Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	11/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 11/18/2014 through 11/20/2014.	D 000		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on interview, and record review, the facility failed to assure 4 of 5 medication aides sampled (Staff A, D, G, and H) received training by a licensed health professional on the care of diabetic residents prior to administering insulin to residents. The findings are:	D 164		

Approved Jane Goodell 12/23/14

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D 164	Continued From page 1 1. Review of Staff A's personnel record revealed: -She was hired as a Nursing Assistant (NA) on 12/14/2012. -She completed her medication clinical skills validation on 04/07/2014. -She passed the Medication Aide exam on 06/12/2014. -No documentation of the 5 hour/10 hour or 15 hour state medication training. -No documentation of diabetes training. Interview with Staff A on 11/20/2014 at 09:30 a.m. revealed: -She could not remember if she had any specific or detailed training on diabetes. -She was a medication aide on the Special Care Unit on the first shift from 07:00 a.m. - 03:00 p.m. -She administered insulin to diabetic residents. Review of the facility's medication administration records (MAR) revealed Staff A administered insulin in September, October, and November 2014. Refer to interview with the Special Care Unit Coordinator on 11/19/14 at 02:00 p.m. Refer to interview with the Administrator on 11/19/14 at 02:30 p.m. Refer to interview with the Owner on 11/20/14 at 04:00 p.m. 2. Review of Staff D's personnel record revealed: -She was hired as a medication aide on 04/28/2014. -She completed her medication clinical skills validation on 05/05/2014. -She passed the Medication Aide exam on	D 164	Diabetic training was taught by our RN with Southern Pharmacy for all Med Techs. All topics related to care of diabetic residents were covered with certificates issued. Training for diabetic care will be included as part of the 5 hour training and Infection Control Course prior to med techs administering medications or insulin as per regulation. Administrator, RCC, SCUC and/or designee will monitor to ensure compliance. Completion date of 1/16/2015	

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D 164	Continued From page 2 07/24/2000. -No documentation of diabetes training. Interview with Staff D on 11/20/2014 at 10:00 a.m. revealed: -She did not recall having a specific or detailed training on diabetes. -She checked her training records she kept in her car and did not have a training certificate for diabetes. -She was a medication aide on the Assisted Living Unit on first shift from 07:00 a.m. - 03:00 p.m. -She administered insulin to diabetic residents. Review of the facility's medication administration records (MAR) revealed Staff D administered insulin in November 2014. Refer to interview with the Resident Care Coordinator for the Assisted Living Unit on 11/20/2014 at 11:30 a.m. Refer to interview with the Administrator on 11/19/14 at 02:30 p.m. Refer to interview with the Owner on 11/20/14 at 04:00 p.m. 3. Review of Staff G's personnel record revealed: -She was hired as a medication aide on 02/06/2013. -She completed her medication clinical skills validation on 02/26/2013. -She passed the Medication Aide exam on 08/10/2011. -No documentation of diabetes training. Staff G was not available for interview.	D 164		

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D 164	Continued From page 3 Review of the facility's medication administration records (MAR) revealed Staff A administered insulin in September, October, and November 2014. Refer to interview with the Special Care Unit Coordinator on 11/19/14 at 02:00 p.m. Refer to interview with the Resident Care Coordinator for the Assisted Living Unit on 11/20/2014 at 11:30 a.m. Refer to interview with the Administrator on 11/19/14 at 02:30 p.m. Refer to interview with the Owner on 11/20/14 at 04:00 p.m. 4. Review of Staff H's personnel record revealed: -She was hired as a medication aide on 09/24/2013. -There was no documentation she completed her medication clinical skills validation. -She passed the Medication Aide exam on 12/04/2011. -No documentation of diabetes training. Interview with Staff H on 11/20/2014 at 05:00 p.m. revealed: -She had training on diabetes in the past but was unsure of when and where it was. -She had been checked off on a clinical skills checklist by a registered nurse including finger stick blood sugars and on insulin administration which should be in her personnel file. -She had been a medication aide on the Special Care Unit and the Assist Living unit on first and second shift (07:00 a.m. - 03:00 p.m. and 03:00 p.m. - 11:00 p.m.). -She administered insulin to diabetic residents.	D 164		

