STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G071	A. BUILDING _____ B. WING _____	C 06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKILL CREATIONS OF TARBORO	811 WESTERN BOULEVARD TARBORO, NC 27886

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W 000	INITIAL COMMENTS A complaint survey was completed on June 25, 2025 for Intakes #NC00231791, #NC00232011, #NC00232016 and #NC00232114. The complaint was substantiated and deficiencies cited.	W 000		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on document review and interviews, the facility failed to immediately notify the director, once discovering an injury of unknown origin. This affected 1 of 3 audit clients (#3). The finding is: Review on 6/25/25 of the facility's Incident Response Improvement System (IRIS) report filed on 6/23/25 revealed on 6/22/25 at 8:00am, Staff A reported to the Nurse that client #3 had a swollen face, a cut in her mouth and numerous bruises. Review on 6/25/25 of the Nurse's Note on 6/22/25 at 9:40pm revealed she was contacted by Staff A about client #3 having a swollen left side of her face. The nurse revealed she assessed the situation via video and pictures and also noted there was swelling on the right side of the face along with a cut in the inside of the mouth. The nurse acknowledged she notified the primary care provider but did not notify the director.	W 153		

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

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W 153	Continued From page 1 Review on 6/25/25 of the facility's policy of "Abuse/Neglect, Exploitation and Mistreatment" revealed: Upon knowledge of an incident involving client abuse/neglect/mistreatment (or allegation of such), or an injury of unknown cause, the administrator or designee shall immediately begin a preliminary inquiry. Interview on 6/23/25 with the Habilitation Coordinator (HC) revealed she did not learn of the new injuries of client #3 until 6/23/25, when Staff G showed her pictures of client #3's face. The HC revealed Staff A was on-call the weekend of the incident and staff were trained to immediately notify the director in the event of injuries. The HC further revealed that Staff D witnessed the incident of Staff E pushing and striking client #3 on 6/21/25 and did not report the incident to management. Interview on 6/25/25 with the Director revealed that staff have received training on their abuse policy and were expected to immediately notify the Director of any concerns of abuse or injury of unknown origin. The Director confirmed she did not learn of the new injuries until Staff G informed her on 6/23/25. The Director revealed Staff D and Staff E were suspended on 6/23/25 after the incident was reported and an investigation was launched. The Director confirmed Staff D and Staff E were no longer employees of the facility.	W 153		
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.	W 186		

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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:

Observation on 6/25/25 in the home at 11:18am revealed Staff B leading the read aloud activity in the large dayroom seating area with clients #4, #8, and #13. Clients #7 and #14 sat across the room. No other staff was present. At 11:20am, Staff A opened the door and stated that she would be back after she assisted client #1 bathe due to a toileting accident. Staff B continued to be the only staff in the dayroom. At 11:35am, a second staff was observed to join Staff B in the large dayroom to prepare for lunch. Staff B did not stay within arm's reach of client #4 due to assisting other clients prepare the table for lunch.

Additional observations at 11:25am in the small dayroom revealed one staff at the table completing a community service activity with clients #2, #3, #6, #9, #10, and #12. Three clients were in wheelchairs, and client #3 repeatedly attempted to leave the room with the staff pausing the read aloud to prompt her. A second staff walked in and out of the dayroom attending to other duties.

Review on 6/25/25 of staff schedules, dated 4/1/25 - 6/30/25 revealed six staff assigned for 1st and 2nd shift in April, May, and June. Two to

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Three staff were assigned to 3rd shift, with only two 3rd shift staff on every weekend.

Review on 6/25/25 of staff assignment sheets from 4/1/25 - 6/30/25 revealed actually five working staff during this time on 1st and 2nd shift for some days, and only two staff worked in 59 out of 70 nights.

Interview on 6/25/25 with Staff A revealed the facility has five staff on duty today, with one staff providing 1:1 coverage. The facility never has less than five staff on 1st and 2nd, but does have only two staff from 9:00 pm to 11:45 pm. In addition, it is usually only two staff that works on 3rd shift. The facility should not ever have less than three staff on duty during these times because two staff would not be able to provide safe supervision in case of a fire, severe behavior, or elopement. One person has to always be in the hallway to provide visual supervision. A staff member must be able to see client #4 at all times, even at night. During activity time, coverage is supposed to be at least two staff in the large dayroom because client #4 has 1:1 supervision. That person cannot cover other clients. It is best if there are three staff in the large dayroom because two staff can tend to the other clients, and client #13 is visual at all times. The coverage in the small dayroom is three staff due to three clients in wheelchairs and client #3 needing constant redirection due to behavior.

