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 _____ | R 06/06/2016 |

JUL 25 2016 RALEIGH

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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 |
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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section and the Wilson County Department of Social Services conducted an annual and follow-up survey on 06/01/16 - 06/03/16 and 06/06/16. | D 000 | | |
| D 131 | 10A NCAC 13F .0406(a) Test For Tuberculosis<br><br>10A NCAC 13F .0406 Test For Tuberculosis<br>(a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with 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 the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on interview and record review, the facility failed to assure 5 of 6 staff (A, C, D, E, F) sampled were tested upon employment for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services.<br><br>The findings are:<br><br>1. Review of Staff A's personnel file revealed:<br>-She was hired as a medication aide on 03/22/16.<br>-There was a tuberculosis (TB) skin test placed on 04/04/16 and read as negative on 04/07/16.<br>-There was no documentation of any other TB skin test for Staff A. | D 131 | All staff records have been audited and anyone requiring a 1st or 2nd step TB test have been completed by RN.<br><br>Potential employees are required to have a 1st step before hire. A 2nd step will be administered within 30 days. New hire names will be given to RN to complete 2nd step. All new hires will be monitored weekly by Administrator and/or RCC to ensure compliance. | 7/18/16 |

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donna Dawson — TITLE: Administrator — (X6) DATE: 7/21/16

FORM CMS-2567(02-99) 6899 MXC711 If continuation sheet 1 of 73

* The plan of correction with addendum was reviewed and accepted on 7/26/16. Refer to addendum on pages 2, 9, 16, 20, 31, 41, 43, 46, 62, and 67 of this Statement of Deficiencies.
-W. Williams 7/26/16

Division of Health Service Regulation

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| D 131 | Continued From page 1<br><br>Interview with the Administrator on 06/06/16 at 2:10 p.m. revealed:<br>-Staff A should have a second test TB skin test on file.<br>-Staff A was a rehire and should also have TB skin tests on file from her previous employment.<br>-They were looking for more records on Staff A but had not been able to locate any.<br>-Staff A usually worked first shift but she was off today.<br><br>Staff A was unavailable for interview on 06/06/16.<br><br>No further information was received by the end of the survey for Staff A's TB skin test.<br><br>Refer to interview with the Administrator on 06/06/16 at 10:15 a.m.<br><br>Refer to interview with the Resident Care Coordinator (RCC) on 06/06/16 at 11:35 a.m.<br><br>Refer to interview with the Registered Nurse (RN) Consultant on 06/06/16 at 1:30 p.m.<br><br>2. Review of Staff C's personnel file revealed:<br>-She was hired as a nurse aide on 03/18/16.<br>-She had one tuberculosis (TB) skin test placed on 06/15/15 and read as negative on 06/17/15.<br>-There was no documentation of any TB skin test upon hire for Staff C.<br><br>Interview with the Administrator on 06/06/16 at 2:10 p.m. revealed:<br>-Staff C was a new employee and should have had a TB skin test upon hire.<br>-Staff C usually worked on third shift.<br>-She would check their records and with the Registered Nurse (RN) Consultant about any other TB skin tests for Staff C. | D 131 | D131<br><br>Addendum per telephone with Donna Dawson on 7/26/16:<br><br>The Administrator will put a list of new staff in the RN's box at the facility and verbally tell the RN every Monday when RN comes to the facility. Documentation of TB tests will be maintained in personnel files in the Administrator's office. Administrator / RCC will check personnel files weekly to assure compliance.<br><br>W. Williams<br>7/26/16 | |

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| D 131 | Continued From page 2<br><br>Staff C was unavailable for interview on 06/06/16.<br><br>No further information was received by the end of the survey for Staff C's TB skin test.<br><br>Refer to interview with the Administrator on 06/06/16 at 10:15 a.m.<br><br>Refer to interview with the Resident Care Coordinator (RCC) on 06/06/16 at 11:35 a.m.<br><br>Refer to interview with the Registered Nurse (RN) Consultant on 06/06/16 at 1:30 p.m.<br><br>3. Review of Staff D's personnel file revealed:<br>-She was hired as a nurse aide / medication aide on 03/03/14.<br>-There was a tuberculosis (TB) skin test placed on 03/06/14 and read as negative on 03/08/14.<br>-There was no documentation of any other TB skin test for Staff D.<br><br>Interview with the Administrator on 06/06/16 at 10:04 a.m. revealed:<br>-Staff D should have a second test TB skin test on file.<br>-The Registered Nurse (RN) Consultant said she did a TB skin test for Staff D.<br>-She could not find any other TB skin tests on file for Staff D.<br>-She was looking for more records on Staff D but had not been able to locate any.<br>-Staff D usually worked first shift but she was off today.<br><br>Staff D was unavailable for interview on 06/06/16.<br><br>No further information was received by the end of the survey for Staff D's TB skin test. | D 131 | | |

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| D 131 | Continued From page 3<br><br>Refer to interview with the Administrator on 06/06/16 at 10:15 a.m.<br><br>Refer to interview with the Resident Care Coordinator (RCC) on 06/06/16 at 11:35 a.m.<br><br>Refer to interview with the Registered Nurse (RN) Consultant on 06/06/16 at 1:30 p.m.<br><br>4. Review of Staff E's personnel file revealed:<br>-She was hired as a nurse aide / medication aide on 01/27/16.<br>-There was a tuberculosis (TB) skin test read as negative on 02/11/16.<br>-There was no documentation of any other TB skin test for Staff E.<br><br>Interview with the Administrator on 06/06/16 at 2:10 p.m. revealed:<br>-Staff E should have a second test TB skin test on file.<br>-Staff E was a rehire and should also have TB skin tests on file from her previous employment.<br>-They were looking for more records on Staff E but had not been able to locate any.<br><br>Review of documentation from Staff E's previous personnel file revealed:<br>-There was one TB skin test placed on 01/08/13 and read as negative on 01/10/13.<br>-There was no documentation of any other TB skin tests for Staff E.<br><br>Telephone interview with Staff E on 06/06/16 at 2:48 p.m. revealed:<br>-Staff E had only one TB skin test when she was rehired at the facility in January 2016.<br>-She was unsure how many TB skin tests she had during her previous employment with the | D 131 | | |

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| D 131 | Continued From page 4<br>facility.<br><br>Refer to interview with the Administrator on 06/06/16 at 10:15 a.m.<br><br>Refer to interview with the Resident Care Coordinator (RCC) on 06/06/16 at 11:35 a.m.<br><br>Refer to interview with the Registered Nurse (RN) Consultant on 06/06/16 at 1:30 p.m.<br><br>5. Review of Staff F's personnel file revealed:<br>-She was hired as a nurse aide on 02/29/16.<br>-There was a tuberculosis (TB) skin test placed on 03/06/15 and read as negative on 03/08/15.<br>-There was a TB skin test placed on 08/14/15 and read as negative on 08/16/15.<br>-There was no documentation of any TB skin test upon hire for Staff F.<br><br>Interview with the Administrator on 06/06/16 at 2:10 p.m. revealed:<br>-Staff F was a new employee and should have had at least one TB skin test upon hire.<br>-She did not know why it was not done.<br>-Staff F usually worked third shift and she was not currently on duty.<br>-She would try to contact Staff F about the TB skin test.<br><br>Staff F was unavailable for interview on 06/06/16.<br><br>No further information was received by the end of the survey for Staff F's TB skin test.<br><br>Refer to interview with the Administrator on 06/06/16 at 10:15 a.m.<br><br>Refer to interview with the Resident Care Coordinator (RCC) on 06/06/16 at 11:35 a.m. | D 131 | | |

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| D 131 | Continued From page 5<br><br>Refer to interview with the Registered Nurse (RN) Consultant on 06/06/16 at 1:30 p.m.<br><br>Interview with the Administrator on 06/06/16 at 10:15 a.m. revealed:<br>-The RCC was supposed to notify the RN Consultant when new staff was hired.<br>-The RCC usually gave a list of new staff to the RN Consultant.<br>-The RN Consultant was supposed to do the TB skin tests when she received the list from the RCC.<br>-The list was usually filed in a book in the business office with the TB results.<br>-The RCC was responsible for following up to make sure the TB tests were done.<br>-The Administrator had just started working at the facility in February 2016 and the RCC had just started working at the facility in March 2016.<br>-The previous RCC was not getting the TB skin tests done as required.<br>-The Administrator and the current RCC were aware there were some problems with the personnel files.<br>-They had not had an opportunity to review all personnel files to determine which files had missing or incomplete information.<br><br>Interview with the Resident Care Coordinator (RCC) on 06/06/16 at 11:35 a.m. revealed:<br>-Staff were supposed to have one TB skin test upon hire that staff were responsible to get on their own.<br>-The facility's RN Consultant usually gave staff the second TB skin test.<br>-The RCC usually told the RN Consultant verbally and gave the RN Consultant a folder with a list of names when TB skin tests were needed for new | D 131 | | |

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| D 131 | Continued From page 6<br>staff.<br>-The RN Consultant was responsible for doing the TB skin test and giving the folder with the results to the Administrator.<br>-The Administrator would then take the folder to the business office.<br>-The RCC did not follow up on the TB skin tests because she thought the Administrator was doing it.<br><br>Interview with the Registered Nurse (RN) Consultant on 06/06/16 at 1:30 p.m. revealed:<br>-She usually worked one day a week at the facility.<br>-Her responsibilities included doing TB skin tests for new staff.<br>-The facility recently had a lot of staff turnover and some rehires.<br>-She was out on medical leave for a couple of weeks in May 2016 and she had been trying to catch up with her duties for the last two weeks.<br>-New staff were supposed to already have one TB skin test done upon hire.<br>-She usually did the second step TB skin test for staff.<br>-She would do the TB skin test when the RCC told her it needed to be done.<br>-She usually gave documentation of TB skin tests to the RCC.<br>-She usually placed the TB skin test but facility staff were supposed to get a home health nurse to read it since the RN Consultant was only at the facility one day per week.<br>-The RCC coordinated with home health nurses who came in the facility to read the TB skin tests.<br>-She did not track it or keep copies for her records.<br><br>Review of the facility's plan of protection dated | D 131 | | |

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| D 131 | Continued From page 7<br>06/06/16 revealed:<br>-All staff records will be audited immediately to determine who needs TB tests.<br>-Any needed TB tests will be done immediately by RN Consultant.<br>-Documentation of required TB testing will be maintained on file at the facility.<br>-New hires will be required to have first step TB skin test prior to hiring within required time frame.<br>-Upon hire, a second step TB skin test will be completed by RN Consultant.<br>-RCC will track to make sure TB tests are done and copies will be kept in Administrator's office as well as with the RN Consultant.<br>-Administrator will monitor once a week to ensure TB tests are completed and documentation is on file.<br>-RCC will notify RN Consultant when TB tests are needed.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 21, 2016. | D 131 | | 7/18/16 |
| D 161 | 10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks<br><br>10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task<br>(a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff | D 161 | Staff records have been audited and staff requiring LHPS validations have been completed by RN. All new hires will have LHPS Skills Validations completed before working on the floor. Administrator and/or RCC will communicate with RN any new hires needing LHPS Skills Validations and will be monitored weekly. | |

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| D 161 | Continued From page 8<br>oversight and supervision.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to assure 4 of 6 facility non-licensed staff (A, C, D, E) sampled had been competency validated for personal care tasks specified as licensed health professional support (LHPS) tasks such as assistance with ambulation with assistive devices, transfers, and applying and removing TED hose, oxygen, dressing changes, restricting fluids, and feeding assistance for residents with swallowing problems.<br><br>The findings are:<br><br>1. Review of Staff A's personnel file revealed:<br>-She was hired as a nurse aide / medication aide on 03/22/16.<br>-There was no licensed health professional support (LHPS) competency validation for Staff A.<br><br>Observation on 06/02/16 during first shift revealed:<br>-Staff A was working as a medication aide on the 300 hall of the facility.<br>-Staff A assisted residents with ambulation with assistive devices.<br>-Staff A provided and feeding assistance to a resident with swallowing problems (crushed medications, put in pudding and fed to resident) during the 12:00 noon medication pass.<br>-Staff A provided fluids to a resident on fluid restrtiction during the 12:00 noon medication pass.<br><br>Interview with the Administrator on 06/06/16 at 2:10 p.m. revealed: | D 161 | D161 Addendum per telephone with Donna Dawson on 7/26/16:<br><br>The Administrator will put a list of new staff requiring LHPS competency validation in the RN's box at the facility and verbally tell the RN every Monday when the RN comes to the facility. Staff will not perform LHPS tasks until validation is completed. The Administrator / RCC will check personnel files weekly to assure compliance.<br><br>W. Williams<br>7/26/16 | |