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D 164	Continued From page 4 Review of the facility's medication administration records (MAR) revealed Staff H administered insulin in September, October, and November 2014. Refer to interview with the Special Care Unit Coordinator on 11/19/14 at 02:00 p.m. Refer to interview with the Resident Care Coordinator for the Assisted Living Unit on 11/20/2014 at 11:30 a.m. Refer to interview with the Administrator on 11/19/14 at 02:30 p.m. Refer to interview with the Owner on 11/20/14 at 04:00 p.m. --- Interview with the Special Care Unit Coordinator on 11/19/2014 at 02:00 p.m. revealed: -The last training on diabetes for the medication aides took place in June 2014. -The pharmacist was scheduled to come 12/01/2014 to do another training on diabetes for the medication aides. -She had no documentation Staff A, G, and H had training on diabetes. -She was unaware this was required before a medication aide could administer insulin. Interview with the Resident Care Coordinator for the Assisted Living Unit on 11/20/2014 at 11:30 a.m. revealed all training documentation for staff was in their personnel files. Interview with the Administrator on 11/19/2014 at 02:30 p.m. revealed: -The Unit Coordinators for the Special Care Unit	D 164		

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D 164	Continued From page 5 and the Assisted Living were responsible for overseeing clinical training requirements were met for the staff on each unit. -He was hired as the Administrator in April 2014 and was still learning about state regulations for assisted living facilities. -He was not aware the facility was not meeting the diabetes training requirement for all their new medication aides. -He was planning on making changes to their current monitoring system to assure new and existing staff met clinical training requirements. Interview with the Owner on 11/20/2014 at 04:00 p.m. revealed: -The Unit Coordinators for the Special Care Unit and the Assisted Living were responsible for overseeing clinical training requirements were met for the staff on each unit. -The Unit Coordinators provided the Business office manager with the personnel files when they were complete and she double checked them to make sure there was nothing missing. -Changes were going to be made to improve this process to assure all personnel requirements were met.	D 164		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting	D 234	Administrator, RCC or SCUC will ensure all new residents have at least a 1st step TB skin test prior to admission. RN will administer the 2nd step after admission. Copies of each step will be kept in resident chart as well as Administrators office. Resident found to have missing skin test has been updated with skin tests or x-ray on 11/19/2014.	

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D 234	Continued From page 6 the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 3 of 7 residents (#2, #4, #6) residing in the facility were tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: 1. Review of Resident #6's current FL-2 dated 09/02/14 revealed diagnoses included dementia (presumed Alzheimer's), benign prostatic hypertrophy, and allergic rhinitis. Review of Resident #6's Resident Register revealed an admission date of 09/02/14. Review of Resident #6's record revealed no documentation of any tuberculosis (TB) skin test. Interview with the Resident Care Coordinator (RCC) on 11/19/14 at 3:00 p.m. revealed: - Residents were supposed to have at least one TB skin test when they were admitted to the facility. - She would then have the facility's licensed health professional support (LHPS) nurse to place a second step once the residents were admitted. - Resident #6 did not have any TB skin tests when he was admitted on 09/02/14. - She thought the LHPS nurse had placed a first step TB skin test on Resident #6 shortly after he was admitted but she could not find the documentation. - Once the TB skin tests are placed, LHPS nurse gives the paperwork to the Special Care	D 234		

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D 234	Continued From page 7 Unit Coordinator (SCUC) who has a home health nurse to read the TB skin tests. Interview with the Special Care Unit Coordinator (SCUC) on 11/19/14 at 3:40 p.m. revealed: - Residents usually have one step TB skin test upon admission. - The facility's LHPS nurse usually places a second step TB skin test when a resident is admitted and gives the SCUC the paperwork. - SCUC gets any nurse from a local home health agency that services the facility to read the TB skin tests when they are there for facility visits. - Home health nurse will document on the paperwork and SCUC will forward the completed TB test paperwork to the RCC for residents living on the assisted living side of the facility. - SCUC did not recall if she had received any TB test paperwork for Resident #6 because she focused more on the paperwork for the residents who resided in the special care unit. Telephone interview with the facility's LHPS nurse on 11/19/14 at 3:42 p.m. revealed: - She remembered placing one TB skin test for Resident #6 shortly after he was admitted. - She would have given the paperwork to the SCUC. - She does not usually read the TB skin tests so she did not know if the TB skin test she placed on Resident #6 had been read. - She had not placed any other TB skin tests on Resident #6. - She usually placed a second step TB skin test because residents were already supposed to have one step upon admission. Interview with the facility's LHPS nurse at the facility on 11/20/14 revealed: - She placed a TB skin test on Resident #6	D 234		

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D 234	Continued From page 8	D 234		

today.
- Facility was aware and the facility will be responsible to have the TB skin test read by a nurse over the weekend.

