STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PINE VALLEY ADULT CARE HOME	3522 CAMDEN ROAD FAYETTEVILLE, NC 28306

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on February 22-24, 2017.	D 000		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 1 of 4 staff (Staff A) sampled had been tested for Tuberculosis (TB) disease in compliance with TB control measures (2 step Tuberculin skin test) adopted by the Commission for Health Services. The findings are: Review of Staff A's personnel file revealed: -Staff A was hired on 09/28/2016 as an Aide/Attendant/Housekeeper. -There was documentation of a TB skin test administered on 09/27/2016 and read as negative on 09/29/2016. -There was no documentation of a second step TB skin testing. Interview with the Aide/Attendant on 02/23/2017 at 11:40am revealed:	D 131		

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D 131	Continued From page 1 -She had worked at the facility for about 6 months. -She assisted the residents at the facility with bathing, dressing, grooming, feeding, and toileting. -She had one TBST (tuberculosis skin test) completed before she was employed at the facility. -She had not been requested by anyone at the facility to get a second TBST. Interview with the Administrator/Owner on 02/24/2017 at 4:30pm revealed: -She was aware of the requirement for a 2-step TBST for Staff A. -The staff were responsible to get the 2-step TBST and provide a copy of the results to the facility to be placed in the employee personnel file. -There was a registered nurse who sometimes administered the TBST at the facility. -She did not see any more TBST results in Staff A's personnel file "guess that's an oversight". -The Administrator/Owner was not aware Staff A needed a 2-step TBST. -She used to have an assistant working at the facility who was responsible for ensuring the 2-step TBST were completed and filed in the staff personnel file. -Since the assistant was no longer employed at the facility, there probably was no one responsible for checking the personnel files to make sure appropriate documents were in the staff personnel files. Interview with the Aide/Attendant on 02/24/2017 at 4:50pm revealed she had not had a TBST in the last year other than the one she had done to start work at the facility.	D 131		

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D 306	Continued From page 2	D 306		
D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure residents were served water and another beverage at each meal. The findings are: Review of the Winter Cycle Week 3 January, February and March Wednesday Regular diet lunch menu included 8 ounces (oz) 2% milk was to be served to the residents. Observation during the lunch meal on 2/22/17 at 11:38 a.m. revealed: -A Dietary Aide offered the residents milk or water. -Three residents agreed to receive 12 oz milk only. -Nine residents agreed to receive 12 oz water only. -Three residents received milk and water. Interview with 2 residents on 2/22/17 at 12:41 p.m. who received milk and water revealed they did not want anything else to drink. Interview with 3 other residents on 2/22/17 at 12:45 p.m. revealed they just wanted water to	D 306		

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D 306	Continued From page 3	D 306		

drink for lunch on 2/22/17.

Review of the Winter Cycle Week 3 January, February and March Wednesday Regular diet breakfast menu included 8 oz of 2% milk.

Observation during the breakfast meal on 2/23/17 at 8:10 a.m. revealed:
-Sixteen residents were in the dining room.
-The Dietary Supervisor had passed out 12 oz milk to all of the 16 residents.
-Water was not served or offered to any of the residents.

Interview with the Dietary Supervisor on 2/23/17 at 8:23 a.m. revealed:
-During breakfast, the residents usually received milk. The residents are not offered or served water during breakfast.
-If a resident wanted water, they could request it.
-For lunch and dinner, the residents received water.

Further interview with the Dietary Supervisor on 2/24/17 at 12:13 p.m. revealed he made an error when he did not give the residents water during the breakfast meal on 2/23/17.

Interview with a Personal Care Aide (PCA) on 2/23/17 at 11:26 a.m. revealed:
-For breakfast, the residents are offered orange juice or milk.
-For lunch, the residents are offered milk or water. If a resident wanted milk and water, they could have both.
-For dinner, the residents are offered soda and water.