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| D 161 | Continued From page 9<br>-Staff A should have been LHPS competency validated.<br>-Staff A was a rehire and should have at least had the LHPS validation from her previous employment.<br>-They were looking for more records on Staff A but had not been able to locate any.<br>-Staff A usually worked first shift but she was not working today.<br>-Staff A was responsible for performing any LHPS tasks needed for residents at the facility.<br><br>Review of a 2014 LHPS validation tracking form found by the Administrator on 06/06/16 revealed:<br>-Staff A's name was included on a list of employee names indicating Staff A participated in LHPS competency validation on 09/22/14.<br>-There was no documentation on the form to indicate which tasks any of the staff listed on the form had been validated to perform.<br><br>Review of the May 2016 medication administration records (MARs) revealed Staff A had changed oxygen tubing for a resident receiving oxygen on 05/26/16.<br><br>No further information was received by the end of the survey for Staff A's LHPS validation.<br><br>Staff A was unavailable for interview on 06/06/16.<br><br>Refer to interview with the Administrator on 06/06/16 at 10:15 a.m.<br><br>Refer to interview with the Resident Care Coordinator (RCC) on 06/06/16 at 11:35 a.m.<br><br>Refer to interview with the Registered Nurse (RN) Consultant on 06/06/16 at 1:30 p.m. | D 161 | | |

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| D 161 | Continued From page 10<br><br>2. Review of Staff C's personnel file revealed:<br>-She was hired as a nurse aide on 03/18/16.<br>-There was no licensed health professional support (LHPS) competency validation for Staff C.<br><br>Interview with the Administrator on 06/06/16 at 2:10 p.m. revealed:<br>-Staff C was a new employee and should have been LHPS competency validated.<br>-Staff C usually worked third shift.<br>-Staff C was responsible for performing any LHPS tasks needed for residents at the facility.<br><br>Staff C was unavailable for interview on 06/06/16.<br><br>No further information was received by the end of the survey for Staff C's LHPS validation.<br><br>Refer to interview with the Administrator on 06/06/16 at 10:15 a.m.<br><br>Refer to interview with the Resident Care Coordinator (RCC) on 06/06/16 at 11:35 a.m.<br><br>Refer to interview with the Registered Nurse (RN) Consultant on 06/06/16 at 1:30 p.m.<br><br>3. Review of Staff D's personnel file revealed:<br>-She was hired as a nurse aide / medication aide on 03/03/14.<br>-There was no licensed health professional support (LHPS) competency validation for Staff D.<br><br>Observation on 06/02/16 during first shift revealed:<br>-Staff D was working as a medication aide in the special care unit.<br>-Staff D assisted residents with ambulation with | D 161 | | |

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| D 161 | Continued From page 11<br>assistive devices.<br>-Staff D provided and feeding assistance to a resident with swallowing problems (crushed medications, put in pudding and fed to resident) during the 9:00 a.m. medication pass.<br><br>Interview with the Administrator on 06/06/16 at 10:04 a.m. revealed:<br>-Staff D had worked at the facility for a while and should have been LHPS competency validated.<br>-They were looking for more records on Staff D but had not been able to locate any.<br>-Staff D usually worked first shift but she was off today.<br>-Staff D was responsible for performing any LHPS tasks needed for residents at the facility.<br><br>No further information was received by the end of the survey for Staff D's LHPS validation.<br><br>Staff D was unavailable for interview on 06/06/16.<br><br>Refer to interview with the Administrator on 06/06/16 at 10:15 a.m.<br><br>Refer to interview with the Resident Care Coordinator (RCC) on 06/06/16 at 11:35 a.m.<br><br>Refer to interview with the Registered Nurse (RN) Consultant on 06/06/16 at 1:30 p.m.<br><br>4. Review of Staff E's personnel file revealed:<br>-She was hired as a nurse aide / medication aide on 01/27/16.<br>-There was no licensed health professional support (LHPS) competency validation for Staff E.<br><br>Interview with the Administrator on 06/06/16 at 2:10 p.m. revealed:<br>-Staff E should have been LHPS competency | D 161 | | |

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| D 161 | Continued From page 12<br>validated.<br>-Staff E was a rehire and should have at least had the LHPS validation from her previous employment.<br>-They were looking for more records on Staff E but had not been able to locate any.<br>-Staff E was responsible for performing any LHPS tasks needed for residents at the facility.<br><br>Telephone interview with Staff E on 06/06/16 at 2:07 p.m. revealed:<br>-She had been LHPS competency validated by the RN Consultant in January 2016.<br>-She did not know where the documentation for the LHPS validation would be located and she did not have a copy.<br>-She performed LHPS tasks for residents at the facility.<br><br>Review of the May 2016 medication administration records (MARs) revealed Staff E had changed oxygen tubing for a resident receiving oxygen on 05/12/16.<br><br>Review fluid restriction logs for a special care unit resident revealed Staff E had documented amount of fluids served for the resident's fluid restriction.<br><br>Refer to interview with the Administrator on 06/06/16 at 10:15 a.m.<br><br>Refer to interview with the Resident Care Coordinator (RCC) on 06/06/16 at 11:35 a.m.<br><br>Refer to interview with the Registered Nurse (RN) Consultant on 06/06/16 at 1:30 p.m.<br><br>Interview with the Administrator on 06/06/16 at | D 161 | | |

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| D 161 | Continued From page 13<br>10:15 a.m. revealed:<br>-The RCC was supposed to notify the RN Consultant when new staff was hired.<br>-The RCC usually gave a list of new staff to the RN Consultant.<br>-The RN Consultant usually came to the facility every Monday and that was when she was supposed to do the training.<br>-The RN was supposed to give the certificates to the RCC.<br>-The RCC was supposed to forward the certificates to the Business Office Manager for filing.<br>-The RCC was responsible for following up to make sure the LHPS validations were done.<br>-The Administrator had just started working at the facility in February 2016 and the RCC had just started working at the facility in March 2016.<br>-The previous RCC was not getting the LHPS validations done as required.<br>-The RN had been out on medical leave recently and she was out for about 6 weeks.<br>-There was no back up plan to get the validations done while the RN was on medical leave.<br>-The Administrator and the current RCC were aware there were some problems with the personnel files.<br>-They had not had an opportunity to review all personnel files to determine which files had missing or incomplete information.<br>-All medication aides and nurse aides were responsible for performing LHPS tasks required by residents at the facility which included ambulation with assistive device, transfers, and applying and removing TED hose, oxygen, dressing changes, restricting fluids, and feeding assistance for residents with swallowing problems.<br><br>Interview with the Resident Care Coordinator | D 161 | | |

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| D 161 | Continued From page 14<br>(RCC) on 06/06/16 at 11:35 a.m. revealed:<br>-The RCC usually told the RN Consultant verbally when a staff person needed LHPS validation.<br>-The RCC would give a folder with a list of names to the RN Consultant.<br>-The RN Consultant was responsible for doing the LHPS validation and giving the folder with the documentation to the Administrator.<br>-The Administrator would then take the folder to the business office.<br>-The RCC did not follow up on the LHPS validations because she thought the Administrator was doing it.<br><br>Interview with the Registered Nurse (RN) Consultant on 06/06/16 at 1:30 p.m. revealed:<br>-She usually worked one day a week at the facility.<br>-Her responsibilities included doing LHPS validations for new staff.<br>-The facility recently had a lot of staff turnover and some rehires.<br>-She was out on medical leave for a couple of weeks in May 2016 and she had been trying to catch up with her duties for the last two weeks.<br>-She would do the LHPS validation checklist when the RCC told her it needed to be done.<br>-She usually gave documentation of LHPS validations back to the RCC.<br>-She did not track it or keep copies for her records. | D 161 | | |
| D 164 | 10A NCAC 13F .0505 Training On Care Of Diabetic Resident<br><br>10A NCAC 13F .0505 Training On Care Of Diabetic Residents<br>An adult care home shall assure that training on the care of residents with diabetes is provided to | D 164 | | |

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| D 164 | Continued From page 15<br>unlicensed staff prior to the administration of insulin as follows:<br>(1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner.<br>(2) Training shall include at least the following:<br>(a) basic facts about diabetes and care involved in the management of diabetes;<br>(b) insulin action;<br>(c) insulin storage;<br>(d) mixing, measuring and injection techniques for insulin administration;<br>(e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms;<br>(f) blood glucose monitoring; universal precautions;<br>(g) universal precautions;<br>(h) appropriate administration times; and<br>(i) sliding scale insulin administration.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, the facility failed to assure 2 of 4 medication aides (B, E) sampled received training by a licensed health professional on the care of diabetic residents prior to administering insulin to residents. The findings are:<br><br>1. Review of Staff B's personnel file revealed:<br>-She was hired as a medication aide on 05/09/16.<br>-She completed the Medication Aide Clinical Skills checklist on 05/16/16.<br>-She passed the written medication aide exam on 05/18/11.<br>-She had medication aide employment verification documented for 07/2012 - 03/2016.<br>-There was no documentation of any diabetes | D 164 | All Med Techs have completed an In-Service on Diabetes and Insulin by the RN. Administrator and/or RCC will communicate with RN when training for newly hired Med Techs is needed. Med Techs will receive training before working on cart. Monitoring by Administrator and/or RCC will be done monthly to ensure compliance.<br><br>D164 Addendum per telephone with Donna Dawson on 7/26/16:<br>Diabetes training will be completed prior to a medication aide administering insulin. The documentation will be kept in the personnel files. Administrator and/or RCC will check personnel files monthly to assure compliance.<br>W. Williams 7/26/16 | 6/8/16 |

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| D 164 | Continued From page 16<br>training for Staff B.<br><br>Review of the facility's medication administration records revealed Staff B had administered insulin in May 2016 and June 2016.<br><br>Interview with the Administrator on 06/06/16 at 2:10 p.m. revealed:<br>-Staff B should have diabetes training on file.<br>-Staff B was a rehire and should have diabetes training from her from her previous employment.<br>-They were looking for more records on Staff B but had not been able to locate any.<br>-Staff B usually worked second shift but she was not working today.<br><br>Staff B was unavailable for interview on 06/06/16.<br><br>Refer to interview with the Resident Care Coordinator (RCC) on 06/06/16 at 11:35 a.m.<br><br>Refer to interview with the Registered Nurse (RN) Consultant on 06/06/16 at 1:30 p.m.<br><br>2. Review of Staff E's personnel file revealed:<br>-She was hired as a nurse aide / medication aide on 01/27/16.<br>-She completed the Medication Aide Clinical Skills checklist on 02/01/16.<br>-She passed the written medication aide exam on 12/13/07.<br>-There was no documentation of any diabetes training for Staff E.<br><br>Review of the facility's medication administration records revealed Staff E had administered insulin in May 2016.<br><br>Interview with the Administrator on 06/06/16 at 2:10 p.m. revealed: | D 164 | | |

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| D 164 | Continued From page 17<br><br>-Staff E should have diabetes training on file.<br>-Staff E was a rehire and should have diabetes training from her from her previous employment.<br>-They were looking for more records on Staff E but had not been able to locate any.<br><br>Telephone interview with Staff E on 06/06/16 at 2:07 p.m. revealed:<br>-Staff E administered insulin to residents at the facility.<br>-She did not recall having diabetes training.<br><br>Refer to interview with the Resident Care Coordinator (RCC) on 06/06/16 at 11:35 a.m.<br><br>Refer to interview with the Registered Nurse (RN) Consultant on 06/06/16 at 1:30 p.m.<br><br>---<br><br>Interview with the Resident Care Coordinator (RCC) on 06/06/16 at 11:35 a.m. revealed:<br>-There should be a record of diabetes training in the facility's computerized training system.<br>-The RCC and the Administrator could not locate any diabetes training in the computer system for Staff B or Staff E.<br>-Staff B and Staff E administer medications including insulin.<br>-The RCC was not aware diabetes training was required prior to staff administering insulin.<br><br>Interview with the Registered Nurse (RN) Consultant on 06/06/16 at 1:30 p.m. revealed:<br>-She usually worked one day a week at the facility.<br>-Her responsibilities included some training for staff.<br>-She had not done any diabetes training for the facility. | D 164 | | |