2. Review of Resident #2's current FL-2 dated 08/27/2014 revealed:
-Diagnoses included: Alzheimer's Dementia, Seizures, Hypoglycemia, Hypertension, Diabetes Mellitus, History of Mood Disorder, and Leukocytosis.

Review of Resident #2's Resident Registry revealed he was admitted 07/31/2013.

Review of Resident #2's record revealed:
-Step 1 tuberculosis test done on 07/18/2013 and read as negative on 07/20/2013.
-No documentation of a Step 2 tuberculosis test.

Interview with the Special Care Unit Coordinator on 11/20/2014 at 11:00 a.m. revealed:
-She had contacted Resident #2's primary care physician's office on 11/19/2014 to see if there was a record of a second tuberculosis test at their office and she had not heard back yet.
-She had made arrangements for a tuberculosis test to be placed by the licensed health professional nurse at the facility on 11/24/2014.
-She would have a second tuberculosis test placed in 2 weeks if there was not a second step tuberculosis test on file at Resident #2's primary care physician's office.

3. Review of Resident #4's current FL-2 dated 01/16/14 revealed:
-Diagnoses of Sigmoid Volvulus, Benign Prostatic Hyperplasia, Chronic Obstructive Pulmonary Disease, Hypertension, Atrial

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D 234	Continued From page 9 Fibrillation, Diabetes Mellitus Type II, Vision and Hearing impairment, Hypothyroidism, Do Not Resuscitate, History Positive Purified Protein Derivative (PPD). Review of Resident #4's Resident Registry revealed he was admitted on 05/12/1987. Review of Resident #4's records revealed: -A positive PPD dated 09-17-1998. -There was no documentation concerning follow-up of a positive TB skin test in 1998. -A negative Yearly Record Tuberculosis Screening dated 02-10-2014. -An x-ray which was performed on 11-19-2014 after the concern was brought to the facility's attention by the surveyor with negative results for active tuberculosis disease. Interview with Resident Care Coordinator for Assisted Living on 11-18-2014 at 04:30 P.M. revealed: -She was not aware that Resident #4 had a history of positive PPD. -She did not know why he had not received a PPD test upon admission in 1987. -She was not aware that there needed to be a follow-up chest x-ray after a positive PPD test. -Will make sure that Resident #4 received a chest x-ray tomorrow. Based on attempted interview with Resident #4 on 11-19-2014 at 11:45 A.M. Resident #4 was not interviewable. Attempts were made to speak with Resident #4's guardian with no success.	D 234		

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D 273	Continued From page 10	D 273		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure referral and follow-up to meet the routine and acute health care needs for 1 of 3 residents (#8) sampled receiving blood thinning medicatin who did not have labwork as ordered to monitor the effectiveness of the blood thinner. The findings are: Review of Resident #8's record revealed: - Diagnoses on the current FL-2 dated 05/13/14 included aortic stenosis, diabetes mellitus, hypertension, anemia, asthma, chronic obstructive pulmonary disease, and osteoarthritis. - Hospital discharge record dated 06/13/09 noting the resident had a history of pulmonary embolism (blood clot in lungs) and was receiving Coumadin (a blood thinner). Review of Resident #8's record revealed: - Order dated 09/09/14 to keep current Coumadin dose at 7.5mg Monday through Saturday and 7mg on Sunday based on an INR of 2.1 (within therapeutic range). [INR is a lab value used to monitor Coumadin therapy. The INR is generally recommended to be 2.0 - 3.0 for most clinical situations or as specified by the physician.] - Order dated 09/09/14 to have INR rechecked in 1 week.	D 273		

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D 273	Continued From page 11 Review of Resident #8's record revealed: - No documentation of an INR one week later on 09/16/14. - Next documented INR was a progress note by the home health nurse (HHN) indicating the INR was 2.1 (within therapeutic range) on 09/23/14. - HHN nurse documented he reported it to the Nurse Practitioner and there were no changes in the order and INR was to be rechecked in 2 weeks. Review of Resident #8's record revealed: - Order dated 10/07/14 to keep current dose of Coumadin at 7.5mg Monday through Saturday and 7mg on Sunday based on an INR of 2.4 (within therapeutic range) and recheck in 2 weeks. - No documentation of an INR being done since 10/07/14. Interview with the Resident Care Coordinator (RCC) on 11/18/14 at 5:34 p.m. revealed: - She was unaware the INRs due on 09/16/14 and 10/21/14 were not in the resident's record. - HHN usually came to the facility to draw the INRs for Resident #8. - She could not find documentation of the INRs but she would contact the home health agency. Interviews with the RCC on 11/19/14 at 12:30 p.m. revealed: - She contacted the home health agency and the INRs for 09/16/14 and 10/21/14 were not done. - She was unsure why the INRs were not done. Telephone interview with the home health nurse (HHN) on 11/19/14 at 1:47 p.m. revealed: - Order dated 10/07/14 for Resident #8's INR to be rechecked in 2 weeks somehow got lost in the	D 273	RCC, SCUC or designee will review resident charts weekly that have INR's to ensure they are current. The home health nurse will update the RCC, SCUC or designee to ensure the INR information is accurate and up to date. INR form has been implemented for completion in resident charts. RCC, SCUC has set electronic reminders to inform them of dates and residents in need of labs. Completion date of 1/16/2015	

