STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043006	A. BUILDING: _____ B. WING _____	05/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS VILLAGE	504 WEST CANAL DRIVE DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on 05/12/15 - 05/14/15.	D 000		
D 150	10A NCAC 13F .0501 Personal Care Training And Competency 10A NCAC 13F .0501 Personal Care Training And Competency (a) An adult care home shall assure that staff who provide or directly supervise staff who provide personal care to residents successfully complete an 80-hour personal care training and competency evaluation program established by the Department. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties. Copies of the 80-hour training and competency evaluation program are available at the cost of printing and mailing by contacting the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. (b) The facility shall assure that training specified in Paragraph (a) of this Rule is successfully completed within six months after hiring for staff hired after September 1, 2003. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure the 80-hour personal care training and competency evaluation program was completed within six months of hire for 2 of 5 staff sampled (Staff A and E). The findings are:	D 150		

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D 150	Continued From page 1 1. Review of Staff A's personnel record revealed: - Staff A's date of hire was 03/12/12. - Staff A was hired as a medication aide. - There was no documentation of the 80-hour personal care training and competency evaluation in Staff A's personnel record. - Staff A's job duties included personal care tasks for residents. Interview with Staff A on 05/12/15 at 10:30 a.m. revealed: - She was hired as a medication aide. - She had not had any personal care training. - She did not provide personal care tasks to the residents. - She administered medications only. Interview with the Business Office Manager (BOM) on 05/14/15 at 3:30 p.m. revealed: - It was her responsibility to maintain employee records and schedule staff training and competencies. - Staff A did not have the personal care training because she only administered medications. - She was not aware the personal care training was required if a medication aide only administered medications. Observation on 05/13/15 at 11:20 a.m. revealed Staff A assisted a resident transfer to a chair during the medication pass. Interview with another medication aide on 05/14/15 at 3:45 p.m. revealed: - When she was administering medications she assisted residents with positioning and checked blood pressures and weights. - There are two residents that require medications to be given with applesauce; she	D 150		

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D 150	Continued From page 2	D 150		

feeds the applesauce to those residents.
- When she was finished administering medications, she answered call bells and helped residents with anything they may need assistance with, such as toileting, transferring, and dressing.

Interview with the Resident Care Coordinator on 05/14/15 at 4:00 p.m. revealed:
- When the personal care aides are busy, the medication aides answer call bells and assist residents.
- The medication aides are required to assist the residents with toileting, transfers, positioning and grooming.
- The medication aides are required to assist residents with any and all needs, the same as the personal care aides.

Refer to the interview with the BOM on 05/14/15 at 3:30 p.m.

2. Review of Staff E's personnel record revealed:
- Staff E's date of hire was 06/17/13.
- Staff E was hired as a personal care aide.
- There was no documentation of the 80-hour personal care training and competency evaluation in Staff E's personnel record.
- Staff E's job duties include performing personal care tasks for residents.

Review of the job description of a personal care aide revealed the personal care aide was to assist residents with all personal care needs, such as toileting, transfers, positioning, bathing, showering, dressing and grooming.

Interview with the Business Office Manager (BOM) on 05/14/15 at 3:30 p.m. revealed:
- Staff E did not receive the personal care aide training.

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D 150	Continued From page 3 - She thought the ongoing training classes all of the staff received would meet the requirement. Refer to the interview with the BOM on 05/14/15 at 3:30 p.m. _____ Interview with the Business Office Manager (BOM) on 05/14/15 at 4:05 p.m. revealed she would ensure all direct care staff received the required personal care training immediately.	D 150		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration.	D 164		

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D 164	Continued From page 4	D 164		

This Rule is not met as evidenced by:
Based on interview and record review, the facility failed to assure 2 of 3 medication aides sampled (Staff B and D) received training by a licensed health professional on the care of diabetic residents prior to administering insulin to residents. The findings are:

1. Review of Staff B's personnel record revealed:
- She was hired as a medication aide (MA) on 03/31/14.
- She completed her medication clinical skills validation on 03/18/14.
- She passed the medication aide written exam on 04/24/14.
- There was no documentation of training on the care of residents with diabetes.

Staff B was not available for interview.