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| D 270 | Continued From page 18<br><br>10A NCAC 13F .0901(b) Personal Care and Supervision<br><br>10A NCAC 13F .0901 Personal Care and Supervision<br>(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.<br><br>This Rule is not met as evidenced by:<br>TYPE A2 VIOLATION<br><br>Based on observations, interviews, and record review, the facility failed to ensure the level of supervision for the resident was modified after continued repeated falls for 1 of 5 sampled residents (#4) with one fall resulting in a hospitalization for a head injury with bilateral subdural hematomas.<br><br>The findings are:<br><br>Review of Resident #4's current FL2 dated 04/18/16 revealed the resident's diagnoses included advanced Alzheimer's dementia, urinary tract infection, bilateral subdural hematomas slip/post fall, hypernatremia.<br><br>Review of the Resident Register revealed Resident #4 was admitted to the facility on 9/10/10.<br><br>Observation of Resident #4 on 6/02/16 at 11:00 a.m. revealed the resident seated in a wheelchair with peers and a staff in the living room area of the special care unit. | D 270 | D 270<br><br>Fall Risk Policy has been developed and put in place.<br><br>New residents that present with a possible risk for falls will be assessed by our in-house physical and occupational therapy department, provided by [redacted]<br><br>When a fall occurs incident report is completed family and physician are notified. Physician orders will be followed and a referral for therapy will be requested.<br><br>Physical and/or Occupational Therapy will assess resident and should it be determined they are at risk for falls will take the necessary steps to prevent falls from occurring and minimize the chance of injury. This can include but not limited to low beds, mats, cushions, alarm devices and/or adjustments to routine monitoring by staff.<br><br>Administrator, RCC, SCUC and/or designee will monitor weekly to ensure safety and compliance. | 7/5/16 |

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| D 270 | Continued From page 19<br><br>Review of Resident #4's Incident Reports dated from 02/11/16 through 05/30/16 revealed:<br>-On 02/11/16, resident was found on the floor of the dining area by staff. No injuries noted.<br>-On 03/05/16, resident stood up from the dining table, took a few steps, and fell. Resident was sent to the ER with bruising noted.<br>-On 03/20/16, resident slid out of her wheelchair and went to the floor. No injuries were noted.<br>-On 04/14/16, resident fell in her bedroom doorway. Resident hit her head on the floor and sustained a hematoma to the left side of head and was hospitalized.<br>-On 04/30/16, resident was found on the floor in her room. No injuries were noted.<br>-On 05/03/16, resident was found on the floor in her room. No injuries were noted.<br>-On 05/14/16, resident was found on the floor of her room. No injuries were found.<br>-On 05/27/16, the resident was found in another resident's room on the floor. No injuries were found.<br>On 05/28/16, resident was found on the floor in her room wrapped up in her cover. No injuries were found.<br><br>Review of Nurses' Notes for Resident #4 revealed:<br>-On 05/16/16, the resident was found on the floor in the dining room over the weekend. No visible signs of injury were noted.<br>-On 05/30/16, following the resident being found on the floor in her room wrapped up in covers, the resident's bed was moved against the wall for bed "boundaries".<br><br>Review of Resident #4's Care Plan dated 5/10/16 revealed:<br>-The resident was noted as "totally dependent" in all areas except eating and ambulation. | D 270 | D270 Addendum per telephone with Donna Dawson on 7/26/16:<br><br>Residents who are assessed to be fall risks will be monitored @ 30 minutes or more often as determined by assessment. Administrator, RCC/SCC and/or designee will do random observations of staff to assure appropriate supervision of residents, and they will monitor incident/accident reports to help assure compliance.<br><br>W. Williams 7/27/16 | |

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| D 270 | Continued From page 20<br>-The resident required "extensive assistance" which was noted as "staff assist" in the areas of eating and ambulation.<br><br>Based on observation, interview, and record review, Resident #4 was not interviewable due to her cognitive status.<br><br>Interview with a Nurses' Aide (NA) from the Special Care Unit (SCU) regarding Resident #4 on 6/02/16 at 11:30 a.m. revealed:<br>-She was unaware of any falls for the resident.<br>-She checked on all the residents every 2 hours as required including Resident #4..<br>-Staff were always on the hall because it was a locked unit.<br>-She had not found resident on the floor but she had heard other staff had.<br>-She was aware that the resident had attempted to stand and walk on her own.<br>-The resident needed a staff person for assistance when transferring and during ambulation.<br>-The resident used a wheelchair due to being unsteady.<br>-The resident could not call for help because of her cognitive status.<br><br>Interview with a second NA from the SCU regarding Resident #4 on 6/02/16 at 11:45 a.m. revealed:<br>-She was aware the resident had falls.<br>-She was not sure of the number of her falls, but the resident had fallen "often".<br>-The resident does spend time in her room and had stood up to walk on her own on several occasions.<br>-She had not found the resident on the floor after she had fallen.<br>-The resident spent the majority of her time in a | D 270 | | |

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| D 270 | Continued From page 21<br><br>group with peers.<br>-Staff were required to perform 2 hour checks on all residents including Resident #4.<br>-She checked the resident every hour because she knew the resident was a "falls risk" person because she had tried to get up on her own and attempted to walk.<br>-She was not asked to monitor Resident #4 more often then every two hours after she had fallen.<br><br>Interview with the Medication Aide Supervisor (MAS) for the SCU regarding Resident #4 on 6/02/16 at 12:10 p.m. revealed:<br>- Staff are required to perform 2 hour checks on all residents in the SCU Resident #4 included.<br>-The resident was a "high fall risk" resident and she checked on her every hour or so. "<br>-Staff were always assigned to be on the hall and possibly checked the resident more often than every hour.<br>-When the resident was with the group, staff were always present to assist as needed.<br>-The resident had fallen "often" and "stood up a lot."<br>-The resident required staff assistance to transfer and ambulate safely.<br>-Resident #4 was receiving hospice services but was recently feeling better and had attempted to stand and walk more.<br>-She was unaware of a "Fall Policy" for the facility.<br><br>Interview with the Nurse Practitioner (NP) for Resident #4 on 6/02/16 at 5:28 p.m. revealed:<br>-The facility contacted her regarding all falls with and without injury for the resident.<br>-The resident had a lot of falls.<br>-Falls were going to occur with the resident unless "some type of restraint was used".<br>-She said a one-on-one staff would help prevent | D 270 | | |

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| D 270 | Continued From page 22<br>her falls if this were possible.<br>-The resident needed "increased supervision" more than the 2 hour facility checks.<br>-The resident had knee and leg weakness as well as foot deformities which attributed to her falls.<br>-The NP was not aware of any fractures for the resident but was aware of the two ER visits with one resulting in a four day hospital stay in April of this year.<br>-The resident is more active for the past month which resulted in more falls because she "felt better".<br>-The resident was a "High Fall Risk" person and needed staff assistance with transfers and ambulation.<br>-She felt the facility met the resident's needs and provided care to the resident well in the SCU.<br><br>Interview with a third NA from the SCU regarding Resident #4 on 6/02/16 at 5:20 p.m. revealed:<br>-All residents in the SCU were checked every 2 hours as required.<br>-She was aware that the resident had fallen "a couple of times" but she was unsure of how many times she had fallen.<br>-A staff person was always on the hall to check on the residents more often than every 2 hours.<br>-She checked on the resident "every 10 minutes" when she was in her bedroom.<br>-She was told by the Medication Aides (MAs) to "keep a close eye on the resident" but she was not sure what that meant.<br>-She knew the resident needed staff help with transfers and with ambulation because of her falls.<br><br>Interview with a fourth NA from the SCU regarding Resident #4 on 6/02/16 at 5:30 p.m. revealed:<br>-The residents were checked by staff every 2 | D 270 | | |

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| 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 |
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| D 270 | Continued From page 23<br>hours.<br>-The staff person on the hall possibly checked on the residents every hour.<br>-She checked all residents every hour.<br>-She was not aware of the resident's falls but had seen her bruises from her falls.<br>-She recalled one "really bad fall" in April of this year because of her injuries.<br>-She was not asked to check on her any differently than the 2 hour checks following her falls.<br>-She was told to "watch out for her because she got up a lot".<br>-No one told her the resident needed assistance during transfers and when walking but she already knew "by looking at her that she needed help".<br>-She was only required to perform 2 hour checks when she was assigned to the resident.<br><br>Interview with a fifth NA from the SCU regarding Resident #4 on 6/02/16 at 5:50 p.m. revealed:<br>-She was required to check all residents every 2 hours.<br>-She checked the resident every 30-minutes to an hour because she had frequent falls.<br>-She was told to "keep a watch on her" by the Medication Aide (MA) because she got up often.<br>-She knew the resident needed staff assistance when getting up and transferring.<br>-She checked the resident every 20-30-minutes when she was in her room.<br><br>Interview with a second MA from the SCU regarding Resident #4 on 6/02/16 at 5:58 p.m. revealed:<br>-Two hour checks were performed on all SCU residents.<br>-She checked all the residents every 30-minutes.<br>-She was not aware of the facility having a Falls | D 270 | | |

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| D 270 | Continued From page 24<br>Policy or Protocol.<br>-She followed procedure to include checking vitals, completing an incident report, and informing the medical provider, etc. when a fall occurred for all residents.<br>-The resident fell often and she tried to keep her with the group because of her falls.<br>-She asked staff to "keep a close eye" on the resident when she was in her room.<br>-A staff was assigned to the hall and checked on the resident every 30-minutes or so when she was in her bedroom.<br>-Her bed and chair were repositioned in her bedroom after her last fall at the end of May.<br>-The resident required staff assistance when transferring and ambulating.<br>-She checked on the resident every 30-minutes due to her falls.<br><br>Second observation of Resident #4's room on 6/02/16 at 6:10 p.m. revealed the resident's bed was against the wall with her recliner positioned at the head of her bed.<br><br>Interview with the Special Care Coordinator (SCC) regarding Resident #4 on 6/03/16 at 3:30 p.m. revealed:<br>-Two hour checks were required on all SCU residents including Resident #4.<br>-The resident was checked every 30 minutes when in her bedroom.<br>-Two staff were always present when the resident was in the living room with a group.<br>-She said she "did her best to keep the resident with the group".<br>-She knew the resident was an increased "Falls Risk" resident.<br>-She had not seen a Falls Risk Protocol or Policy at the facility but followed procedure when falls occurred which included checking vitals and | D 270 | | |

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| D 270 | Continued From page 25<br>completing an incident report.<br>-The Nurse Practitioner was notified of all falls with or without injury.<br>-When the resident had a fall, no changes were recommended or made in her supervision other than the 2 hour facility checks and 30 minute checks when she was in her room.<br>-One staff person was always on the hall to monitor and to assist residents as needed.<br>-The resident required staff assistance with transfers and ambulation.<br>-Her bed and recliner were repositioned on May 30th of this year to aid in preventing her falls.<br>-The SCC would speak with the Nurse Practitioner or Hospice Nurse and the Administrator regarding trying some type of restraint such as a chair and bed alarm as well as a floor mat for the resident.<br><br>Interview with the Guardian of Resident #4 on 6/03/16 at 3:53 p.m. revealed:<br>-He was aware the resident had "frequent falls".<br>-The resident tried to get up and walk on her own often and would fall.<br>-Due to her age and cognitive ability, she was not able to understand that she needed staff to help her.<br>-The facility had contacted him after all falls.<br>-He visited often and felt staff were taking care of the resident well.<br>-The guardian had no issues or concerns regarding her quality of care at the facility.<br><br>Interview with the Administrator regarding Resident #4 on 6/03/16 at 4:10 p.m. revealed:<br>-She was aware that the resident had "frequent" falls.<br>-All residents are monitored and checked every 2 hours by facility staff.<br>-Facility staff were always present in the hallways | D 270 | | |

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| D 270 | Continued From page 26<br>to assist all residents in between the 2 hour checks when needed.<br>-She said the resident did not comprehend verbal prompting from staff due to her cognitive status to not get up without staff assistance.<br>-She was not aware of a Falls Protocol or Policy for the facility.<br>-They had tried other interventions when falls occurred that included physical therapy and repositioning her bed and chair<br>-She said the resident's supervision level was not increased following her falls and "it should have been increased for her and all residents who were identified as a Falls Risk."<br>-She would speak with the Nurse Practitioner regarding the resident's supervision needs and possible supports to aid in preventing future falls.<br><br>Review of an Occupational Therapist's (OT) Progress and Discharge summary for Resident #4 dated 02/26/16 revealed:<br>-The resident was discharged on 02/23/16 due to goals were met.<br>-The resident had maximized her potential in OT at that time.<br>-The staff were independent with assisting the resident with self-care and mobility on the Special Care Unit (SCU).<br>-The Resident would remain in the SCU with 24 hour supervision and assistance for all self-care and mobility.<br>-The resident had precautions of a fall risk, decreased safety and dementia.<br><br>Telephone interview with the OT on 06/06/16 at 4:34pm revealed:<br>-Resident #4 required SCU level of care.<br>-All of the residents on a SCU required more eyes laid upon them.<br>-The OT expected all SCU residents to receive 24 | D 270 | | |