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computer system.
- He did not know why the orders did not show up on the system because he would have entered them at the time of his visit on 10/07/14.
- He was currently working on setting up a time to recheck Resident #8's INR.
- He was unsure if the INR was checked on 09/16/14.
- He would check his records and call back with information for the INR due on 09/16/14.

Interview with the RCC on 11/19/14 at 3:20 p.m. revealed:
- The facility has a Coumadin tracking worksheet they keep in each resident record for any residents who receive Coumadin.
- RCC has not been using the Coumadin worksheet and she has not been tracking the labs.
- She gave no explanation for not using the worksheet to track the Coumadin labs.
- RCC relies on the home health nurse (HHN) to draw the labs when needed.
- She does not utilize a system to make sure the labs are drawn as ordered.
- HHN usually contacts the prescribing practitioner when labs are drawn to get verbal orders.
- RCC will fax any orders to the pharmacy and the prescribing practitioner to get countersigned.

Review of the Coumadin worksheet in Resident #8's record revealed it was blank with no documentation of any INRs.

Interview with the HHN on 11/20/14 at 11:10 a.m. revealed:
- He was at the facility to recheck Resident #8's INR.
- He just started working as HHN at this facility

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D 273	Continued From page 13 on 09/23/14. - INR due on 09/16/14 must have been overlooked when the home health agency transitioned and changed nurses in 09/2014. - He had recertified Resident #8 in his computer system on 10/07/14 and entered the order dated 10/07/14 but for some reason the order did not flag in the system and did not generate to show an INR was due. - He has spoken to the Nurse Practitioner and he will recheck the INR today and notify the Nurse Practitioner. Interview with Resident #8 on 11/20/14 at 11:57 a.m. revealed: - Home health nurse (HHN) usually checked her INR every 1 to 2 weeks. - HHN just checked it today on 11/20/14. - Prior to today, they had not checked it in a while and she did not know why. - She denied any current symptoms of unusual bleeding/bruising or symptoms of blood clots. Telephone interview with Resident #8's Nurse Practitioner (NP) on 11/20/14 at 3:04 p.m. revealed: - She received a call on the previous day, 11/19/14, from the home health nurse (HHN) who notified her that Resident #8 had somehow been dropped from their system and the INR had not been drawn as ordered. - HHN usually calls the NP when labs are drawn and NP gives the HHN verbal orders for any dose changes and instructions on when to redraw the INR. - She was unaware of the missed INR on 09/16/14. - NP stated the HHN would be checking Resident #8's INR today on 11/20/14.	D 273		

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D 273	Continued From page 14 Review of the home health INR results form dated 11/20/14 revealed: - Resident #8's INR was 1.9 (below therapeutic range) on 11/20/14. - Verbal order from Nurse Practitioner to keep the Coumadin dose the same and recheck in 2 weeks.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 2 of 12 residents (#2, #9) observed during the medication pass which included errors with the administration of insulin for both residents. The findings are: The medication error rate was 7% as evidenced by the observation of 2 errors out of 27 opportunities during the 5:00 p.m. medication pass on 11/18/14 and the 9:00 a.m. / 11:00 a.m. - 12:00 noon medication passes on 11/19/14. 1. Review of Resident #9's record revealed: - Current FL-2 dated 03/10/14 included diagnosiss of diabetes mellitus.	D 358		