Refer to interview with a medication aide on 05/14/15 at 3:55 p.m.

Refer to interview with the Business Office Manager (BOM) on 05/14/15 at 4:00 p.m.

2. Review of Staff D's personnel record revealed:
- She was hired as a medication aide on 12/14/12.
- She completed her medication clinical skills validation on 02/07/13.
- She passed the medication aide written exam on 04/11/13.
- There was no documentation of training on the care of residents with diabetes.

Staff D was not available for interview.

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D 164	Continued From page 5 Refer to interview with the Business Office Manager (BOM) on 05/14/15 at 4:00 p.m. Refer to interview with a medication aide on 05/14/15 at 3:55 p.m. Interview with a medication aide on 05/14/15 at 3:55 p.m. revealed all medication aides do fingerstick testing for blood sugars and administer insulin. Interview with the Business Office Manager (BOM) on 05/14/15 at 4:00 p.m. revealed: - She thought Staff B and Staff D had completed the diabetes training, but she was unable to find any documentation showing they completed the training. - She checked with the pharmacist who taught diabetes training to the medication aides at the facility and was informed Staff B and Staff D did not receive the training. - She will check all staff records and set up a class for all of the medication aides to take the diabetes training as soon as possible.	D 164		
D 319	10A NCAC 13F .0905 (f) Activities Program 10A NCAC 13F .0905 Activities Program (f) Each resident shall have the opportunity to participate in at least one outing every other month. Residents interested in being involved in the community more frequently shall be encouraged to do so.	D 319		

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D 319	Continued From page 6 This Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide residents with the opportunity to participate in at least one outing every other month. The findings are: Confidential interview with a resident revealed: - The facility does not offer any outside activities in the community for residents. - The resident would like to go on outings. - The resident stated it would be "great" if the facility offered outside activities. Confidential interview with a second resident revealed: - The resident was not aware of the facility offering outings. - The resident had not been on any facility outings. Confidential interview with a third resident revealed: - The facility does not offer outings. - The resident would like to go on outings to local stores. Confidential interview with a fourth resident revealed: - The last outing the resident could recall was about 3 months ago. - The resident had gone to a physician's appointment and asked the staff person transporting the resident to stop at a local dollar store. - The resident would like to go on outings into the community. Confidential interview with a fifth resident revealed: - They used to go out to a local retail store.	D 319		

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D 319	Continued From page 7 - They have not been on an outing in a few months. - The resident did not know why they stopped going on outings. - The resident would like to go on outings. Review of the May 2015 Activities Calendar on 05/12/15 revealed there were no planned / scheduled outings on the calendar. Interview with Activities Director (AD) on 05/12/15 at 3:35 p.m. revealed: - There were no outings scheduled for the month of May 2015. - There had been no outings scheduled on calendar for years. - AD was not aware there needed to be at least one outing every other month.. - AD would discuss arrangements of outings for residents with the Administrator. Interview with Administrator on 05/14/15 at 3:30 p.m. revealed: - Administrator was aware there needed to be scheduled outings on the Activities Calendar. - Outings for residents were stopped due to insurance liability and bad experiences on previous outings. - There had been no scheduled activities on the Activities Calendar for around 2 years. - The Transportation Person sometimes stopped at local stores to let residents go in and to buy personal items. - Administrator stated he would discuss with Activities Director about restarting scheduled outings for residents. Interview with Transportation Person on 05/14/15 at 3:55 p.m. revealed: - When residents are taken to their doctor's	D 319		

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D 319	Continued From page 8 appointment, they may request to go to other places such as local stores. - Residents had never asked her about going on outings into the community.	D 319		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 3 of 14 residents (#6, #7, #8) observed during the medication pass which included errors with the administration of insulin. The findings are: The medication error rate was 15% as evidenced by the observation of 4 errors out of 26 opportunities during the 11:00 a.m. / 11:30 a.m. and 1:00 p.m. medication passes on 05/13/15 and 05/14/15. 1. Review of Resident #8's record revealed: - Current FL-2 dated 01/30/15 included diagnoses of chronic kidney disease - stage II, transient ischemia attack, thyrotoxicity, iron deficiency, urinary incontinence, osteoarthritis, unspecified debility, difficulty walking, and Vitamin	D 358		

