STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G056	A. BUILDING _____ B. WING _____	C 05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILL CREATIONS OF KENANSVILLE	200 SOUTH STOKES STREET KENANSVILLE, NC 28349

(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 for intakes #NC00229663 and #NC00230367 was conducted on May 15, 2025. The complaint was substantiated and deficiencies were cited.	W 000		
W 186	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide sufficient direct care staff to supervise and provide services to 15 of 15 clients (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, and #15). The findings are: A. Review on 5/15/25 of the Incident Response Improvement System Report (IRIS), dated 5/14/25, revealed an incident on 5/8/25 in which client #6 had exited the facility at 8:08pm through the back side of the facility by unhooking a chain on the fence. She then walked across the highway and down the street to Staff G's home. Staff G returned her to the facility in her car at 8:13pm. Review on 5/15/25 of the facility event report, dated 5/8/25, revealed Staff F reported client #6 walked out of the building at 8:04pm and returned at 8:15pm.	W 186		

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

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W 186	Continued From page 1 Review on 5/15/25 of the facility investigation, dated 5/9/25, revealed on 5/8/25 at 8:04pm, client #6 had left the facility to walk to Staff G's home during activity in the home to include an alarm reset and ongoing client behavior. Client #6 left out of the back gate area and returned to the home with Staff G at 8:12pm. The nurse completed a body check on client #6 and found no injuries. The investigation concluded that several events occurred in the home during the event to include medication administration while Staff I was monitoring the clients, Staff F was on lunch break, and Staff H was scheduled to leave at 8:00pm. The home staffing statement revealed "The shift was short staffed and did not manage time wisely". Prevention included a new gate latch. In addition, staff will be inserviced on arming the door alarm system and the system will be serviced by the alarm company to ensure it is working. Staff will also be inserviced on client #6's behavior guidelines after the core team meets. On 5/9/25, it was decided that no one staff was at fault for incident. Review on 5/15/25 of client #6's behavior intervention plan (BIP), dated 9/24/24, revealed target behaviors to include physical aggression, verbal aggression, self-injury, and elopement. Due to her history of elopement, steps will be taken to keep her environment safe. Review on 5/15/25 of client #6's individual program plan (IPP), dated 8/12/24, revealed she displays high frequencies of agitation and aggression. No supervision requirement or information on elopement was noted. Interview on 5/15/25 with Staff B revealed staffing was low at the time client #6 eloped on 5/8/25.	W 186		

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W 186	Continued From page 2 Interview on 5/15/25 with Staff E revealed client #6 had eloped to the nearby staff home. Because the facility had cut overtime for staff, it had lowered their numbers with staff on duty from six staff to four at times. Staff E stated staff were low when client #6 eloped and they did not realize she was gone. Interview on 5/15/25 with Staff H revealed staffing was very low on 5/8/25 when client #6 eloped and had dropped to four on duty. She felt low staffing and lack of bringing additional staff in for overtime until more staff are hired put them at risk. Interview on 5/15/25 with the director revealed staffing was low on 5/8/25 when client #6 eloped and they had not seen her leave the property. The director acknowledged this was a risk to client #6. While the facility had immediately amended the back gates where client #6 exited and had scheduled multiple additional trainings for staff to ensure safe supervision, continued staff shortages made it more difficult to safely supervise at times. B. During observation on 5/15/25 in the dayroom at 10:05am, there was one staff, Staff A, monitoring eight clients. Client #4 sat in his wheelchair with his hand behind him. At 10:10am, Client #6 ran to him and told him to take his hand from his pull-up. Client #4 then removed his hand and held it up to reveal a large amount of feces covering his hand. Client #6 then went to Staff A and told her client #4 had soil on his hand. Staff A remained seated with other clients. At 10:14am, the habilitation coordinator entered the dayroom. At 10:15am, the habilitation coordinator saw client #4's soiled hand and asked Staff A if he had soil	W 186		

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W 186	Continued From page 3	W 186		

on his hand. Staff A stated she had just changed him earlier. The habilitation coordinator called another staff to assist in changing client #4.

After returning to the dayroom at 10:38am, client #4 pulled his helmet off and threw it on the floor. Staff were not monitoring him and at an approximate five foot distance from him. At 10:40am, Staff A noticed his helmet was off and secured it to his head again.

Review on 5/15/25 of client #4's individual program plan (IPP), dated 9/16/25, revealed he requires total staff assistance to ensure his cleanliness and safety. He wears pull-ups due to incontinence of bowel and bladder function. In addition, he wears a helmet 24 hours per day for safety due to seizures. If he is ever out of the helmet, such as for showering, staff must remain within arms reach.

Interview on 5/15/25 with Staff B revealed staffing was low on this day and four staff were trying to cover the facility.

Interview on 5/15/25 with Staff E revealed client #4 wore pull-ups and needed help with toileting. In addition, he has seizures and needed to wear his helmet at all times unless in the shower or having specified time out with staff near. However, staffing was short on today.

Interview on 5/15/25 with Staff H revealed staffing was very low on this day and it was "a lot" to catch everything with high behaviors and needs.

Interview on 5/15/25 with the director revealed staffing was at minimum today with only four staff to cover the 15 clients. However, staff are

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W 186	Continued From page 4	W 186		

expected to ensure clients are changed and have their adaptive equipment monitored. Client #4 should have been changed promptly and monitored for wearing his helmet.

C. Observation on 5/15/25 revealed four staff to monitor 15 clients in the facility, with clients not attending the day program. In the dayroom from 10:00am - 10:40am, Staff A monitored eight clients. No activities and interaction were observed, except for the television being played. Clients were observed to sit or walk around the room with no direction. During this time, staff also attended to ongoing behavioral needs and personal care needs in the other areas of the home. At 1:50pm, staff continued to attend behavioral episodes with client #12 in the hallway and foyer area. Clients were observed in the dayroom area with the television on and no interaction or activies.

Interview on 5/15/25 with Staff B revealed client care and behavior management is a struggle with only four staff on duty. She attempts to help as much as possible, but when overtime was decreased, it stopped extra help to make six staff a possibility.

Interview on 5/15/25 with Staff E revealed the facility had cut overtime for staff and it had lowered their numbers with staff on duty from six to four at times. Personal care and behavioral needs are "a lot" when you need to do activities too and there are only four staff working. The home has high needs with the wheelchairs and behaviors also.

Interview on 5/15/25 with Staff H revealed the needs of the home are high with behaviors

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W 186	Continued From page 5 ongoing and having to change people. It is hard to do activities with only four people and do everything else for safety. Interview on 5/15/25 with the director revealed staffing had been an ongoing issue and had affected staff morale, as well as being able to monitor client care as closely while providing activities. When staffing is low during the week, such as at four only, the habilitation coordinator, office staff, and director may work on the floor to help cover. However, clients were not able to attend their day program today due to low staffing. The facility had cut back on offering overtime, which had ensured six staff were on duty. At this time, the facility has hired a professional staffing agency to assist in increasing numbers of new hires.	W 186		