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D 358	Continued From page 15 - Physician's order dated 01/22/14 for fingerstick blood sugars (FSBS) to be checked with meals and administer Apidra according to the following scale: <200 = 0 units; 200 - 250 = 5 units; and >250 = 10 units. (Apidra is rapid-acting insulin used to lower blood sugar. The manufacturer recommends Apidra should be taken within 15 minutes before or within 20 minutes after starting a meal.) [According to the Apidra manufacturer, a safety test should be performed before every injection of the Apidra insulin pen. A dose of 2 units should be dialed up and the injection button pressed until the dose window shows a "0". This removes air bubbles and ensures the pen and needle are working properly. (Air bubbles displace the amount of insulin in the syringe and prevents the full dose from being administered.) The safety test should always be performed before each injection.] Observation during the 5:00 p.m. medication pass on 11/18/14 revealed: - Medication aide checked Resident #9's blood sugar at 4:07 p.m. and it was 236. - Medication aide stated she would give the resident insulin at 4:30 p.m. when it got closer to suppertime which was 5:00 p.m. - Medication aide dialed the Apidra pen to 5 units and injected the insulin into Resident #9 at 4:33 p.m. - Medication aide did not perform a safety test prior to dialing the 5 units and administering the insulin. - Resident #9 was not served supper meal until 5:23 p.m., 50 minutes after receiving Apidra, a rapid-acting insulin. Interview with Resident #9 on 11/18/14 at 5:12	D 358	Diabetic training was taught for all med techs by Southern Pharmacy RN on 11/19/2014. Training included proper times and techniques for checking diabetic residents prior to their meals. Training also covered proper priming of pens from different manufacturers to ensure the accurate dosage of insulin is given to each resident. As indicated earlier, diabetic training will be held prior to med techs administering insulin or medication per regulations.	

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p.m. revealed:
- Resident #9 was sitting in dining room waiting to be served supper.
- Sometimes she got her insulin 30 minutes or longer before she received her meals.
- She can tell when her blood sugar gets below 70 because she gets a hot feeling.
- She was not currently experiencing any symptoms of low blood sugar.

Interview with the medication aide on 11/18/14 at 5:25 p.m. revealed:
- She usually checked blood sugars around 4:00 p.m. when she started her 5:00 p.m. medication pass to save time.
- She would then go back and give any insulin around 4:30 p.m. since supper was served around 5:00 p.m.
- Staff started serving supper at 5:00 p.m. in the special care unit and then the small dining room in the assisted living side of the facility.
- The large dining room in the assisted living side of the facility, where Resident #9 eats, was the last to be served supper so it would usually be after 5:00 p.m. when they received their meal.
- She was unaware of the need to perform a safety test with the Apidra insulin pen.
- She did not know what a safety test was or how to perform it.

Interview with the Resident Care Coordinator (RCC) on 11/18/14 at 5:34 p.m. revealed:
- Staff should be trained to prime the insulin pens before each use with the safety test.
- They have been trained to her knowledge and should know to dial to 2 units before each use to do a safety test.
- Staff are supposed to check the blood sugars and administered the insulin at the same time.
- Orders for blood sugars and insulin pop up on

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the electronic MARs at 4:00 p.m. but staff usually wait until around 4:30 p.m. or just before the residents eat to give the insulin.
- Facility's policy is to give rapid-acting insulin about 15 minutes before the resident eats.
- RCC stated they would retrain the medication aides and adjust the times on the MARs to correspond better with meal times.

Review of the November 2014 medication administration records (MARs) revealed Resident #9's blood sugar ranged from 75 - 272 from 11/01/14 - 11/18/14.

Attempt to contact Resident #9's primary care physician was unsuccessful.

2. Review of Resident #2's current FL-2 dated 08/27/14 revealed:
- Diagnoses included diabetes mellitus, hypoglycemia, and Alzheimer's dementia.
- Order for fingerstick blood sugars (FSBS) to be checked before meals and at bedtime and administer Novolog sliding scale insulin according to the following: 0 - 200 = 0 units; 201 - 300 = 5 units; 301 - 400 = 10 units; 401 - 500 = 15 units; and >500 = 20 units and call physician. (Novolog is rapid-acting insulin used to lower blood sugar.)

[According to the Novolog manufacturer, Novolog pen should be primed using an air shot before each injection. Perform the air shot before each injection by turning the dose selector to 2 units. Hold the pen with the needle pointing up and tap cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Press the injection button all the way in until dose selector returns to "0". A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure. (This

