PRINTED: 12/01/2015
FORM APPROVED

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
	HAL043022	A. BUILDING: ______ B. WING ______	11/13/2015

RECEIVED DEC - 7 2015 ADULT CARE LICENSURE SECTION RALEIGH

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINECREST GARDENS	1984 OLD US 421 LILLINGTON, NC 27546

(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 Section conducted an annual survey on 11/12/15 through 11/13/15.	D 000		11/14/15
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure that food being served was protected from contamination. The findings are: During breakfast service on 11/13/2015 at 8:20 AM the following observations were made: - The residents took their plates to the kitchen door if they wanted additional food. - The kitchen staff wore food service gloves while serving food. - The kitchen staff took the resident's plate, often with her gloved thumb resting on the eating service of the plate. - The kitchen staff placed additional food on the plate using a serving utensil that was returned to the pan of remaining food on the hot bar. - The kitchen staff did not change food service gloves during the period of time observed. - Approximately 10-12 residents received "seconds" of different food items. Interview with Facility Manager and Resident	D 283	A meeting was conducted by the facility manager and all staff serving food were present. A review of proper procedures was discussed. All staff serving food will use clean bowls/plates for any additional servings given after initial plates are used. Food service staff will change to clean gloves also if needed to prevent contamination. No "used" plates will be reused to give second helpings.	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] [signature]

TITLE Manager Administrator

(X6) DATE 12/3/15

STATE FORM 6899 FU0W11

Reviewed & accepted [signature] 12/8/15

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D 283	Continued From page 1 Care Coordinator (RCC) at 10:50 AM on 11/13/2015 revealed: - The Facility Manager stated that the facility did not have enough plates to serve "seconds" on a clean plate. - The Facility Manager stated that she would place an order immediately for additional plates. - The Facility Manager stated that she would assure that, until extra plates arrive, food would be served in a safe manner. -The RCC will review how to serve food without risking contamination with the kitchen staff.	D 283	Clean bowls were available for "seconds" at the time of the survey however additional plates have been purchased and will be used as needed for second helpings.	11/16/15
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, interviews and record reviews, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 4 of 14 residents (#6,#7,#8, #9) observed during the medication pass which included errors with the administration of medications for diabetes, treatment of blood pressure, a calcium supplement and an iron supplement. The findings are:	D 358	Facility manager and RCC will observe meal times daily to insure continued compliance in this area.	

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D 358	Continued From page 2 The medication error rate was 13% as evidence by observation of 4 errors out of 29 opportunities during the 4:00 pm/5:00 pm medication pass on 11/12/15 and the 8:00 am/9:00 am medication pass on 11/13/15. A. Review of Resident #6's FL-2 dated 7/31/15 revealed: -Diagnoses included cerebral palsy, mental retardation, osteoporosis and gastroesophageal reflux disease. -There was an order for Oyster Calcium 500mg twice a day with food. (Oyster Calcium is used to prevent and treat calcium deficiencies. Taking Calcium with food may increase the absorption of Calcium). Review of November 2015 medication administration record (MAR) revealed Oyster Calcium 500mg was scheduled to be administered twice a day at 8:00 am and 5:00 pm with food. Observation of the 4:00pm/5:00 pm medication pass on 11/12/15 revealed: -Resident #6 received his Oyster Calcium 500mg at 4:12 pm. -The medication aide did not offer any food with the resident's medication. -Oyster Calcium was not administered with food as ordered. Observation of the dinner meal on 11/12/15 revealed Resident #6 received his food at 5:23 pm. Observation, interview and record review revealed Resident #6 was not able to be interviewed.	D 358	11/16/15 Facility manager and RCC reviewed procedures with all medication aides regarding orders for medications "taken with food" All medications ordered to be taken with food will be administered immediately after meal times or with a snack. RCC will monitor medication passes daily and insure all medications are administered as ordered. Facility manager will observe medication passes at least weekly to insure continued compliance in this area.	

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D 358	Continued From page 3 Refer to Interview with the Medication Aide on 11/12/15 at 6:10 pm. Refer to interview with the Resident Care Coordinator (RCC) on 11/12/15 at 6:08 pm. Refer to interview with the Facility Manager on 11/12/15 at 6:20 pm. B. Review of Resident #7's FL-2 dated 7/14/15 revealed: -Diagnoses included chronic obstructive pulmonary disease, hypertension, coronary artery disease, cerebrovascular accident, atrial fibrillation, anxiety, depression and transient ischemia attack. -There was an order for Ferrous Sulfate 325mg twice a day with meals. (Ferrous Sulfate is used to treat iron deficiency anemia. Taking Ferrous Sulfate with food or meals may decrease stomach upset). Review of November 2015 medication administration record (MAR) revealed Ferrous Sulfate 325mg was scheduled to be administered twice a day at 8:00 am and 5:00 pm with meals. Observation of the 4:00pm/5:00 pm medication pass on 11/12/15 revealed: -Resident #7 received his Ferrous Sulfate 325mg at 4:35 pm. -The medication aide did not offer any food with the resident's medication. -Ferrous Sulfate was not administered with a meal as ordered. Observation of the dinner meal on 11/12/15 revealed Resident #7 received his food at 5:28 pm.	D 358		