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| D 270 | Continued From page 27<br>hour supervision.<br>-In the SCU, Resident #4 would be checked on every 30 minutes and they "usually don't leave residents in a room alone for extended times."<br><br>Interview with the physical therapy assistant (PTA) on 06/06/16 at 4:12 p.m. revealed:<br>-The PTA had worked with Resident #4 a few months ago.<br>-When Resident #4 stood up, she would lean back away from the PTA and resist.<br>-After standing for a few minutes, Resident #4 would walk with assistance from the PTA.<br>-Sometimes Resident #4 would require minimal assistance from the PTA and sometimes she would require moderate assistance.<br>-The PTA educated the facility staff on cueing Resident #4 and the PTA showed staff how to walk with Resident #4.<br>-The PTA educated the facility staff to make sure they walked with the resident.<br>-Resident #4 was usually sitting in the common living room when the PTA saw the resident.<br>-The PTA usually saw facility staff in the living room with the residents.<br>-She thought facility staff were supposed to do two hour incontinence checks on the residents but she was not sure how often staff were supposed to monitor the residents otherwise.<br>-Resident #4 was discharged from physical therapy due to not meeting goals because of the resident's confusion and cognitive status.<br><br>Based on observation, interview and record review::<br>-The facility had no policy for falls.<br>-There was no modification of supervision for Resident #4 after multiple falls including a fall resulting in a hospitalization for bilateral subdural | D 270 | | |

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| D 270 | Continued From page 28<br>hematomas.<br>-Facility staff continued to monitor Resident #4 routinely every 2 hours and every 30 minutes while in room after multiple falls.<br>-The facility staff were not instructed to modify their supervision of Resident #4 after multiple falls.<br>-The resident continued to have falls after returning to the facility from the hospitalization for the subdural hematomas with no modification of supervision for the resident.<br><br>Review of the facility's plan of protection dated 06/02/16 revealed:<br>-Resident #4 will have a one-on-one aide from 7:00 p.m. - 11:00 p.m., 11:00 p.m. - 7:00 a.m., and 7:00 a.m. - 3:00 p.m. and then the NP will assess the resident on 06/03/16.<br>-The NP will assess Resident #4 on 06/03/16 to determine if the facility can meet the resident's needs and how often the resident needs to be supervised.<br>-The NP will also assess other residents on 06/03/16 that are fall risk residents.<br>-If determined by PCP that a resident needs a chair alarm (and approved by owner) then an order will be obtained.<br>-A Fall Risk policy will be developed and put in place.<br>-Other fall risk residents will be monitored every 30 minutes or more often as determined by assessment.<br><br>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 6, 2016. | D 270 | | |
| D 276 | 10A NCAC 13F .0902(c)(3-4) Health Care<br><br>10A NCAC 13F .0902 Health Care | D 276 | | |

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| D 276 | Continued From page 29<br>(c) The facility shall assure documentation of the following in the resident's record:<br>(3) written procedures, treatments or orders from a physician or other licensed health professional; and<br>(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interviews and record review, the facility failed to assure an ordered daily fluid restriction of 1.2- 1.5 liters per day was monitored and documented for 1 of 5 residents (#3) sampled for review.<br><br>The findings are:<br><br>Review of Resident #3's current FL-2 dated 04/09/16 revealed:<br>-The resident's diagnoses included acute hypoxic respiratory failure likely secondary to healthcare acquired pneumonia, metabolic encephalopathy, end stage renal disease on dialysis, gastroesophageal reflux disease, hypertension, type 2 diabetes, dyslipidemia, and glaucoma.<br>-The section on the FL-2 for nutritional information noted no special nutritional needs.<br>-There was an additional information section on the FL-2 that noted to resume fluid restriction as resident was on dialysis.<br><br>Review of a FL-2 dated 01/15/16 revealed a physician order for 1.2 liters per day.<br><br>Review of subsequent physician's orders revealed:<br>-There was a physician's order dated 04/19/16 to | D 276 | **Proper documentation form has been put in place for recording fluid intake of residents and staff has been in-serviced on its use and the importance of the daily log. RCC, SCUC, Med Tech and/or designee will monitor weekly to ensure compliance.** | 6/6/16 |

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| D 276 | Continued From page 30<br><br>restrict fluid consumption to 1.2 to 1.5 liters per day.<br>-There was a physician's order dated 5/20/16 for mighty shakes daily.<br><br>Interview on 06/01/16 at 10:55 a.m. with a Personal Care Aide (PCA) on the Special Care Unit (SCU) revealed:<br>-Resident #3 went to dialysis three times per week and left around 11:00 to 11:30a.m.<br>-Resident #3 ate his breakfast, snack and lunch at the facility on his dialysis days.<br>-Resident #3 was on a fluid restriction but she was unsure of the exact daily amount.<br>-The PCA staff members did not keep up with fluid restrictions for residents, this was the Medication Aides (MA) responsibility.<br>-Some of the MAs would ask her for the fluid intake for some of the residents in the SCU after meals and snacks but not for Resident #3.<br>-Resident #3 would drink out of a "little glass" at breakfast, lunch and dinner.<br>-Resident #3 would typically drink all fluids offered to him.<br>-Resident #3 needed assistance to eat and drink at times but not always.<br><br>Based on observation, Resident #3 was not interviewable secondary to dementia.<br><br>Observation of Resident #3 during the noon meal on 06/02/16 in the Special Care Unit revealed:<br>-Resident #3 sat alone at his table at 12noon, and immediately asked for water.<br>-The MA gave him 6 ounces of water in a plastic cup at 12:05pm.<br>-Resident #3 drank all the water at once.<br>-The MA removed his empty cup from the table.<br>-A second resident joined him at the table, and was served her plated meal and two beverages | D 276 | D276 Addendum per telephone with Donna Dawson on 7/26/16:<br><br>Resident records and daily logs for all residents on fluid restrictions have been reviewed. Medication aides are responsible for documenting on the daily logs for all fluid intake including meals, snacks, med pass, etc. The amount of fluid intake will be noted on the daily logs. Any non-compliance will be reported to the physician. Monitoring will include observations and review of daily logs.<br><br>The correction date is 6/10/16.<br><br>W. Williams<br>7/26/16 | |

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| D 276 | Continued From page 31<br>by a PCA.<br>-Resident #3 was observed making two attempts at 12:15pm and 12:25pm to pick up her beverages; the PCA intervened and removed them from his hands.<br>-Resident #3 asked the PCA and the MA for more water three times during the meal.<br>-At 12:30pm, the PCA gave him a plastic cup containing 6 ounces of iced tea; Resident #3 immediately drank all of the tea.<br>-At 12:35pm, a third resident joined him at the table, and was served his plated meal and 2 glasses of beverages by a PCA.<br>-Resident #3 was observed attempting to take his beverages at 12:40pm.<br>-The third resident cried out when Resident #3 tried to take his beverages, he would not let Resident #3 touch his beverages.<br>-Resident #3 was immediately escorted back to his room by a PCA.<br><br>Interview on 06/03/16 at 3:00 p.m. with a second PCA revealed:<br>-Resident #3 was on a fluid restriction but she was unsure of exact amount.<br>-A cup was used with measuring lines on it to measure his beverages at snacks and at meals.<br>-The MA had never asked how much fluid intake Resident #3 had because he was on a set amount that he could have with meals and snacks.<br><br>Interview with a MA on 06/03/16 at 3:10 p.m. revealed:<br>-Resident #3's daily fluid restriction was at 40 ounces daily.<br>-A fluid log for Resident #3 was kept on the medication cart for the MA's to fill out daily; the form was then given to the SCU Coordinator (SCC). | D 276 | | |

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| D 276 | Continued From page 32<br>-The MA could not find a log for 06/03/16 and no blank copies could be found on the medication cart.<br>-The MA had not documented the resident's intake of fluids for 06/03/16 at that time.<br>-Resident #3's beverages were poured in small cups that were measured.<br>-The MA always tried to be in the dayroom to monitor what he drank.<br>-Resident #3 had to be watched because he would drink other residents' beverages and would ask for additional fluids.<br><br>Interview with the SCC at 3:15 p.m. on 06/03/16 revealed:<br>-The resident received a certain amount of fluids at meals and with medication passes.<br>-The MAs were responsible for logging Resident #3's fluid consumption daily on the fluid restriction log.<br>-The SCC reviewed all the fluid restriction logs and then filed the forms in a folder.<br>-The MAs were responsible to report to the SCC and the primary physician if the daily restriction was exceeded.<br><br>Interview with Resident #3's family member on 06/03/16 at 3:35 p.m. revealed:<br>-The family member was happy with the residents overall care.<br>-The staff kept him informed of any changes or concerns.<br>-Resident #3 had a tendency to grab other residents' beverages at meals and at snacks at the facility.<br><br>Review of the Fluid Restriction daily logs used for April-June 2016 for Resident #3 revealed:<br>-The daily fluid allowance was 41 ounces.<br>-There was a separated column to document the | D 276 | | |

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| D 276 | Continued From page 33<br>type of fluids for breakfast, lunch, dinner, snacks, other, total and ounces left over.<br>-There was a column for ounces to be documented along with an indicated amount that Resident #3 was allowed as follows: 6 ounces for breakfast, 6 ounces for lunch, 6 ounces for dinner and 3 ounces each for the 3 daily snacks.<br>-There was an entry of 14 ounces that was located close to the bottom of the forms in the number of ounces column with no label or scheduled time indicated.<br>-There was a column for the documentation of initials.<br>-There was a column to document comments.<br><br>Review of Resident #3's April 2016 fluid restriction logs revealed:<br>-There were 16 daily logs for the month of April.<br>-There was not a section labeled med pass and to give 2 ounces with each med pass on the forms used in April; the number 14 was noted in the number of ounces column and was unlabeled.<br>-There was no documentation for 6 times out of the 17 logs for April to reflect the resident's fluid intake of the 14 ounces.<br>-There was no documentation to reflect the resident's fluid intake during one of the daily snacks on 2 logs and no documentation for 2 snacks on 1 log.<br>-There was no documentation listed in the section labeled other.<br>-There was no documentation for the totals or ounces left over on the daily fluid logs except for 04/23/16 which noted 41 ounces however the documented total when calculated equaled 36 ounces.<br>-On 04/04/16, the amount of ounces given was 46 ounces which exceeded the amount of 1.2 liters ordered on 01/05/16. | D 276 | | |

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| D 276 | Continued From page 34<br>-There were 3 documented logs with differing fluid amounts for 04/16/16.<br>-Based on the calculated daily fluid amount totals that were documented for April 2016, the resident's daily totals ranged from 23 ounces to 46 ounces.<br><br>Review of Resident #3's May 2016 fluid restriction logs revealed:<br>-There were 24 daily logs for the month of May.<br>-There was no section labeled med pass and to give 2 ounces with each med pass on the forms used in May; the number 14 was noted in the number of ounces column and was unlabeled.<br>-There was no documentation 15 times out of the 24 logs for May to reflect the resident's fluid intake of the 14 ounces.<br>-There was no documentation to reflect the resident's fluid intake during one of the daily snacks on 14 logs for May and 1 log that did not document the intake of fluids for 2 daily snacks.<br>-There was no documentation listed in the section labeled other.<br>-There was no documentation for the totals or ounces left over on the daily fluid logs except for 05/13/16 and 05/16/16.<br>-The documented total for 05/13/16 was 38 ounces with 3 ounces left over however, based on the calculated daily amount from the documentation the total was 40 ounces.<br>-The documented total for 05/16/16 was 38 ounces with 3 ounces left over however, based on the calculated daily amount from the documentation the total was 40 ounces.<br>-Based on the calculated daily fluid amount totals that were documented for May 2016, the resident's daily totals ranged from 18 ounces to 44 ounces.<br><br>Review of Resident #3's June 2016 Fluid | D 276 | | |

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| D 276 | Continued From page 35<br><br>restriction logs revealed:<br>-There were 4 daily logs for the month of June.<br>- There was no section labeled med pass and to give 2 ounces with each med pass on the forms used in May; the number 14 was noted in the number of ounces column and was unlabeled.<br>-There was no documentation on the 4 logs for June to reflect the resident's fluid intake of the 14 ounces.<br>-There was no documentation to reflect the resident's fluid intake during all 3 snacks on 2 logs for June.<br>-There was no documentation listed in the section labeled other.<br>-There was no documentation for the totals or ounces left over on the daily fluid logs.<br>-Based on the calculated daily fluid amount totals that were documented for June 2016, the resident's daily totals ranged from 7 ounces to 34 ounces.<br><br>Interview with a third PCA on 06/06/16 at 9:40 .m. on the SCU revealed:<br>-Resident #3 was on a fluid restriction but she was unsure of the exact daily amount but it was posted on the wall in the day room.<br>-Resident #3's beverages were measured by the SCU staff with the use of a measuring cup provided by dietary.<br>-PCA's do not have to report Resident #3's fluid intake after meals and snacks to the MA.<br>-Resident #3 would drink all fluids that were given to him.<br>-The MAs were responsible for keeping up with Resident #3's daily fluid intake.<br>-SCU staff would have to keep an eye on Resident #3 to assure he did not take other residents beverages during meals and snacks.<br>-If Resident #3 accidentally grabbed and drank someone else's beverage at meals or snacks it | D 276 | | |