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D 358	Continued From page 18 removes air bubbles and ensures the pen and needle are working properly. Air bubbles displace the amount of insulin in the syringe and prevents the full dose from being administered.)] Observation during the 11:30 a.m. medication pass on 11/19/14 in the special care unit revealed: - Medication aide checked Resident #2's blood sugar at 11:59 a.m. and it was 260. - Medication aide placed a new needle on the Novolog insulin pen and dialed to 2 units and aimed the pen down toward the trash can and pressed the injection button until it dialed to zero. - Medication aide then removed the primed needle and put a new needle on the pen. - She then dialed to 5 units and injected the insulin into Resident #2 at 12:02 p.m. - Medication aide did not prime the second needle she placed on the pen by performing the 2 unit air shot. Interview with the medication aide on 11/19/14 at 12:10 p.m. revealed: - She was aware an air shot was required prior to each injection with the Novolog insulin pen. - She thought she had to change the needle after the air shot was done because she could hear the pen click. - She thought the clicking sound meant she could not dial up another dose without changing the needle. Interview with the Special Care Unit Coordinator (SCUC) on 11/19/14 at 3:05 p.m. revealed: - Staff are supposed to prime the insulin pens before each use with the 2 unit air shot. - They are supposed to dial to 2 units then press button until it gets back to zero and then they dial up amount to give to resident using the same	D 358		

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D 358	Continued From page 19 needle. - They are not supposed to change the needle after priming. - She thought in the past they may have had some pens that would not dial up once they clicked so staff may have been thinking about some old pens they had a long time ago. - She will retrain staff to make sure they know how to do the air shot to prime the pens. Based on observation, interview and record review, Resident #2 was not interviewable due to diagnoses of dementia. Review of the November 2014 medication administration records (MARs) revealed Resident #2's blood sugar ranged from 72 - HI (>600 according to the glucometer manufacturer) from 11/01/14 - 11/19/14.	D 358		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the	D 468		

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D 468	Continued From page 20 special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on record review and interview the facility failed to assure 2 of 6 staff sampled working on the Special Care Unit (Staff C and G) completed 6 hours of orientation on the nature and needs of those residents within the first week of employment, and 6 of 6 staff sampled (Staff A, C, E, F, G, and H) received 20 hours of additional training specific to the population being served. The findings are: 1. Review of Staff A's personnel record revealed: -She was hired as a Nursing Assistant (NA) on 12/14/2012. -Documentation she had completed the 6 hour training on the nature and needs of the residents with Dementia on 12/14/2012. -No documentation of 20 hours of training specific to caring for residents with Dementia. Interview with Staff A on 11/20/2014 at 09:30 a.m. revealed: -She was a medication aide on the Special Care	D 468	Twenty hour SCU training for all Special Care Unit staff has been held per state regulations. Additional 20 hour training has been scheduled to include all staff eligible to work in SCU. New hires will receive the 20 hour training as specified in state regulations. Administrator, RCC and/or SCUC will monitor for compliance. Completion date for SCU staff was 12/16/14	

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D 468	Continued From page 21 Unit on the first shift from 07:00 a.m. - 03:00 p.m. -Ahe did not recall 20 hours of additional training in her first 6 months of employment related to caring for the resident with Dementia. Refer to interview with the Special Care Unit Coordinator on 11/19/14 at 02:00 p.m. Refer to interview with the Administrator on 11/19/14 at 02:30 p.m. Refer to interview with the Owner on 11/20/14 at 04:00 p.m. 2. Review of Staff C's personnel record revealed: -She was hired as a Personal Care Aide on 02/09/2012. -No documentation of completing 6 hours of orientation on the nature and needs of the residents with Dementia or 20 hours of additional training within the first 6 months of employment. -1 hour CEU training certificates related to the nature and needs of residents with Dementia were received on 10/02/2014, 10/31/2012, 01/30/2013, 07/06/2013, 07/16/2013, and 08/20/2013. Interview with Staff C on 11/19/2014 at 02:45 p.m. revealed: -She worked as a medication aide on the Special Care Unit first shift from 07:00 - 03:00 p.m. -She tries to attend all the classes offered at the facility and has attended classes on caring for the resident with Dementia. -She was familiar with the videos used to orient staff to the Special Care Unit population. -She did not recall if she had 20 hours of additional training within the first 6 months of employment.	D 468		

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D 468	Continued From page 22 Refer to interview with the Special Care Unit Coordinator on 11/19/14 at 02:00 p.m. Refer to interview with the Administrator on 11/19/14 at 02:30 p.m. Refer to interview with the Owner on 11/20/14 at 04:00 p.m. 3. Review of Staff E's personnel record revealed: -She was hired as a Nursing Assistant on 03/05/2014. -There was a 6 hour training sheet certificate on the nature and needs of the residents with Dementia in her record which was not dated or signed by the Unit Coordinator. -No documentation of 20 hours of training specific to caring for residents with Dementia. Interview with the Special Care Unit Coordinator on 11/19/2014 at 02:00 p.m. revealed Staff E had the 6 hour training on her date of hire and she must have forgotten to sign and date it. Staff E was not available for interview. Refer to interview with the Special Care Unit Coordinator on 11/19/14 at 02:00 p.m. Refer to interview with the Administrator on 11/19/14 at 02:30 p.m. Refer to interview with the Owner on 11/20/14 at 04:00 p.m. 4. Review of Staff F's personnel record revealed: -She was hired as a NA on 10/29/2012.	D 468		

