	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED 11/09/2016			
		FCL054042	B. WING					
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	EET ADDRESS, CITY, STATE, ZIP CODE					
IOBBS AS	SSISTED LIVING 2		WERHILL ROAD N, NC 28501					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE		
C 000	Initial Comments		C 000					
	The Adult Care Licen annual survey on Nor	sure Section conducted an vember 9, 2016.						
C 174	10A NCAC 13G .050 Diabetic Residents	5(1)(2) Training On Care Of	C 174					
	Diabetic Residents A family care home s the care of residents unlicensed staff prior insulin as follows: (1) Training shall be p nurse, registered pha practitioner. (2) Training shall incl (a) basic facts about in the management of (b) insulin action; (c) insulin actor; (d) mixing, measuring for insulin administration (e) treatment and pre- hyperglycemia, including (f) blood glucose more	g and injection techniques tion; evention of hypoglycemia and ding signs and symptoms; nitoring; universal iate administration times;						
	facility failed to ensur B) had completed tra	as evidenced by: and record reviews, the e 1 of 3 sampled staff (Staff ining on the care of the r to the administration of						
	The findings are:							

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		FCL054042	B. WING		11/09/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	SSISTED LIVING 2	2504 TO	WERHILL ROAD			
		KINSTO	N, NC 28501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETI DATE
C 174	Continued From page	9 1	C 174			
	11/9/16 at 8:45am rev -Staff B had been em 1/2016 through 3/23/- -No documentation of found in the personne -A Medication Clinical was partially complete not validated to admin -Staff B left employme -Staff B was rehired a Medication Aide. - No documentation of found in the personne B had been validated he was rehired 7/18/1 Review of Resident # medication administra revealed Staff B docu insulin. Review of Resident #	ployed at the facility from 16 as a Medication Aide. f Diabetic Care training was el record for Staff B. I Skills Checklist for Staff B ed on 2/6/16 and Staff B was hister insulin. ent at the facility on 3/23/16. at the facility on 7/18/16 as a of Diabetic Care training was el record for Staff B and Staff to administer insulin since 16. 4's October 2016 ation records (MARS) imented administration of				
	revealed:	on 11/9/16 at 9:05am at the facility about 2-3				
	months before as a N	-				
		l insulin injections at the				
	facility since he was r					
	-There was one resid required insulin to be					
	-He had not complete					
		al Skills Checklist since he				
	was rehired.					
	-He was not sure if he	e had been checked off to				

STATE FORM

AND PLAN OF CORRECTION IDENTIFICATION NUMBE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:			E SURVEY PLETED
		FCL054042	B. WING		11/09/2016	
IAME OF PR	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
IOBBS AS	SSISTED LIVING 2		WERHILL ROAD N, NC 28501			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN (OF CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	O THE APPROPRIATE	COMPLETE
C 174	Continued From page	e 2	C 174			
	required to have diab administering insulin. -He was a diabetic ar do for a diabetic resid -The Administrator wa all of his Medication A check off and the Dia needed. Interview with medica 11/9/16 at 10:20am re -She had not complet training with Staff B s -Staff B still needed to Administration Clinica documented the tasks his Medication Admin Checklist from 2/6/16 -If the tasks on the M Clinical Skills Checkli then Staff B should no administration tasks. -The Administrator co schedule Staff B for th Medication Administra and Diabetic Care tra Interview with the Adr 10:45am revealed: -Staff B had previous Aide at the facility from March 2016.	al Skills Checklist. (at medication aides were etes training prior to and felt that he knew what to fent. (as responsible to schedule Administration Clinical Skills betic Care training if it was ation trainer for the facility on evealed: ted any Diabetic Care ince he was rehired. to complete the Medication al Skills Checklist but she is Staff B could perform on istration Clinical Skills edication Administration st had not been validated ot perform that medication puld contact her and he completion of the ation Clinical Skills Checklist				
	2016 as a Medication	Aide. ered insulin in the facility				