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| D 276 | Continued From page 36<br><br>was expected that the PCA report this to the MA.<br>-The PCA could not remember the last time this happened.<br>-Resident #3 went to dialysis on Monday, Wednesday and Friday, he would leave the facility around 11:00 a.m. to 11:30 a.m. and would eat breakfast, a snack and lunch at the facility prior to leaving for dialysis.<br><br>Review of a second Fluid Restriction daily log for Resident #3 revealed:<br>-A handwritten entry at the top of the log for No ice in glass in large print with a black marker.<br>-The daily fluid allowance was 41 ounces.<br>-There was a separated column to document the type of fluids for breakfast, lunch, dinner, snacks, Med pass, other, total and ounces left over.<br>-There was a column for ounces to be documented along with an indicated amount that Resident #3 was allowed as follows: 6 ounces for breakfast, 6 ounces for lunch, 6 ounces for dinner, 3 ounces each for the 3 daily snacks, 14 ounces with 2 ounces to be given with each med pass.<br>-There was a column for the documentation of initials.<br>-There was a column to document comments.<br><br>Interview with a second MA on 06/06/16 at 9:50 a.m. on the SCU revealed:<br>-Resident #3 could not have over 41 ounces of fluid per day.<br>-They had a monitoring form to record all of Resident #3's fluid intake.<br>-The MA was responsible for monitoring and recording Resident #3's daily fluids.<br>-Resident #3 did not have any issues with compliance in regards to his fluid restriction but would occasionally ask the MA for more water.<br>-There was no communication or documentation | D 276 | | |

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| D 276 | Continued From page 37<br>shared with the dialysis provider or the transportation staff to account for any intake of fluids when Resident #3 was at a dialysis treatment or during his transportation to and from dialysis.<br>-The MAs gave Resident #3 most of his fluids.<br>-Resident #3 was given between 1 to 2 ounces of water with his medications.<br><br>Observation on the SCU on 06/06/16 at 10:10 a.m. revealed:<br>-Resident #3 was in the dayroom sitting in a chair beside other residents.<br>-A snack cart was wheeled into the dayroom by a PCA.<br>-The PCA put a small amount of ice in a Styrofoam cup, filled the cup approximately ¾ full with a yellow colored beverage and handed the beverage to Resident #3.<br>-Resident #3 ate his snack and drank all of the yellow colored beverage; the PCA took the empty Styrofoam cup and placed it on the middle rack of the snack cart along with other residents' used cups.<br>-Resident #3 asked for "more juice" several times however the PCA did not respond to him.<br><br>Interview with a fourth PCA on 06/06/16 at 10:30 a.m. revealed:<br>-The PCA did not actually measure the beverage poured for Resident #3 during the 10:00 a.m. snack.<br>-The PCA was aware that she accidentally poured "too much" for Resident #3 during his snack.<br>-The PCA agreed that the line marked on the Styrofoam cup by the surveyor was at the level that was poured which was ¾ full.<br><br>Observation of the Styrofoam cup used during the 10:00am snack revealed: | D 276 | | |

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| D 276 | Continued From page 38<br>-The cup used during the snack would hold 8 ounces.<br>-Resident #3 drank approximately 7 ounces of fluid during the 10:00 snack.<br><br>-Observation of the Fluid Restriction Daily Log for 06/06/16 revealed the MA documented that Resident #3 had a total of 3 ounces of lemonade during his snack.<br><br>Telephone Interview with the nurse manager at the dialysis center on 06/06/16 at 12:30 p.m. revealed:<br>-There had been no communication from the facility related to Resident #3's fluid restriction.<br>-She had reviewed the resident's record from March 2, 2016 until current which reflected there had been no issues with his volumes or weight gain in between treatments.<br>-There were risk factors associated with not monitoring and restricting fluids as ordered for Resident #3 which included congestive heart failure, respiratory failure and even death.<br>-Resident #3 required a family member to come and sit with him during his dialysis treatments due to behaviors associated with his diagnosis of dementia.<br><br>Interview with the MA on 06/06/16 at 12:45 p.m. revealed:<br>-The PCA told the MA she may have given Resident #3 too much fluids during his snack at 10:00am but the PCA did not give the MA an exact amount.<br>-The MA documented 3 ounces for the 10:00am snack and would just lessen the amount the resident consumes later in day; the resident had left for dialysis and would not return until later in the day. | D 276 | | |

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| D 276 | Continued From page 39<br><br>Interview with the SCC on 06/06/16 at 12:52pm revealed:<br>-The SCC did not know why the MAs were not documenting all of the resident's fluid intake.<br>-The SCC was not aware that there were 2 forms that were being used to monitor daily fluids.<br>-The SCC did not know the facility had to document the amount of water the resident consumed with his medications.<br>-The facility did not check with the dialysis center to see if the resident received fluids during his treatments.<br><br>Interview with the Administrator on 06/06/16 at 1:15 p.m. revealed she was not aware that all of Resident #3's fluid intake was not monitored and documented. | D 276 | | |
| D 287 | 10A NCAC 13F .0904(b)(2) Nutrition And Food Service<br><br>10A NCAC 13F .0904 Nutrition And Food Service<br>(b) Food Preparation and Service in Adult Care Homes:<br>(2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the facility failed to serve cake to residents on non-disposable tableware.<br><br>The findings are: | D 287 | **Residents are to have a napkin and be served on non-disposable plates with non-disposable utensils and glasses/cups. Any special exceptions must be approved by Administrator. Staff has been in- serviced on the regulation and its importance. Administrator, RCC, and /or SCUC will monitor weekly to ensure compliance.** | 6/8/16 |

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| D 287 | Continued From page 40<br><br>Observations of the noon meal service in the Special Care Unit (SCU) on 06/02/16 revealed:<br><br>-Iced sheet cake was served to SCU residents on a paper napkin.<br>-Dessert was served to residents at the end of the meal, from 12:40 p.m. to 1:15 p.m.<br>-Approximately 75% of residents had finished their meal, and their plates and silverware had been removed by the personal care aide (PCA) staff.<br>-Those residents without plates and flatware were served a square of iced cake on a paper napkin.<br>-Some residents picked up the napkins with their hands and bit into the cake.<br>-Some residents picked at the cake with their fingers, breaking it into small pieces.<br>-Some residents smeared cake crumbs and icing on the bare table surfaces, and tried to pick them up and eat the cake that had fallen all over the table.<br><br>Confidential interview with a resident's family member revealed:<br>-It was not unusual for residents to receive meals and beverages served with disposable tableservice.<br>-This usually occurred when a resident was having a meal or snack outside the dining room.<br>-Between-meal beverages were offered in Styrofoam or clear plastic cups, and snacks were served on napkins or placed in disposable cups.<br><br>Interview with the Dietary Manager at 1:30 p.m. on 06/02/16 revealed:<br>-Disposable plastic and paper products were used "for convenience, to save time".<br>-Disposable products were used because they were accessible in the facility. | D 287 | D287 Addendum per telephone with Donna Dawson on 7/26/16:<br><br>Exceptions will be based on documented needs or preferences of the resident. The facility has a sufficient supply of non-disposable tableware and place settings. Monitoring will include random observations of meals and snacks.<br><br>W. Williams 7/26/16 | |

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| D 287 | Continued From page 41<br><br>-They had not been told not to use disposable products.<br>-Many small plates had been broken in the SCU and the dietary department did not have enough small plates to offer all residents a plated dessert.<br>-She had been serving desserts and snacks on napkins in the SCU "for a long time".<br>-She had not notified the Administrator that additional small plates needed to be purchased for the facility.<br>-She would discuss the need for additional table service, especially small plates and cups, with the Administrator.<br>-She was not aware that daily use of disposable tableservice was not allowed under state regulations.<br><br>Interview with the Administrator on 06/03/16 at 2:55 p.m. revealed:<br>-She was not aware disposable table service, including cups, plates, bowls, spoons, forks, and knives were disallowed for routine food service.<br>-If the dietary department did not have enough hard plastic cups, glasses, dishes, and bowls, she would purchase more tableware. | D 287 | | |
| D 311 | 10A NCAC 13F .0904(f)(1) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(f) Individual Feeding Assistance in Adult Care Homes:<br>(1) Sufficient staff shall be available for individual feeding assistance as needed.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to provide adequate staffing for 1 of 4 sampled residents (#10) who | D 311 | | |

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| D 311 | Continued From page 42<br>required feeding assistance.<br><br>The findings are:<br><br>Review of Resident #10's FL-2 dated 2/16/17 revealed:<br>-The resident's diagnoses included Alzheimer's disease, dementia, hypertension, multi-infarct, debilitation/deconditioning, gastro-esophageal reflux disease, and insomnia.<br>- There was an order for a mechanical soft diet.<br><br>Review of Resident #10's care plan dated 02/17/16 revealed she was totally dependent on staff for eating; staff was to feed her at all meals.<br><br>Observation of Resident #10 at 1:00 p.m. on 06/02/16 revealed:<br>- She picked up the cake on the napkin and held it to her mouth to eat.<br>-She licked the napkin in order to eat the cake.<br>-The napkin was slippery and wet from her saliva, but did not disintegrate.<br>-With pronounced sucking and tongue thrusting, Resident #10 ate the cake and sucked part of the napkin into her mouth.<br><br>Observation of Resident #10 at 1:02 p.m. on 06/02/16 revealed:<br>-Two inches of wet napkin was hanging over her lower lip.<br>-No staff were at the table at that time; they were busy assisting other residents.<br>-Staff were busy serving meals to other residents and escorting residents back to their rooms or to special care unit (SCU) activity areas.<br>-Surveyor informed a personal care aide (PCA) that Resident #10 had put the napkin in her mouth, along with the cake, when feeding herself.<br>-The PCA checked the resident's oral cavity for | D 311 | Residents that require feeding or additional assistance during meals have been identified. Table assignments have been adjusted to aid staff in efficiency and ensure proper attention to residents needs/feeding. Administrator, RCC and/or SCUC will monitor weekly to ensure meal service continues to meet the needs of the residents and is efficient. 6/9/16<br><br>D311 Addendum per telephone with Donna Dawson on 7/26/16:<br>Sufficient staff are available to feed residents requiring assistance. Staff will notify RCC or SCC if more assistance is needed. Monitoring will include random observation of meals and snacks.<br>W. Williams<br>7/26/16 | |

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| D 311 | Continued From page 43<br>residue with a gloved hand, cleaned the resident's mouth, face and hands, and escorted the resident to her room.<br><br>Interview with the PCA at 1:05 p.m. on 06/02/16 revealed:<br>-Resident #10 enjoyed her meals and would take foods from the plates of her tablemates.<br>-She liked to feed herself, but "was not safe to feed herself".<br>-Resident #10 sat next to Resident #4, who was fed by staff 1:1.<br>-The PCA left the dining table to get another plate of food for another resident so she was not at the table to remove the napkin from Resident #10.<br><br>Confidential interviews with medication aides (MAs) and PCAs in the SCU revealed:<br>-More staff was needed to serve residents their meals.<br>-MAs ensured residents got the correct diet order and supplements.<br>-Staff brought residents to the dining room, seated them, and circulated in the dining room to ensure residents' requests were met.<br>-It took a lot of time to round up residents, get them ready to go to the dining room, escort them to the dining room, and seat them.<br>-PCAs and MAs were assigned to help residents needing assistance with feeding.<br>-Too often, "staff is stretched, PCAs must attend to [activities of daily living] of a resident in the resident's room, but are assigned to work in the dining room at the same time".<br><br>Interview with the Administrator on 06/03/16 at 2:55 p.m. revealed:<br>-She had 2 MAs and 4 PCAs in the dining room during mealtimes, and met the minimum staffing requirements for the number of residents living in | D 311 | | |