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D 468	Continued From page 23 -Documentation she had completed the 6 hour training on the nature and needs of the residents with Dementia on 10/29/2012. -No documentation of 20 hours of training specific to caring for residents with Dementia. Staff F was not available for interview. Refer to interview with the Special Care Unit Coordinator on 11/19/14 at 02:00 p.m. Refer to interview with the Administrator on 11/19/14 at 02:30 p.m. Refer to interview with the Owner on 11/20/14 at 04:00 p.m. 5. Review of Staff G's personnel record revealed: -She was hired as a medication aide on 02/06/2013. -No documentation of completing 6 hours of orientation on the nature and needs of the residents with Dementia or 20 hours of additional training within the first 6 months of employment. Staff G was not available for interview. Refer to interview with the Special Care Unit Coordinator on 11/19/14 at 02:00 p.m. Refer to interview with the Administrator on 11/19/14 at 02:30 p.m. Refer to interview with the Owner on 11/20/14 at 04:00 p.m. 6. Review of Staff H's personnel record revealed: -She was hired as a medication aide on	D 468		

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D 468	Continued From page 24 09/24/2013. -Documentation she had completed the 6 hour training on the nature and needs of the residents with Dementia on 09/24/2013. -No documentation of 20 hours of training specific to caring for residents with Dementia. Interview with Staff H on 11/20/2014 at 05:00 p.m. revealed: -She had been a medication aide on the Special Care Unit and the Assist Living unit on first and second shift (07:00 a.m. - 03:00 p.m. and 03:00 p.m. - 11:00 p.m.). -She did not recall having an additional 20 hours of additional training within the first 6 months of employment on caring for residents with Dementia. -The training she has had should be in her personnel file. Refer to interview with the Special Care Unit Coordinator on 11/19/14 at 02:00 p.m. Refer to interview with the Administrator on 11/19/14 at 02:30 p.m. Refer to interview with the Owner on 11/20/14 at 04:00 p.m. --- Interview with the Special Care Unit Coordinator on 11/19/2014 at 02:00 p.m. revealed: -When new staff are hired she provides them with the 6 hours of orientation on the nature and needs of the residents with Dementia so they will be prepared to work on both the Special Care Unit and the Assisted Living Unit. -The 6 hour training is usually done on the day of hire or shortly afterward.	D 468		

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D 468	Continued From page 25 -There are some staff who only work on the Assisted Living Unit (Staff B and D). -Staff A, C, E, F, G, and H work on both the Special Care Unit and the Assisted Living Unit. -All staff training certificates should be in their personnel files. Interview with the Administrator on 11/19/2014 at 02:30 p.m. revealed: -He was a new Administrator and was hired in April 2014. -The previous Administrator had been providing the 20 hours of training on caring for residents with Dementia. -It had not been done for approximately 16 months and it was going to be started up again. -The Unit Coordinator for the Special Care Unit was responsible for overseeing clinical training requirements were met for the staff working on the Special Care Unit. -He was not aware the facility was not meeting the Special Care Unit training requirements for staff responsible for personal care and supervision of the residents on the Special Care Unit. -He was planning on making changes to their current monitoring system to assure new and existing staff met clinical training requirements. -He had scheduled the 20 hour training to start again in December scheduled for 4 five hour days on 12/10/2014, 12/11/2014, 12/15/2014 and 12/16/2014. Interview with the Owner on 11/20/2014 at 04:00 p.m. revealed: -She was aware of the 6 hour and 20 hour training requirement for staff who work on the Special Care Unit on care of the residents served. -The Unit Coordinators for the Special Care Unit and the Assisted Living were responsible for	D 468		

