #6 touched the knob on the radio and then clients #2 and #9 also touched the same knob on the radio. At 5pm, Staff C touched the knob to the radio and turned it off. At no time were the clients or staff observed to wash their hands after touching the contaminated radio knob. Review on 4/8/25 of the facility's Infection Control policy dated 8/14/23 stated, "Standard precautions are defined as: a. Performing hand hygiene...Hand Hygiene: 1. Hand hygiene is the	W 454		

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W 454	Continued From page 4	W 454		

single most effective way to prevent the spread of organisms and potential infection. 2. The goal of hand hygiene is to eliminate or reduce carriage of pathogenic organisms and reduce the spread of infectious diseases by preventing client, staff, and environmental exposures...."

During an interview on 4/8/25, the Habilitation Specialist (HS) confirmed handwashing should have occurred after clients #2, #6, #9 and Staff C touched the knob on the radio.

B. During breakfast observations in the home on 4/8/25 at 8:35am, client #9 placed his stuffed toy on the dining room table while he was eating. Further observations revealed client #1 was also eating next to client #9. Both client #1 and #9 were observed touching the stuffed toy while they both were eating. Prior to being placed on the table, the stuffed toy was observed on the floor.

During an interview on 4/8/25, the HS stated client #9's stuffed toy should have been removed from the table.

C. During observations in the large dining room on 4/7/25 at 5:45pm, Staff C was observed to repeatedly repositioning client #14 from leaning on the left side of the wheelchair to an upright position, while she ate dinner. Staff C was also assisting client #15 to eat her meal and was observed to place long straws in the cup of client #15 plus wipe her mouth, after touching client #14; but not washing or sanitizing her hands, in between contact.

During an interview on 4/8/25 with the nurse revealed the best way to avoid cross contamination between clients is to "wash your

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W 454	Continued From page 5 hands, as the first line of defense." D. During observations in the large dining room on 4/8/25 at 8:40am, Staff D was observed checking the temperature of the oatmeal in the serving bowl before serving it to the clients #14 and #15 at table 1. Staff B became aware through Staff D that the food was hot and went to table 2 to check the food temps of the clients who had already began eating. Staff B took the probe of the thermometer and placed it in oatmeal on the plate while client #11 continued to eat. Staff B did not sanitize the probe and used it to test the temperature of the oatmeal in the plate of client #15 while she continued to eat. During an interview on 4/8/25 with the nurse revealed she was not responsible for training the staff on the infection control policy, however staff were aware of how to prevent cross-contamination.	W 454		