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D 358	Continued From page 9 B complex deficiencies. - Physician's order dated 02/02/15 for fingerstick blood sugars (FSBS) before meals and at bedtime and administer Humalog insulin according to the following scale: 0 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; and >400 = call physician; no sliding scale insulin at bedtime. (Humalog is rapid-acting insulin used to lower blood sugar. The manufacturer recommends Humalog be taken within 15 minutes before eating a meal.) - Physician's order dated 03/20/15 for Humalog insulin 4 units 3 times a day with meals. - Physician's order dated 04/30/15 for scheduled Humalog 4 units to be administered with meals and Humalog sliding scale with meals. Observation during the 11:30 a.m. medication pass on 05/14/15 revealed: - Medication aide checked Resident #8's blood sugar at 11:39 a.m. and it was 247. - Medication aide stated she would administer 4 units of Humalog for the sliding scale now and she would administer the 4 units of scheduled Humalog closer to lunch. - She usually administered the sliding scale and the scheduled insulin separately. - Lunch was usually served at 12:15 p.m. - Medication aide administered 4 units of Humalog sliding scale insulin to Resident #8 at 11:45 a.m. - Resident #8 was not served the lunch meal until 12:16 p.m., 31 minutes after receiving Humalog, a rapid-acting insulin, instead of with the meal as ordered. - Medication aide was not observed to administer the scheduled 4 units of Humalog insulin as ordered.	D 358		

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Interview with the medication aide on 05/14/15 at 12:18 p.m. revealed:
- She had not administered the scheduled 4 units of Humalog insulin to Resident #8.
- She had gotten busy changing out medications in the medication cart.
- She forgot to administer the scheduled insulin to Resident #8.
- She was unaware the order was to give the sliding scale and the scheduled Humalog with the meal.
- She would give the insulin to the resident after the resident came out of the dining room.

Observation on 05/14/15 at 12:52 p.m. revealed Resident #8 was administered 4 units of scheduled Humalog insulin after the meal instead of with the meal as ordered.

Interview with Resident #8 on 05/14/15 at 4:30 p.m. revealed:
- Her blood sugar was usually checked 4 times a day.
- She usually got insulin prior to meals.
- She got the sliding scale and the scheduled insulin separately.
- It did not bother her to get the shots separately.
- Her blood sugar usually ran high but if it got low, she would get orange juice.

Interview with the Resident Care Coordinator (RCC) on 05/14/15 at 1:28 p.m. revealed:
- Resident #8's most current order was for the sliding scale and scheduled Humalog to be administered with the meals.
- She would make sure the resident had food on the table and was going to eat prior to her insulin being administered.

Review of the May 2015 medication

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administration records (MARs) and blood sugar logs revealed Resident #8's blood sugar ranged from 82 - 356.

2. Review of Resident #6's record revealed:
- Current FL-2 dated 08/20/14 included diagnoses of diabetes mellitus type II without complications, essential hypertension, and chronic airway obstruction.
- Physician's order dated 03/24/15 for fingerstick blood sugars (FSBS) 4 times a day and administer Humalog insulin according to the following scale: <150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 8 units; 301 - 350 = 10 units; 351 - 400 = 12 units; and >400 = 14 units. (Humalog is rapid-acting insulin used to lower blood sugar. The manufacturer recommends Humalog be taken within 15 minutes before eating a meal.)

[According to the Humalog manufacturer, the pen should be primed before each injection. A dose of 2 units should be dialed up and the injection button pressed until the dose window shows a "0" and a stream of insulin is seen coming from the needle. This removes air bubbles and ensures the pen and needle are working properly. (Air bubbles displace the amount of insulin in the syringe and prevents the full dose from being administered.)]

Observation during the 11:30 a.m. medication pass on 05/13/15 revealed:
- Medication aide checked Resident #6's blood sugar at 11:25 a.m. and it was 166.
- Medication aide dialed the Humalog pen to 2 units and injected the insulin into Resident #6 at 11:28 a.m.
- Medication aide did not prime the Humalog pen with a 2 unit air shot prior to dialing the 2

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units ordered and administering the insulin.
- Resident #6 was not served the lunch meal until 12:18 p.m., 50 minutes after receiving Humalog, a rapid-acting insulin.