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| D 311 | Continued From page 44<br>the SCU.<br>-There were 4 residents in the SCU that needed feeding assistance from staff.<br>-She was aware the SCU staff were responsible for the overall supervision of safe meal consumption for all residents.<br>-She did not consider other duties of staff that may occur during meal times, such as availability of staff supervision for the residents who needed assistance with personal care needs during meals.<br>-She did not consider the amount of time needed to escort and seat all SCU residents to the dining room. | D 311 | | |
| D 358 | 10A NCAC 13F .1004(a) Medication Administration<br><br>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.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observation, interview, and record review, the facility failed to administer medications as ordered for 4 of 7 residents (#6, #7, #8, #9) observed during the medication passes, including errors with insulin (#8), a phosphate binder (#9), an inhaler for breathing problems and a lubricant eye drop (#6), a seizure/mood disorder medication and a calcium | D 358 | Medication error reports will be completed and sent to physician when errors are identified. Medication in-services have been completed. RCC and /or SCUC will do medication pass observations to ensure medications are administered as ordered. Medication audits and medication orders will be compared w/MARS to medications on hand. Administrator, RCC, SCUC, or designee will monitor weekly to ensure all systems are in place and being completed. | 6/13/16 |

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| D 358 | Continued From page 45<br><br>with vitamin D supplement (#7), and for 1 of 5 residents (#5) sampled for record review including errors with a blood thinner, an inhaler for breathing problems, and an iron supplement.<br><br>The findings are:<br><br>1. The medication error rate was 24% as evidenced by the observation of 6 errors out of 25 opportunities during the 8:00 a.m. / 9:00 a.m. and 12:00 noon / 1:00 p.m. medication passes on 06/02/16 and the 12:00 noon medication pass on 06/03/16.<br><br>A. Review of Resident #8's current FL-2 dated 09/21/15 revealed:<br>-The resident's diagnoses included diabetes mellitus type II without complications, essential hypertension, esophageal reflux, atherosclerosis, and acute angle closure glaucoma.<br>-There was an order for Novolog insulin before meals and at bedtime according to the following sliding scale: 200 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; and <60 or >400 call physician. (Novolog is rapid-acting insulin that lowers blood sugar.)<br><br>Review of the May and June 2016 medication administration records (MARs) revealed:<br>-Novolog sliding scale insulin was scheduled to be administered at 8:00 a.m., 12:00 noon, 5:00 p.m. and 8:00 p.m.<br>-The resident's blood sugar ranged from 68 - 380 from 05/01/16 - 06/02/16.<br><br>Observation of the 12:00 noon medication pass on 06/02/16 revealed:<br>-The medication aide (MA) checked Resident #8's blood sugar at 12:11 p.m. and it was 282.<br>-The MA stated she was going to administer 6 | D 358 | D358 Addendum per telephone with Donna Dawson on 7/26/16:<br><br>RCC/SCC observe med passes at least weekly. Monitoring includes review of records and med error reports.<br><br>W. Williams 7/26/16 | |

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| D 358 | Continued From page 46<br><br>units of Novolog insulin for the sliding scale.<br>-The syringe had lines marking 1 unit increments with the lines alternating on each side of the syringe.<br>-There was a longer line marking each 5 unit increment with the number printed on the syringe starting with 5 units.<br>-The MA drew up the Novolog insulin into the syringe to the line marking 7 units.<br>-The MA stated there was 6 units of insulin in the syringe.<br>-The MA took the syringe and walked into the room to the resident and started to administer the insulin.<br>-The surveyor asked the MA to step outside of the room to the medication cart.<br>-The surveyor asked the MA again how much insulin was in the syringe and the MA stated 6 units.<br>-The surveyor asked the MA to count the increments on the syringe.<br>-The MA started with the line marking 5 units and then counted the first line marked on the left of the syringe as 6 units.<br>-The surveyor then asked the MA to turn the syringe to the right so the MA could see the increments marked on the right side of the syringe.<br>-The MA then realized the line marking 6 units was on the right side of the syringe while the line she had drawn the insulin to on the left side was actually 7 units.<br>-The MA adjusted the dosage to 6 units of insulin.<br>-The MA then administered 6 units of Novolog insulin to Resident #8 at 12:15 p.m.<br><br>Interview with the MA on 06/02/16 at 12:16 p.m. revealed:<br>-She had not noticed the scale on the syringe had alternating marked increments. | D 358 | | |

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| D 358 | Continued From page 47<br><br>-They used the same kind of syringe for all of the residents to her knowledge.<br>-She had training on diabetes in the past and she had been checked off by a nurse for insulin administration.<br><br>Interview with the Resident Care Coordinator (RCC) on 06/02/16 at 1:45 p.m. revealed:<br>-The MAs have been trained on insulin administration and they should know how to read the scale on the syringes.<br>-She would make sure she retrained staff to read the markings on the insulin syringes correctly.<br><br>B. Review of Resident #9's current FL-2 dated 04/29/16 revealed:<br>-The resident's diagnoses included diabetes mellitus type II, acute Hepatitis C without mention of hepatic coma, hypertension, hyperlipidemia, proteinuria, and membranoproliferative nephrosis.<br>-There was an order for Renvela 800mg take 1 by mouth with meals. (Renvela is a phosphate binder used to lower phosphorus levels in dialysis patients. According to the manufacturer, Renvela should be taken with meals because it binds to the phosphorus in the foods eaten so the body does not absorb as much.)<br><br>Review of a subsequent physician's order dated 04/27/16 revealed there was an order for Renvela 800mg take 2 per meal and 1 per snack.<br><br>Review of the June 2016 medication administration records (MARs) revealed:<br>-There was an entry for Renvela 800mg take 2 tablets 3 times a day with meals.<br>-Renvela 2 tablets was scheduled to be administered at 8:00 a.m., 12:00 noon, and 5:00 p.m. | D 358 | | |

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| D 358 | Continued From page 48<br><br>-There was an entry for Renvela 800mg take 1 tablet with snacks and it was scheduled to be administered at 10:00 a.m., 2:00 p.m., and 8:00 p.m.<br><br>Observation of the 12:00 noon medication pass on 06/02/16 revealed:<br>-The medication aide (MA) administered 2 Renvela 800mg tablets to Resident #9 at 12:19 p.m.<br>-Resident #9 was in the hallway and had not eaten any lunch.<br><br>Observation in the dining room on 06/02/16 revealed:<br>-Resident #9 was served lunch at 12:50 p.m., 31 minutes after the Renvela was administered.<br>-Renvela was administered before the meal instead of with the meal as ordered.<br><br>Interview with the MA on 06/02/16 at 1:35 p.m. revealed:<br>-She thought medications ordered with meals could be given within 15 minutes of the meal.<br>-Lunch was usually served between 12:20 p.m. and 12:30 p.m.<br>-She did not realize lunch was not served to Resident #9 today until 12:50 p.m.<br><br>Interview with the Resident Care Coordinator (RCC) on 06/02/16 at 1:45 p.m. revealed:<br>-Lunch was usually served around 12:30 p.m.<br>-Medications ordered with meals were supposed to be administered when the resident got their food in front of them.<br><br>Interview with Resident #9 on 06/02/16 at 4:15 p.m. revealed:<br>-He usually got his medications before he ate his meals. | D 358 | | |

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| D 358 | Continued From page 49<br>-He could not say how long he usually waited for his meals after he received his medications.<br><br>C. Review of Resident #6's current FL-2 dated 10/26/15 revealed the resident's diagnoses included dementia (neurosyphilis), blindness, deafness, chronic obstructive pulmonary disease, depressive disorder, sarcoidosis, hypertension, diabetes mellitus, and dyslipidemia.<br><br>i. Review of Resident #6's current FL-2 dated 10/26/15 revealed an order for Symbicort 160/4.5mcg inhale 2 puffs twice daily and rinse mouth after use. (Symbicort is used to treat lung disease. The manufacturer instructs to rinse mouth with water after use without swallowing to prevent infections of the mouth and throat.)<br><br>Review of Resident #6's current assessment and care plan dated 11/12/15 revealed:<br>-The resident was legally blind and deaf.<br>-His hearing and vision were "very limited".<br>-Communication with the resident was done by staff writing on his hand or upper body.<br><br>Review of the June 2016 medication administration record (MAR) revealed:<br>-There was an entry for Symbicort 160/4.5mcg inhale 2 puffs twice daily (rinse mouth after use).<br>-Symbicort was scheduled to be administered at 8:00 a.m. and 7:00 p.m.<br><br>Observation of the 8:00 a.m. medication pass on 06/02/16 revealed:<br>-The medication aide (MA) administered 2 quick puffs in a row at 9:16 a.m. without allowing at least 1 minute between the puffs.<br>-The MA did not instruct the resident to inhale the medication when the inhaler was pressed down nor to hold breath in for approximately 10 | D 358 | | |

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| D 358 | Continued From page 50<br>seconds to allow the medication to reach the lungs.<br>-The medication vapors came back out of the resident's mouth.<br>-The medication aide did not offer or instruct the resident to rinse his mouth with water.<br><br>Interview with the MA on 06/02/16 at 11:25 a.m. revealed:<br>-She had training on use of inhalers and she was aware she was supposed to wait between puffs.<br>-Resident #6 cannot see so it was hard to communicate with the resident and the resident would get agitated at times.<br>-Resident #6 could hear if you "yell".<br>-She did not notice the instructions to rinse mouth but the resident usually brushed his teeth in the mornings.<br>-She had not noticed Resident #6 having any shortness of breath.<br><br>Interview with the Special Care Coordinator (SCC) on 06/02/16 at 11:40 a.m. revealed:<br>-She just started working at the facility on 02/11/16.<br>-She was not aware of any inhaler training since she started.<br>-The facility's policy was to give 1 puff, wait 1 minute, and give the second puff.<br>-Staff should be instructing the resident on how to inhale.<br>-If ordered, they should rinse the resident's mouth after use of inhaler.<br>-Resident #6 can hear if you talk loud.<br>-They also tap his hand or write on his hand to communicate with him.<br>-Resident #6 would understand if he was instructed on how to use the inhaler.<br>-Staff knew they were supposed to wait between the puffs. | D 358 | | |

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| D 358 | Continued From page 51<br><br>-She would check into getting Resident #6 a spacer device to help with administration of his inhaler.<br><br>ii. Review of Resident #6's current FL-2 dated 10/26/15 revealed there was an order for Artificial Tears 2 drops in each eye 4 times a day.<br><br>Review of the June 2016 medication administration record (MAR) revealed:<br>-There was an entry for Artificial Tears instill 2 drops into each eye 4 times a day.<br>-Artificial Tears were scheduled to be administered at 8:00 a.m., 1:00 p.m., 5:00 p.m., and 7:00 p.m.<br><br>Observation of the 8:00 a.m. medication pass on 06/02/16 revealed the medication aide (MA) administered Artificial Tears, 1 drop in each eye to Resident #6 at 9:17 a.m. instead of 2 drops as ordered.<br><br>Interview with the MA on 06/02/16 at 11:25 a.m. revealed:<br>-She was going by the instructions on the medication label to give 1 drop in each eye.<br>-She had not noticed the instructions on the MAR was to give 2 drops in each eye.<br><br>Review of medications on hand on 06/02/16 revealed:<br>-There was one bottle of Artificial Tears eye drops dispensed by a veteran's administration (VA) pharmacy on 04/25/16.<br>-The instructions on the label were to instill 1 drop in each 4 times a day.<br><br>Review of Resident #6's physician's orders revealed there was no order for Artificial Tears 1 drop in each eye 4 times a day. | D 358 | | |

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| D 358 | Continued From page 52<br><br>Interview with the Special Care Coordinator (SCC) on 06/02/16 at 11:40 a.m. revealed:<br>-If the MAR and the medication label do not match, the MAs were supposed to put a direction change sticker on the label.<br>-MAs were supposed to administer medications according to the instructions on the MAR.<br>-MAs were also supposed to notify the SCC if something did not match to see if clarification was needed.<br>-The most current order they had for the Artificial Tears was on the current FL-2 for 2 drops in each eye and that is what should have been administered.<br><br>Attempts to contact the VA pharmacy during the survey were unsuccessful.<br><br>D. Review of Resident #7's current FL-2 dated 02/29/16 revealed the resident's diagnoses included Alzheimer's disease, dementia, and insomnia.<br><br>i. Review of Resident #7's current FL-2 dated 02/29/16 revealed an order for Keppra 500mg twice daily. (Keppra is a seizure medication that may also be used to treat mood or behavior disorders.)<br><br>Review of the June 2016 medication administration record (MAR) revealed there was an entry for Keppra 500mg twice daily and it was scheduled to be administered at 9:00 a.m. and 8:00 p.m.<br><br>Observation of the 9:00 a.m. medication pass on 06/02/16 revealed:<br>-The medication aide (MA) prepared and crushed the morning medications for Resident #7 except | D 358 | | |