STATE FORM

6899

ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED 11/09/2016	
	FCL054042				
AME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
OBBS ASSISTED LIVING 2		OWERHILL ROAD ON, NC 28501			
PREFIX (EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
C 174 Continued From p	age 3	C 174			
Care training but s done. -Staff B had not ha since he was rehin -She was not awa Administration Clin had not be comple validated to admin -Staff B would not the facility until his completed -She was respons training for the fac -She would contac the Diabetic Care Medication Admini with Staff B. -She would be rev	B had completed Diabetic the was not sure when it was ad any Diabetic Care training ed in July 2016. The the Medication hical Skills Checklist for Staff B eted and Staff B was not ister insulin. administer any more insulin at Medication Aide training was ible to set up the Diabetic Care				
G.S. 131D-21 De Every resident sha 2. To receive care adequate, appropri relevant federal ar regulations. This Rule is not m Based on observa reviews the facility received care and	Declaration of Residents' Rights claration of Resident's Rights all have the following rights: and services which are riate, and in compliance with ad state laws and rules and net as evidenced by: tions, interviews and record failed to assure residents services which are adequate ion aide training. The findings	C 912			

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		FCL054042	B. WING		11/09/2016	
AME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
IOBBS A	SSISTED LIVING 2		WERHILL ROAD N, NC 28501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETE DATE
C 912	Continued From page	e 4	C 912			
	reviews, the facility fa Medication Aides (Sta 2013, who administer successfully complete Aide training, clinical the written Medication hire. [Refer to Tag DS Care Homes Medicat	aff B), hired after October				
C935	G.S. § 131D-4.5B (b) Aides;Training and C		C935			
	G.S. § 131D-4.5B (b) Medication Aides; Tra Evaluation Requirem	aining and Competency				
	home is prohibited fro any unsupervised me that individual has pro- medication aide durin an adult care home o of the following: (1) A five-hour trainin Department that inclu in all of the following: a. The key principles administration. b. The federal Center Prevention guidelines applicable, safe injec procedures for monitor	ag the previous 24 months in r successfully completed all g program developed by the ides training and instruction of medication rs for Disease Control and s on infection control and, if tion practices and pring or testing in which				
	exists.	e potential for bleeding aluation consistent with 10A				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			R WING			
		FCL054042	B. WING		11	/09/2016
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE DWERHILL ROAD	, ZIP CODE		
HOBBS A	SSISTED LIVING 2		N, NC 28501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
C935	Continued From pag	e 5	C935			
	 (3) Within 60 days from individual must have a. An additional 10-h developed by the Deteraining and instruction 1. The key principles administration. 2. The federal Centeral Centeral Prevention guidelines applicable, safe inject procedures for monit bleeding occurs or the exists. b. An examination of Hereit State and State and	partment that includes on in all of the following: of medication rs of Disease Control and s on infection control and, if				
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
	reviews, the facility fa Medication Aides (St 2013, who administe included insulin injec completed 10/15 hou clinical skills evaluati	n, interviews and record ailed to assure 1 of 2 aff B), hired after October red medications (that tions), had successfully ir Medication Aide training, on, and passed the written within 60 days of hire.				
	The findings are:					
	11/9/16 at 8:45am re -Staff B had been en 1/2016 through 3/23/ -A medication clinica was partially complet	nployed at the facility from 16 as a Medication Aide. I skills checklist for Staff B				

Division of Health Service Regu STATE FORM

6899

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED 11/09/2016	
		FCL054042				
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
OBBS A	SSISTED LIVING 2	2504 TO	WERHILL ROAD			
ODD3 A		KINSTO	N, NC 28501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
C935	Continued From page	9 6	C935			
	per the medication cli 2/6/16 -Staff B left employme -Staff B was rehired a Medication Aide. -There was no docum completed the 15 hou within 60 days of his f -There was no docum Medication Aide writter rehire date of 7/18/16 -The medication clinic was not revalidated s Review of Resident # revealed: -A current FL-2 dated of Type II Diabetes, c chronic obstructive ai hypertension, parano arteriosclerotic heart -A medication order for units subcutaneously medication used to co diabetic patients). Review of Resident # Professional Support -The resident had a ta injections.	d to perform insulin injection nical skills checklist done on ent at the facility on 3/23/16. at the facility on 7/18/16 as a mentation Staff B has urs Medication Aide training rehire date of 7/18/16. mentation Staff B passed the en test within 60 days of his to cal skills checklist for Staff B ince he was rehired. 4's FL-2 on 11/9/16 3/17/16 included diagnoses hronic asthmatic bronchitis, rway disease, benign id schizophrenia, and disease. or Lantus 100ml/unit - 50 every evening (Lantus is a pontrol blood sugar levels in 4's Licensed Health quarterly review revealed: ask of subcutaneous insulin mpetency validated on the				
	Review of Resident # medication administra revealed Staff B docu insulin.					