Interview with Resident #6 on 05/13/15 at 4:07 p.m. revealed:
- Resident #6 usually got her lunch time insulin between 11:15 a.m. and 11:30 a.m.
- Lunch was usually served after 12:00 noon.
- She did not feel like her blood sugar got too low while she was waiting on her meal.

Interview with the medication aide on 05/13/15 at 1:37 p.m. revealed:
- She recalled having training by a nurse on the insulin pens.
- When a pen was first opened, they were supposed to dial 2 to 3 units and press it until they saw a stream of insulin coming from the needle.
- She usually gave insulin about 30 minutes before meals.
- Lunch was usually served at 12:15 p.m.

Interview with the Resident Care Coordinator (RCC) on 05/13/15 at 2:00 p.m. revealed:
- Staff had training on how to use the insulin pens.
- She thought the insulin pens only had to be primed prior to the first use of the pen.
- She did not recall that the insulin pens needed to be primed before each use.
- She would make sure staff were retrained on how to properly prime the insulin pens.
- The facility's policy was to give insulin no more than 30 minutes before a meal.

Interview with a second medication aide on 05/13/15 at 1:45 p.m. revealed:

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 13 - She recalled having training on priming the insulin pens. - She usually did a 2 unit air shot before each injection. Review of the May 2015 medication administration records (MARs) and blood sugar logs revealed Resident #6's blood sugar ranged from 58 - 258. 3. Review of Resident #7's current FL-2 dated 07/09/14 revealed: - Diagnoses included diabetes mellitus, congestive heart failure, hypertension, chronic obstructive pulmonary disease, gastroesophageal reflux disease, and anemia. - Order for fingerstick blood sugars (FSBS) 4 times a day and administer Novolog insulin according to the following scale: 70 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; and >400 = 10 units and call physician. (Novolog is rapid-acting insulin used to lower blood sugar.) [According to the Novolog manufacturer, Novolog pen should be primed using an air shot before each injection. Perform the air shot before each injection by turning the dose selector to 2 units. Hold the pen with the needle pointing up and tap cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Press the injection button all the way in until dose selector returns to "0". A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure. (This removes air bubbles and ensures the pen and needle are working properly. Air bubbles displace the amount of insulin in the syringe and prevents the full dose from being administered.)]	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043006	A. BUILDING: _____ B. WING _____	05/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS VILLAGE	504 WEST CANAL DRIVE DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 14 Observation during the 11:30 a.m. medication pass on 05/13/15 revealed: - Medication aide checked Resident #7's blood sugar at 11:52 a.m. and it was 155. - Medication aide dialed the Novolog pen to 2 units and injected the insulin into Resident #7 at 11:56 a.m. - Medication aide did not prime the Novolog pen with a 2 unit air shot prior to dialing the 2 units ordered and administering the insulin. Interview with Resident #7 on 05/13/15 at 3:58 p.m. revealed: - Resident #7 usually got her insulin before meals. - Her blood sugar was checked 3 or 4 times a day. - She did not have any concerns regarding her insulin. Interview with the medication aide on 05/13/15 at 1:37 p.m. revealed: - She recalled having training by a nurse on the insulin pens. - When a pen was first opened, they were supposed to dial 2 to 3 units and press it until they saw a stream of insulin coming from the needle. Interview with the Resident Care Coordinator (RCC) on 05/13/15 at 2:00 p.m. revealed: - Staff had training on how to use the insulin pens. - She thought the insulin pens only had to be primed prior to the first use of the pen. - She did not recall that the insulin pens needed to be primed before each use. - She would make sure staff were retrained on how to properly prime the insulin pens.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043006	A. BUILDING: _____ B. WING _____	05/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS VILLAGE	504 WEST CANAL DRIVE DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 15 Interview with a second medication aide on 05/13/15 at 1:45 p.m. revealed: - She recalled having training on priming the insulin pens. - She usually did a 2 unit air shot before each injection. Review of the May 2015 medication administration records (MARs) and blood sugar logs revealed Resident #7's blood sugar ranged from 100 - 214.	D 358		