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| D 358 | Continued From page 53<br><br>for enteric coated Aspirin.<br>-The MA administered the crushed medications in pudding to the Resident at 9:27 a.m., including Keppra 500mg.<br>-The resident swallowed the medications without any problems.<br><br>Interview with the MA on 06/02/16 at 11:18 a.m. revealed:<br>-She did not crush the Aspirin because it was enteric coated.<br>-She was not aware the Keppra should not be crushed.<br>-There was a "do not crush" list at one time in the front of the MAR book but she could not find it.<br>-Sometimes the MARs or medication labels would be marked with instructions not to crush certain medications.<br>-None of Resident #7's medications were labeled or marked on the MAR not to crush but she know the Aspirin should not be crushed.<br><br>Interview with the Special Care Coordinator (SCC) on 06/02/16 at 11:40 a.m. revealed:<br>-There was usually a do not crush sticker on the medication packs or it was usually marked on the MAR if something could not be crushed.<br>-She was not sure if they had a do not crush list.<br>-She would check with the pharmacy about getting one.<br>-She would check with the physician about changing the Keppra tablet to a liquid.<br><br>Review of a list of medications that should not be crushed or chewed that was faxed by the pharmacy on 06/02/16 revealed:<br>-Keppra was listed as a medication that should not be crushed or chewed.<br>-The reason noted was due to taste.<br>-The list noted Keppra was available in liquid | D 358 | | |

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| D 358 | Continued From page 54<br>dosage forms.<br><br>ii. Review of Resident #7's current FL-2 dated 02/29/16 revealed an order for Calcium with Vitamin D ½ tablet daily to = 600/400. (Calcium with Vitamin D is a supplement.)<br><br>Review of the June 2016 medication administration record (MAR) revealed there was an entry for Vitamin D ½ tablet daily to = 600/400 and it was scheduled to be administered at 9:00 a.m.<br><br>Observation of the 9:00 a.m. medication pass on 06/02/16 revealed the medication aide (MA) administered ½ tablet of Calcium with Vitamin D from an over-the-counter manufacturer bottle at 9:27 a.m.<br><br>Review of the manufacturer label on the Calcium with Vitamin D bottle revealed:<br>-Each whole tablet contained 600mg of Calcium and 800 units of Vitamin D. (Each ½ tablet would contain 300mg of Calcium and 400 units of Vitamin D.)<br><br>Interview with the MA on 06/02/16 at 11:18 a.m. revealed:<br>-The resident's family brought in the Calcium with Vitamin D bottle and it was the only supply they had at the facility.<br>-She had not noticed the strength of medication on the MAR did not match the strength of medication on the label.<br>-She did not realize the resident was only getting 300mg of Calcium instead of 600mg as ordered.<br><br>Interview with the Special Care Coordinator (SCC) on 06/02/16 at 11:40 a.m. revealed:<br>-They used to have a form for MAs to fill out when | D 358 | | |

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| D 358 | Continued From page 55<br>medications were supplied by the family but they had stopped filling them out.<br>-The MAs had been trained to read and compare the MARs and the labels and if something did not match, the MAs were supposed to stop and find out why it did not match.<br>-She would contact the physician about the Calcium with Vitamin D for Resident #7.<br><br>2. Review of Resident #5's current FL-2 dated 04/20/16 revealed the resident's diagnoses included diabetes mellitus, obstructive pulmonary disease, asthma, anemia, hypertension, aortic stenosis, and osteoarthritis.<br><br>A. Review of Resident #5's current FL-2 dated 04/20/16 revealed an order for Coumadin 7.5mg once daily. (Coumadin is a blood thinner. INR is a lab value used to determine the effectiveness of Coumadin and is usually recommended to be between 2 and 3.)<br><br>Review of the April 2016 medication administration record (MAR) revealed:<br>-There was an entry for Coumadin 7.5mg once daily and it was scheduled to be administered at 5:00 p.m.<br>-Coumadin was documented as not administered on 04/21/16 - 04/23/16 due to "in route" and "waiting for pharmacy".<br><br>Review of pharmacy dispensing records from 01/01/16 - 06/03/16 revealed:<br>-Thirty Coumadin 7.5mg tablets were dispensed on 01/20/16.<br>-Thirty Coumadin 7.5mg tablets were dispensed on 02/21/16.<br>-Thirty Coumadin 7.5mg tablets were dispensed on 03/16/16.<br>-Fourteen Coumadin 7.5mg tablets were | D 358 | | |

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| D 358 | Continued From page 56<br><br>dispensed on 04/24/16.<br>-Fourteen Coumadin 7.5mg tablets were dispensed on 05/05/16.<br>-Thirty Coumadin 7.5mg tablets were dispensed on 05/24/16.<br><br>Review of a fax notification form to the Nurse Practitioner (NP) dated 04/26/16 revealed:<br>-NP was notified the resident did not receive Coumadin for 3 days on 04/21/16, 04/22/16, and 04/23/16.<br>-Medication aides were counseled to make sure all medications were ordered in a timely manner.<br>-The NP signed and dated the form on 04/26/16 with no instructions noted.<br><br>Review of Resident #5's labwork results in the record revealed:<br>-The resident's INR was 2.5 (within therapeutic range) on 04/20/16.<br>-The resident's INR was 1.5 (below therapeutic range) on 05/04/16.<br>-The resident's INR was 1.8 (below therapeutic range) on 05/11/16.<br>-The resident's INR was 2.3 (within therapeutic range) on 05/18/16.<br>-The resident's INR was 2.0 (within therapeutic range) on 06/01/16.<br><br>Interview with a medication aide on 06/03/16 at 3:55 p.m. revealed:<br>-She did not recall why the Coumadin was unavailable for Resident #5.<br>-The MAs were supposed to reorder medications when they got down to the colored strip on the bubble card.<br>-The medications usually come in the same night they are ordered or either the next day.<br><br>Interview with the Resident #5 on 06/03/16 at | D 358 | | |

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| D 358 | Continued From page 57<br><br>4:00 p.m. revealed:<br>-She did not receive Coumadin for 4 days from Thursday through Sunday.<br>-She did not know why the facility ran out of her medication.<br>-The facility told her NP about it.<br>-She got her INR checked about every 1 to 2 weeks.<br>-She had not missed any doses of Coumadin since April 2016 to her knowledge.<br><br>Interview with the NP on 06/03/16 at 5:05 p.m. revealed:<br>-The facility notified her in April 2016 about the Coumadin being unavailable.<br>-The resident's INR went down below therapeutic range during that time.<br>-The NP checked the resident's INR more frequently but she did not change the Coumadin dose.<br>-The INR level eventually came back up to therapeutic range.<br><br>Refer to interview with the Resident Care Coordinator (RCC) on 06/03/16 at 3:45 p.m.<br><br>B. Review of Resident #5's current FL-2 dated 04/20/16 revealed an order for Advair Diskus 250/50 inhale 1 puff twice daily and rinse mouth after use. (Advair is used to treat lung disease and breathing problems.)<br><br>Review of the April 2016 medication administration record (MAR) revealed:<br>-There was an entry for Advair Diskus inhale 1 puff twice daily, rinse mouth after use and it was scheduled to be administered at 9:00 a.m. and 9:00 p.m.<br>-Advair was documented as not administered on 04/09/16 - 04/12/16 due to "awaiting for | D 358 | | |

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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 |
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| D 358 | Continued From page 58<br>pharmacy".<br><br>Review of pharmacy dispensing records from 01/01/16 - 06/03/16 revealed:<br>-One Advair inhaler (30 day supply) was dispensed on 01/25/16.<br>-One Advair inhaler (30 day supply) was dispensed on 02/21/16.<br>-One Advair inhaler (30 day supply) was dispensed on 03/24/16.<br>-One Advair inhaler (30 day supply) was dispensed on 04/14/16.<br>-One Advair inhaler (30 day supply) was dispensed on 05/11/16.<br><br>Interview with a medication aide on 06/03/16 at 3:55 p.m. revealed:<br>-She did not recall why the Advair was unavailable for Resident #5.<br>-The MAs were supposed to reorder the Advair inhaler when the counter on the inhaler got down to 6 puffs left (a 3 day supply).<br><br>Interview with the Resident #5 on 06/03/16 at 4:00 p.m. revealed:<br>-Last month, they could not find her purple inhaler (Advair).<br>-The facility staff had to order her another inhaler.<br>-She had a different inhaler, a white one that she also used that helped with her breathing.<br>-She used it while she was out of the purple inhaler and she did not have problems breathing.<br><br>Refer to interview with the Resident Care Coordinator (RCC) on 06/03/16 at 3:45 p.m.<br><br>C. Review of Resident #5's physician's orders revealed an order dated 04/21/16 for Ferrous Sulfate 325mg twice daily. (Ferrous Sulfate is an iron supplement used to treat anemia.) | D 358 | | |

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| D 358 | Continued From page 59<br><br>Review of the May 2016 medication administration record (MAR) revealed:<br>-There was an entry for Ferrous Sulfate 325mg twice daily and it was scheduled to be administered at 9:00 a.m. and 9:00 p.m.<br>-Ferrous Sulfate was documented as not administered at 9:00 p.m. on 05/15/16 and 05/16/16 due to "awaiting for pharmacy".<br><br>Review of pharmacy dispensing records from 01/01/16 - 06/03/16 revealed:<br>-Sixty Ferrous Sulfate 325mg tablets were dispensed on 01/04/16.<br>-Sixty Ferrous Sulfate 325mg tablets were dispensed on 02/15/16.<br>-Sixty Ferrous Sulfate 325mg tablets were dispensed on 03/15/16.<br>-Sixty Ferrous Sulfate 325mg tablets were dispensed on 04/14/16.<br>-Sixty Ferrous Sulfate 325mg tablets were dispensed on 05/14/16.<br><br>Interview with a medication aide on 06/03/16 at 3:55 p.m. revealed:<br>-She did not recall why the Ferrous Sulfate was unavailable for Resident #5.<br>-The MAs were supposed to reorder medications when they got down to the colored strip on the bubble card.<br>-The medications usually come in the same night they are ordered or either the next day.<br><br>Interview with the Resident #5 on 06/03/16 at 4:00 p.m. revealed:<br>-Last month, the facility ran out of her red pill (referring to Ferrous Sulfate) for a few days.<br>-She did not know why they ran out.<br><br>Refer to interview with the Resident Care | D 358 | | |

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| D 358 | Continued From page 60<br>Coordinator (RCC) on 06/03/16 at 3:45 p.m.<br>---<br>Interview with the Resident Care Coordinator (RCC) on 06/03/16 at 3:45 p.m. revealed:<br>-They do not get cycle fills from the pharmacy.<br>-The MAs were supposed to reorder medications when they got to the last row on the bubble cards with the colored strip.<br>-If medications are ordered by 2:00 p.m., they are usually delivered to the facility that same night.<br>-If a medication was ordered and did not come in, the MAs were supposed to contact the pharmacy.<br>-She counseled the MAs about ordering the medications in a timely manner.<br>---<br>Review of the facility's plan of protection dated 06/03/16 revealed:<br>-Medication error reports will be completed and forwarded to the physicians for any medication errors identified during survey and thereafter.<br>-Medication in-services for medication aides will be arranged to be completed within the next week.<br>-RCC and SCC will do medication pass observations weekly to ensure medications are being administered as ordered.<br>-Medication record audits will be completed weekly by Administrator, RCC, and SCC.<br>-Medication orders will be compared with MARs and medications on hand.<br>-Administrator will monitor weekly to make sure systems are put in place and are being done.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 21, 2016. | D 358 | | |

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| D 464 | Continued From page 61 | D 464 | | |
| D 464 | 10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan<br><br>10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan<br>In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following:<br>(1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment.<br>(2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to ensure Initial and Quarterly Resident Profiles were completed for 2 of 2 sampled residents (#3, #4) who resided on the Special Care Unit.<br><br>The findings are:<br><br>1. Review of Resident #4's current FL2 dated 04/18/16 revealed the resident's diagnoses included advanced Alzheimer's dementia, urinary tract infection, bilateral subdural hematomas slip/post fall, hypernatremia. | D 464 | Resident Profiles and Care Plans have been completed.<br><br>Any resident admitted to the SCU will have a Resident Profile done within 30 days and then quarterly thereafter. Additionally a Care Plan will be developed based on the profile.<br><br>Administrator and/or RCC will monitor monthly to ensure completion in a timely manner.<br><br>D464 Addendum per telephone with Donna Dawson on 7/26/16:<br>SCC is responsible for completing SCU Resident Profiles and Care Plans. They will be filed in the residents' records. Monitoring will include random chart audits.<br><br>W. Williams 7/26/16 | 7/1/16 |