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D 358	Continued From page 4 Interview with Resident #7 on 11/13/15 at 11:50 am revealed: -He always got his "black iron pill" before he ate dinner. -He did not report any stomach upset from taking the Ferrous Sulfate without food. Refer to interview with the Medication Aide on 11/[illegible]/15 at 2:10 pm. Refer to interview with the Resident Care Coordinator (RCC) on 11/12/15 at 6:08 pm. Refer to interview with the Facility Manager on 11/12/15 at 8:20 pm. C. Review of Resident #8's FL-2 dated 6/16/15 revealed: -Diagnoses included abdominal pain, mental retardation, hypoglycemia, lakocytosis and diverticulitis. -There was an order for Metformin 850mg 3 times daily with meals. (Metformin is used to treat diabetes. Metformin should be taken with food to decrease or prevent gastrointestinal side effects.) Review of November 2015 medication administration record (MAR) revealed Metformin 850mg was scheduled to be administered 3 times a day at 8:00 am, 12:00 pm and 5:00 pm with meals. Observation of the 4:00pm/5:00 pm medication pass on 11/12/15 revealed: -Resident #8 received his Metformin 850mg at 5:00 pm. -The medication aide did not offer any food with the Metformin medication.	D 358		

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D 358	Continued From page 5 -Metoprolol was not administered with a meal as ordered. Observation of 11/12/15 dinner meal on 11/12/15 revealed Resident #8 received his food at 5:31 pm. Observation, interview and record review revealed Resident #8 was not able to be interviewed. Reference Service with the Medication Aide on 11/13/15 at 3:10 pm. Reference Service with the Resident Care Coordinator/RN on 11/12/15 at 6:08 pm. Reference Service with the Facility Manager on 11/13/15 at 6:25 pm. Review of Resident #9's FL-2 dated 4/28/15 revealed: -Diagnoses included diabetes mellitus, chronic obstructive pulmonary disease, hyperlipidemia, hypertension, sleep apnea, congestive heart failure, coronary artery disease and depression. -There was an order for Coreg 6.25mg twice a day with food. This is for heart/blood pressure. Coreg should be given with food to slow the rate of absorption and reduce the incidence of orthostatic low blood pressure when standing. Observation of 11:00am/5:00 pm medication pass on 11/12/15 revealed: -Resident #9 received his Coreg 6.25 mg at 5:14 pm. -The nurse did not offer any food with this medication. -This medication was not administered with food as	D 358		

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D 358	[illegible] ued From [illegible] ge 6 [illegible] meal on 11/12/15 [illegible] #[illegible] ceived her food at 5:31 [illegible] [illegible] ew [illegible] #9 on 11/13/15 at 10:00 [illegible] she [illegible] s always given a medication [illegible] ent [illegible] ining room for dinner. [illegible] e Medication Aide on [illegible] [illegible] r to i [illegible] the Resident Care Co [illegible] dinat or [illegible] 1/12/15 at 6:08 pm. Ref [illegible] nt [illegible] the Facility Manager on [illegible] Int [illegible] view [illegible] Medication Aide on 11/12/15 at [illegible] pm [illegible] -M [illegible] s were [illegible] 3:00 am, 12:00 pm and 5:0 [illegible] Di [illegible] (11/12/15). [illegible] ications at the same time sh [illegible] 12 [illegible]). -S [illegible] hour before and 1 hour af [illegible] to administer all m [illegible] atic [illegible] [illegible] wit [illegible] ident Care Coordinator [illegible] 1 [illegible] 15 [illegible] 08 p.m. revealed: [illegible] o administer m [illegible] meals after the resident ea [illegible] -T [illegible] to administer m [illegible] ati [illegible] with food with a snack. [illegible] ks are [illegible] medication room and the [illegible] for the medication aides	D 358		

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D 358	Continued From page 7 Interview with Facility Manager on 11/12/15 at 6:20 pm -The pharmacy trained medication aides on how to administer medications. -The pharmacy adjusted times to ensure medications were given in a timely manner. -Meal times are 8:00 am, 12:00 pm and 5:00 pm. -If a medication is ordered to be given with food the medication aide should have provided a snack with it at a meal time.	D 358		