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY PLETED
		FCL054042	B. WING		11/09/2016	
AME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
	SSISTED LIVING 2	2504 TO	WERHILL ROAD			
		KINSTO	N, NC 28501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
C935	Continued From page	e 7	C935			
	Review of Resident # medication administra revealed Staff B docu insulin.					
	administration record	October 2016 medication s (MARS) revealed Staff B tration of medications.				
	administration record	November 2016 medication s (MARS) revealed Staff B tration of medications.				
		16 at 7:50am of Staff B inistered oral medications to at the facility.				
	Interview with Staff B revealed:	on 11/9/16 at 9:05am				
	months before as a M					
	since he was rehired.	Medication Aide training many Medication Aide				
	training hours he had -He had not complete	completed.				
		al Skills Checklist since he				
	since he was rehired.					
	insulin injections at th	I medications and performed e facility since he was				
	rehired. -There was one resid required insulin to be	administered daily.				
	perform insulin injecti	e had been validated to ons. id felt that he knew the				
	correct procedures.	e Administrator to schedule				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED	
			A. BUILDING.	A. BUILDING:			
		FCL054042	B. WING		11	/09/2016	
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE			
IOBBS A	SSISTED LIVING 2		WERHILL ROAD N, NC 28501				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
C935	Continued From page	e 8	C935				
	training to complete h Clinical Skills Checkli -He had been schedu Medication Aide test canceled due to a hu -He did not know if he take the state Medica -The Administrator wa all of his work-related training and his Medi Interview with Medica 11/9/16 at 10:20am re -Staff B had complete Training in 2/2016 bu Medication training h -She had not comple training with Staff B s -There had been prof Staff B to complete h since he was rehired -Staff B still needed to Administration Clinica the written Medication -She had documente perform on his Medic Skills Checklist from -If the tasks on the M Clinical Skills Checkli then Staff B should n administration tasks. -The Administrator co schedule Staff B for N completion of the Me Clinical Skills Checkli	 Juled to take the state in 10/2016 but the test was rricane. a had been rescheduled to ation Aide test. as responsible to schedule I training's, Medication Aide cation Aide testing. ation trainer for the facility on evealed: ad 5 hours of Medication tt still needed 10 additional ours. ted any Medication Aide training for is Medication Aide training for is Medication Aide training o complete the Medication al Skills Checklist and take in Aide test. d the tasks Staff B could ation Administration Clinical 2/6/16. edication Administration ist had not been validated ot perform that medication buld contact her and Medication Aide training and dication Administration ist. 					
	10:45am revealed:	ministrator on 11/9/16 at ly worked as a Medication					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		FCL054042	B. WING		11	/09/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	SSISTED LIVING 2	2504 TO	WERHILL ROAD			
		KINSTO	N, NC 28501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
C935	Continued From page	9	C935			
	March 2016. -Staff B had been reh 2016 as a Medication -Staff B had administe performed insulin inje was rehired. -She thought Staff B of since he was rehired -Staff B had complete Training in February 2 how many hours Staff time. -She did not know if S hours of Medication A -Staff B had not had a since he was rehired -She scheduled Staff Training about 2 weet bring his Medication A training had to be res -She thought Staff B of medications at the facility -Staff B had been sch Medication Aide Test date had been cancel -She was not aware t Administration Clinica had not be completed -Staff B would not be medications or perfor the facility until he par Aide test, completed	ered medications and ctions in the facility since he could administer insulin employee. Ind some Medication Aide 2016 but she was not sure f B had completed at that Staff B had completed the 15 aide training. any Medication Aide Training in July 2016. B for Medication Aide ks ago but Staff B did not Aide Training packet and the cheduled. could administer cility until he passed the Test since Staff B had before. leduled to take the written in October 2016 but the test ed. Staff B needed to pass the de Test and complete the ing hours within 60 days of the Medication al Skills Checklist for Staff B l.				

STATE FORM

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		FCL054042	B. WING		11	/09/2016
AME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE		
OBBS A	SSISTED LIVING 2		N, NC 28501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
C935	Continued From page	e 10	C935			
	completed. -She was responsible Aide training and Me for Staff B. -She would contact th Medication Aide train Administration Clinica B. -She would register S Medication Aide test Review of the Plan of facility on 11/09/16 re -The Adminsitrator w records for required to -If a staff had not com medication training, h allowed to administer completion of the train- The Adminstrator wood Consultant to schedu -All Medication Aidess training and medication medication administrator -Within 60 days, the	f Protection provided by the evealed: ill review staff personell training. npleted the required ne or she would not be r medications until ining. buld notify the Nurse ile training. would complete the 5 hour on skills checklist prior to ation. Medication Aide would ing 10 hours of training and				