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| D 464 | Continued From page 62<br><br>Review of the Resident Register revealed Resident #4 was admitted to the facility on 9/10/10.<br><br>Review of Special Care Unit (SCU) resident record for Resident #4 revealed:<br>-There was no initial 30 day SCU assessment for the resident.<br>- There were no quarterly resident profiles for the resident.<br><br>Interview with the Special Care Coordinator regarding Resident #4 on 6/03/16 at 12:30 p.m. revealed:<br>-She had not heard of an initial 30 day assessment for SCU residents.<br>-She thought the Resident Care Plan was the only assessment required for all residents.<br>-She was unaware of the requirement for quarterly resident profiles for the resident.<br>-No resident in the SCU had an initial resident assessment or quarterly resident profile.<br>-The SCC would contact the Nurse Practitioner (NP) and Administrator in order to develop a resident profile for all SCU residents.<br><br>Interview with the Administrator on 6/03/16 at 1:45 p.m. revealed:<br>-She was not aware that Initial 30 day assessments were required for SCU residents.<br>-She knew that none of the residents had a Quarterly Resident Profile since she had not heard of the initial resident assessment for SCU residents.<br>-She believed the Resident Care Plans were the only required documents.<br>-She would have the SCC develop an initial and quarterly resident profile form for the SCU residents. | D 464 | | |

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| D 464 | Continued From page 63<br><br>2. Review of Resident #3's current FL-2 dated 04/09/16 revealed:<br>-The resident's diagnoses included acute hypoxic respiratory failure likely secondary to healthcare acquired pneumonia, metabolic encephalopathy, end stage renal disease on dialysis, gastroesophageal reflux disease, hypertension, type 2 diabetes, dyslipidemia, and glaucoma.<br><br>Review of Resident #3's Resident Register revealed an admission date of 08/25/15.<br><br>Review of Resident #3's Special Care Unit (SCU) resident record revealed:<br>-There was no initial 30 day SCU resident profile assessment for the resident.<br>-There were no quarterly resident profile assessments for the resident.<br><br>Interview with the Special Care Coordinator (SCC) on 06/03/16 at 3:15 p.m. revealed:<br>-There were no residents in the SCU with an initial written resident profile assessment or a quarterly written resident profile assessment.<br>-A "sister facility" had been contacted and they would fax the facility a form to use for the SCU profile assessments.<br>-The facility would initiate the quarterly resident profiles on all SCU residents and initial resident profile assessments on all new SCU residents. | D 464 | | |
| D912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21. Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and | D912 | | |

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| D912 | Continued From page 64<br>regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review, and interview, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to test for tuberculosis, personal care and supervision, medication administration, and adult care homes medication aides training and competency evaluation requirements.<br><br>The findings are:<br><br>1. Based on interview and record review, the facility failed to assure 5 of 6 staff (A, C, D, E, F) sampled were tested upon employment for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. [Refer to Tag D131 10A NCAC 13F .0406(a) Test for Tuberculosis (Type B Violation).]<br><br>2. Based on observations, interviews, and record review, the facility failed to ensure the level of supervision for the resident was modified after continued repeated falls for 1 of 5 sampled residents (#4) with one fall resulting in a hospitalization for a head injury with bilateral subdural hematomas. [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation).]<br><br>3. Based on observation, interview, and record review, the facility failed to administer medications as ordered for 4 of 7 residents (#6, #7, #8, #9) observed during the medication | D912 | Facility will provide care and services which are appropriate, adequate and in compliance with federal and state laws, rules and regulations related to Tuberculosis testing, Personal Care Supervision, Medication Administration and Med Tech Training and Competency Evaluations.<br><br>Administrator, RCC, SCUC and/or designee will monitor continuously to ensure residents rights are not violated. | 7/15/16 |

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| D912 | Continued From page 65<br><br>passes, including errors with insulin (#8), a phosphate binder (#9), an inhaler for breathing problems and a lubricant eye drop (#6), a seizure/mood disorder medication and a calcium with vitamin D supplement (#7), and for 1 of 5 residents (#5) sampled for record review including errors with a blood thinner, an inhaler for breathing problems, and an iron supplement. [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).]<br><br>4. Based on observations, interviews, and record reviews, the facility failed to assure 2 of 4 medication aides (A, E) sampled who administered medications had completed the 5 hour and 10 hour or the 15 hour state approved medication administration courses as required, including one medication aide (A) who made two errors during a medication pass observed on 06/02/16. [Refer to Tag D935 G.S. 131D-4.5B (b) Adult Care Homes Medication Aides Training and Competency Evaluation Requirements (Type B Violation).] | D912 | | |
| D935 | G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency<br><br>G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements.<br><br>(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:<br>(1) A five-hour training program developed by the | D935 | | |

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| D935 | Continued From page 66<br>Department that includes training and instruction in all of the following:<br>a. The key principles of medication administration.<br>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.<br>(2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503.<br>(3) Within 60 days from the date of hire, the individual must have completed the following:<br>a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following:<br>1. The key principles of medication administration.<br>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.<br>b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews, and record reviews, the facility failed to assure 2 of 4 medication aides (A, E) sampled who administered medications had completed the 5 | D935 | All Med Tech records have been audited and all Med Techs requiring 5, 10 or 15 hour training have completed that training. All new hire Med Techs will receive the 5 hour training prior to beginning work and the 10 hour training within 60 days. Administrator or RCC will notify RN of any Med Techs requiring training. Administrator, RCC, SCUC or designee will monitor weekly to ensure compliance. | 7/18/16 |

D935 Addendum per telephone with Donna Dawson on 7/26/16:

The Administrator will put a list of new med aides in the RN's box at the facility and verbally tell the RN every Monday when the RN comes to the facility. Med aides will not administer meds until at least 5 hour training and skills checklist are completed as required. Personnel files will be checked to assure compliance.

W. Williams 7/26/16

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| D935 | Continued From page 67<br><br>hour and 10 hour or the 15 hour state approved medication administration courses as required, including one medication aide (A) who made two errors during a medication pass observed on 06/02/16.<br><br>The findings are:<br><br>1. Review of Staff A's personnel file revealed:<br>-She was rehired as a nurse aide / medication aide on 03/22/16.<br>-She completed the Medication Aide Clinical Skills checklist on 07/23/13.<br>-She passed the written medication aide exam on 11/21/13.<br>-There was no documentation of the 5 hour, 10 hour, or 15 hour state approved medication administration courses for Staff A<br><br>Observation during the survey on 06/01/16, 06/02/16 and 06/03/16 revealed:<br>-Staff A administered medications on the 300 hall of the facility during first shift on 06/01/16 and 06/02/16.<br>-Staff A misread the markings on the insulin syringe and drew up the wrong amount of insulin for Resident #8 during the lunchtime medication pass on 06/02/16.<br>-Staff A administered a medication ordered with meals 31 minutes before the meal to Resident #9 during the lunchtime medication pass on 06/02/16.<br>-Staff A administered medications on the 100 hall of the facility during first shift on 06/03/16.<br><br>Review of the April, May, and June 2016 medication administration records revealed Staff A documented administration of medications in all 3 months. | D935 | | |

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| D935 | Continued From page 68<br><br>Interview with the Administrator on 06/06/16 at 2:10 p.m. revealed:<br>-Staff A was a rehire and had administered medications previously at the facility.<br>-She did not realize Staff A needed the state approved medication training since she passed the written exam after 10/01/13.<br>-Staff A usually worked first shift as a medication aide but she was not working today.<br><br>Staff A was unavailable for interview on 06/06/16.<br><br>Refer to interview with the Administrator on 06/06/16 at 10:15 a.m.<br><br>Refer to interview with the Resident Care Coordinator (RCC) on 06/06/16 at 11:35 a.m.<br><br>Refer to interview with the Registered Nurse (RN) Consultant on 06/06/16 at 1:30 p.m.<br><br>2. Review of Staff E's personnel file revealed:<br>-She was hired as a nurse aide / medication aide on 01/27/16.<br>-She completed the Medication Aide Clinical Skills checklist on 02/01/16.<br>-She passed the written medication aide exam on 12/13/07.<br>-There was no medication aide employment verification for Staff E.<br>-There was no documentation of the 5 hour, 10 hour, or 15 hour state approved medication administration courses for Staff A<br><br>Observation during the survey on 06/02/16 and 06/03/16 revealed Staff E administered medications in the special care unit during second shift on 06/02/16 and 06/03/16.<br><br>Review of the April, May, and June 2016 | D935 | | |

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| D935 | Continued From page 69<br>medication administration records revealed Staff E documented administration of medications in all 3 months.<br><br>Interview with the Administrator on 06/06/16 at 2:05 p.m. revealed:<br>-Staff E worked as a medication aide previously at another assisted living facility.<br>-She did not know why there was no medication aide employment verification for Staff E.<br>-She would contact the other facility to try to get verification.<br><br>Telephone interview with Staff E on 06/06/16 at 2:07 p.m. revealed:<br>-Staff E had worked at another assisted living facility in 2011 - 2013.<br>-She also worked at another assisted living facility after that before coming to this facility.<br>-She was not aware verification was needed.<br>-She had not taken the 5 hour, 10 hour, or 15 hour medication administration course.<br>-She administered medications at the facility.<br><br>Interview with the Administrator on 06/06/16 at 2:48 p.m. revealed:<br>-She had contacted one of the assisted living facilities that Staff E had worked previously.<br>-The Administrator for that facility was out of town.<br>-She was unable to get medication aide employment verification for Staff E.<br><br>Refer to interview with the Administrator on 06/06/16 at 10:15 a.m.<br><br>Refer to interview with the Resident Care Coordinator (RCC) on 06/06/16 at 11:35 a.m.<br><br>Refer to interview with the Registered Nurse (RN) | D935 | | |

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| | HAL098027 | A. BUILDING: _____ B. WING _____ | R 06/06/2016 |

| 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 70<br>Consultant on 06/06/16 at 1:30 p.m.<br>_____<br><br>Interview with the Administrator on 06/06/16 at 10:15 a.m. revealed:<br>-The RCC was supposed to notify the RN Consultant when new staff was hired.<br>-The RCC usually gave a list of new staff to the RN Consultant.<br>-The RN Consultant usually came to the facility every Monday and that was when she was supposed to do the training.<br>-The RN was supposed to give the certificates to the RCC.<br>-She thought the 5 hour, 10 hour, and 15 hour training was now set up on their computer system for training.<br>-She was unable to locate any records in the computer system to indicate the 5 hour, 10 hour, or 15 hour course had been completed for Staff A or Staff E.<br>-She would check with the RN Consultant about setting up the training.<br>-The Administrator had just started working at the facility in February 2016 and the RCC had just started working at the facility in March 2016.<br>-The previous RCC was not getting the training done as required.<br>-The RN had been out on medical leave recently and she was out for about 6 weeks.<br>-There was no back up plan to get the training done while the RN was on medical leave.<br>-The Administrator and the current RCC were aware there were some problems with the personnel files.<br>-They had not had an opportunity to review all personnel files to determine which files had missing or incomplete information.<br><br>Interview with the Resident Care Coordinator | D935 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| D935 | Continued From page 71<br><br>(RCC) on 06/06/16 at 11:35 a.m. revealed:<br>-The Administrator was supposed to set up the 15 hour medication administration course on the computer.<br>-The RN Consultant usually came to check off staff on the tasks in the training.<br>-The RCC was not aware the 5 hour training had to be completed prior to administering medications.<br><br>Interview with the Registered Nurse (RN) Consultant on 06/06/16 at 1:30 p.m. revealed:<br>-She usually worked one day a week at the facility.<br>-Her responsibilities included doing some training for new staff.<br>-She used to do the 15 hour medication administration course for new medication aides but she had not done any in the last 6 months.<br>-It was her understanding that the staff were getting that training on their computerized training system.<br>-She did not know who was checking the staff off for the hands on tasks in the training.<br>-She did not know if the training had been done since she had last done it about 6 months ago.<br><br>Review of the facility's plan of protection dated 06/06/16 revealed:<br>-All medication aides' records will be audited immediately to determine if any medication aide requirements have not been met.<br>-The identified medication aides will have 15 hour medication aide training course completed immediately by RN Consultant.<br>-Any new medication aides will have medication clinical skills checklist and at least the 5 hour medication aide training course prior to administering medications. | D935 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| D935 | Continued From page 72<br>-Medication aides will pass the written exam and have additional 10 hour medication aide training course within 60 days of hire.<br>-The facility may choose to do the 15 hour medication aide training course prior to administering medications instead of doing the 5 hour and 10 hour course separately.<br>-RCC will notify the RN Consultant of training needs and will follow up to ensure training is done.<br>-Documentation will be on file in the facility.<br>-Administrator will monitor weekly to ensure compliance.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 21, 2016. | D935 | | |