Interview on 6/25/25 with Staff B revealed client #13 must be watched because he is busy and can "get into something; he is not a 1:1, but he has to be in sight". Client #4 receives 1:1 supervision for his safety. His 1:1 supervision means "to be within arm's reach at all times".

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Staff B confirmed he was client #4's assigned 1:1 staff for the day.

Interview on 6/25/25 with Staff C revealed she has no issue with staffing. If there are only five scheduled on duty or a call-in occurs, they will contact the "on-call" staff for coverage. Sometimes, the administrative staff will cover if needed. Third shift can be run with two staff because the clients are "mostly asleep". If there is a toileting accident or behavior, one staff stays in the hall and the other staff attends to the client. When asked what happens if a toileting and behavior happen at the same time, Staff C stated they could call an on-call staff. If there is an elopement, the alarm will sound, and the fence stops anyone trying to leave the grounds. If there is a fire on 3rd shift, beds can be rolled out for those in wheelchairs, and staff are trained to use bed sheets to drag clients out if necessary.

Interview on 6/25/25 with the Habilitation Coordinator (HC) revealed three clients in the home are in wheelchairs and one client receives 1:1 supervision for their safety. There are always five to six staff scheduled for 1st and 2nd shifts. One staff is assigned to a 1:1 client and five to care for the other 15 clients. On 3rd shift, "We have either two or three scheduled. We do not have any 1:1 clients while asleep, but we do have a client that receives visual supervision at all times". When asked if client #4 would be 1:1 if awaken during either a fire drill or real fire, the Habilitation Coordinator confirmed that he would then become 1:1, leaving only one staff to exit the remaining 14 clients in an emergency when two staff only are scheduled.

Additional interview with the HC revealed there

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W 186	Continued From page 5 should be three staff in each activity room. This ensures activities take place and personal care is attended to. In the large dayroom, there should be one staff to be 1:1 with client #4 and two staff to attend to the other clients. Supervision for client #13 is visual at all times. Interview on 6/25/25 with the Director revealed there should never be one staff in the room with client #4 and four additional clients because he is 1:1 in supervision. In addition, there should be adequate staffing in the dayrooms for activities and care. The Director acknowledged that supervision for client #4 was not met with only one staff in the dayroom.	W 186		
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 document review and interviews, the nurse failed to provide nursing services to 1 of 3 audit clients (#3) after new injuries were reported. The finding is: Review on 6/25/25 of the facility's Incident Response Improvement System (IRIS) reports revealed on 6/20/25 during 2nd shift, client #3 fell backwards during a behavior and caused a laceration to the back of her head. Client #3 was sent to the emergency room to receive stitches. On 6/22/25 at 8:00am, Staff A discovered client #3 with injuries to her face, including a swelling, a cut in her mouth and numerous bruises. Review on 6/25/25 of the Nurse's Note on 6/22/25 at 9:40pm revealed she was contacted by Staff A	W 331		

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and received photos of client #3's injuries through her cellular phone. The nurse documented Staff A told the nurse that she did not know how the injuries occurred. The nurse's note revealed she viewed client #3's injuries based on a video and pictures she received from Staff A and noticed there was swelling on the right side of the face along with a cut in the inside of the mouth. The nurse's note revealed she contacted staff on 2nd shift and they informed her that a fall occurred on 6/21/25 during a behavioral incident, which may have resulted in the mouth injury. The nurse's note also revealed she instructed staff to apply ice and to rinse client #3's mouth with warm water. An additional nurse's note time stamped, 6/24/25 at 10:51am, revealed the previous day, 6/23/25, staff informed her that client #3's swelling had significantly increased overnight (6/22/25) and a decision was made to send her to the emergency room. The nurse's note also revealed she learned from management that camera footage from the weekend revealed potential abuse by 2nd shift staff on 6/21/25.

Interview on 6/25/25 with the Habilitation Coordinator (HC) acknowledged she did not have any nurse's notes that neurological checks were performed after the nurse was notified client #3 had two head injuries over the weekend. The HC confirmed the nurse did not visit the client after either incident to do an exam.

Interview on 6/25/25 with the Director revealed the nurse should have notified her of client #3's injuries. The Director acknowledged the nurse should have examined the client as part of her nursing assessment, instead of making the assumption that the injuries were related to the fall on 6/20/25 from staff interviews.

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