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(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) COMPLETE DATE
D 468	Continued From page 26 overseeing clinical training requirements were met for the staff on each unit. -Changes were going to be made to assure all personnel training requirements were met.	D 468		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration.	D935		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	11/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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) COMPLETE DATE
D935	Continued From page 27 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 3 of 6 medication aides sampled (Staff A, C, and F) met the state requirements to administer medications. The findings are: 1. Review of Staff A's personnel record revealed: -She was hired as a Nursing Assistant (NA) on 12/14/2012. -She completed her medication clinical skills validation on 04/07/2014. -She passed the Medication Aide exam on 06/12/2014. -No documentation of the 5 hour/10 hour or 15 hour state medication aide training. Interview with Staff A on 11/20/2014 at 09:30 a.m. revealed: -She did not recall having a 5 hour/10 hour or 15 hour state medication training when she became a medication aide in June 2014. -She was a medication aide on the Special Care Unit on the first shift from 07:00 a.m. - 03:00 p.m. Review of the September, October, and November 2014 medication administration records (MAR) revealed Staff A administered	D935	Prior to employment, Medication techs must provide evidence of work as a med tech within the last 24 months, if applicable, in addition to other verifications, competency requirements and training. RN will schedule per regulation to fulfill requirements by the state to administer medications. Administrator, RCC, SCUC and/or designee will monitor to ensure compliance. Completion date of 1/16/2015	

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D935	Continued From page 28 medications during these 3 months. Refer to interview with the Special Care Unit Coordinator on 11/19/14 at 02:00 p.m. Refer to interview with the Administrator on 11/19/14 at 02:30 p.m. Refer to interview with the Owner on 11/20/14 at 04:00 p.m. 2. Review of Staff C's personnel record revealed: -She was hired as a Personal Care Aide on 02/09/2012. -She completed her medication clinical skills validation on 07/23/2013. -She passed the Medication Aide exam on 11/21/2013. -No documentation of the 5 hour/10 hour or 15 hour state medication aide training. Interview with Staff C on 11/19/2014 at 02:45 p.m. revealed: -She did not recall having a 5 hour/10 hour or 15 hour state medication training when she became a medication aide in November 2013. -She tries to attend all the classes offered at the facility. Review of the September, October, and November 2014 MAR revealed Staff C administered medications during these 3 months. Refer to interview with the Special Care Unit Coordinator on 11/19/14 at 02:00 p.m. Refer to interview with the Administrator on 11/19/14 at 02:30 p.m. Refer to interview with the Owner on 11/20/14 at	D935		

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D935	Continued From page 29 04:00 p.m. 3. Review of Staff F's personnel record revealed: -She was hired as a nursing assistant on 10/29/2012. -She completed her medication clinical skills validation on 02/09/2014 and again on 08/04/2014. -She passed the Medication Aide exam on 08/28/2014. -No documentation of the 5 hour/10 hour or 15 hour state medication aide training. Review of the September, October, and November 2014 MAR revealed Staff F administered medications during these 3 months. Staff F was not available for interview. Refer to interview with the Special Care Unit Coordinator on 11/19/14 at 02:00 p.m. Refer to interview with the Administrator on 11/19/14 at 02:30 p.m. Refer to interview with the Owner on 11/20/14 at 04:00 p.m. --- Interview with the Special Care Unit Coordinator on 11/19/2014 at 02:00 p.m. revealed: -She was aware of the 5 hour/10 hour or 15 hour state medication aide training requirement and had a copy of the state regulation. -The facility did not have a training plan or procedure in place yet for the medication aides to receive the 5 hour/10 hour or 15 hour state medication aide training requirement.	D935		

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D935	Continued From page 30 Interview with the Administrator on 11/19/2014 at 02:30 p.m. revealed: -The Unit Coordinators for the Special Care Unit and the Assisted Living were responsible for overseeing clinical training requirements were met for the staff on each unit. -He was hired as the Administrator in April 2014 and was still learning about state regulations for assisted living facilities. -He was not aware the facility was not meeting the 5 hour/10 hour or 15 hour state medication aide training requirements. -He was planning on making changes to their current monitoring system to assure new and existing staff met requirements for clinical training. Interview with the Owner on 11/20/2014 at 04:00 p.m. revealed: -The Unit Coordinators for the Special Care Unit and the Assisted Living were responsible for overseeing clinical training requirements were met for the staff on each unit. -The Unit Coordinators provided the Business office manager with the personnel files when they were complete and she double checked them to make sure there was nothing missing. -Changes were going to be made to improve this process to assure all personnel requirements were met.	D935		

Herring, Belverly G

From: Goodell, Jane
Sent: Tuesday, December 23, 2014 10:13 AM
To: eforbes@wilson-co.com
Cc: Herring, Belverly G; Oakley, Eva; Rodgers, Marie
Subject: Wilson Assisted Living 2014-12-17 POC C0RO11
Attachments: Wilson Assisted Living 2014-12-17 POC C0RO11.pdf

Please see attached Plan of Correction. Thanks. Jane