Review of the Winter Cycle Week 3 "January, February and March" Thursday Regular diet

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D 306	Continued From page 4 lunch menu included 8 oz 2% milk was to be served to the residents. Observation during the lunch meal on 2/23/17 at 12:24 p.m. revealed: -Twenty one residents were in the dining room. -A Dietary Aide had asked the residents if they wanted water or milk. -Six residents had 12 oz water and 12 oz milk. -Fifteen residents had 12 oz water only. Interview with a Dietary Aide on 2/23/17 at 4:01 p.m. revealed: -He worked as a Dietary Aide at the facility 3 to 4 times weekly. -He had worked during all three meals. -During breakfast residents are offered milk or water. The residents are offered sweet tea, if it is available. -He offered residents the beverage that was on the menu, which was water or milk. Interview with a second PCA on 2/23/17 at 4:45 p.m. revealed none of the residents complained of receiving only one beverage during a meal. Interview with the Dietary Supervisor on 2/24/17 at 12:13 p.m. revealed: -The Dietary Aide was supposed to pass out water and another beverage during the meals. -He would communicate with the Dietary Aide to make sure he was aware that residents should receive water at every meal and offered another beverage during the meals. Observation of the beverages on hand in the kitchen and pantry on 2/24/17 at 5:17 p.m. revealed there were two one gallon containers of orange juice, three cartons of orange juice, one and three fourth 2.84 liters (L) containers of apple	D 306		

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D 306	Continued From page 5 juice, two and one half gallons of milk, one two liter regular soda bottle and fifteen low calorie powdered drink mixes. Confidential interview with a resident's family member revealed: -Usually when the family member came to see the resident, the residents at the facility had one beverage on the dining room table during that meal. -The family member did not have any concerns about the residents receiving one beverage during a meal. Interview with the Administrator on 2/24/17 at 6:08 p.m. revealed: -She had soda, tea and Kool-Aid to offer the residents. -The diabetics received diet soda. -The residents received water or tea at every meal. -The residents had a choice of beverages to be offered during the meals. -She expected staff to give the residents water at every meal. -Residents were supposed to receive juice and water for breakfast, by choice. -Staff usually know who wanted, which beverage.	D 306		
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	D 358		

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D 358	Continued From page 6 (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to administer medications and treatments to 3 of 5 sampled residents as ordered; including Effexor for Resident #4, Potassium Chloride for Resident #3 and Lac-Hydrin Lotion for Resident #1. The findings are: 1. Review of Resident #4's current FL-2 dated 3/7/16 revealed the resident's diagnoses included dementia, depression, high blood pressure and anxiety. Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 2/1/14. Review of Resident of Resident #4's medication orders revealed: -The resident had an order dated 10/17/16 for Effexor 75 milligrams (mg) daily (used to help treat depression and anxiety disorder.) -There was a subsequent order dated 12/12/16 for Effexor extended release (XR) 75 mg daily and to take with Effexor XR 37.5 mg daily. Review of Resident #4's record revealed the resident had been seen by the primary care physician on 12/12/16 for depression. Review of Resident #4's December 2016, January 2017 and February 2017 electronic Medication Administration Records (MARs) revealed:	D 358		

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D 358	Continued From page 7 -Effexor 75 mg ER take 1 capsule by mouth every day was transcribed on the MAR. -Effexor 75 mg was documented as administered at 8:00 a.m. from 12/1/16-12/31/16, from 1/1/17-1/31/17 and from 2/1/17-2/23/17. Telephone interview with a Pharmacy Technician from Resident #4's local pharmacy on 2/24/17 at 11:54 a.m. revealed: -Resident #4 had a current order dated 10/17/16 for Effexor XR 75 mg take 1 capsule daily and it was last dispensed on 2/14/17 for a 28 day supply. -There was no subsequent orders dated 12/12/16 for Effexor at the pharmacy. -The pharmacy did not receive the order for Effexor dated 12/12/16 from the facility or the resident's primary care physician. Review of Resident #4's medications on hand revealed Effexor ER 75 mg take daily was on the medication label and was dated 2/20/17. Telephone interview with Resident #4's Responsible Party on 2/23/17 at 4:24 p.m. revealed the facility gave the resident medications and he did not have a problem with the resident not receiving medications. Interview with a Supervisor/Medication Aide (MA) on 2/24/17 at 4:24 p.m. revealed: -Resident #4 received Effexor, because she tried to hit staff. -Resident #4 cried a lot. -Currently the resident received 75 mg of Effexor daily. -She last gave the resident the medication the morning of 2/24/17. -When the facility received a medication order, the MA faxed the order to the facility's pharmacy.	D 358		

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D 358	Continued From page 8 -The facility's pharmacy added the medication order on the electronic MAR by that evening or the next day. Interview with the same Supervisor/MA on 2/24/17 at 5:00 p.m. revealed every month she checked the residents' MARs against the medication orders to make sure it was matching. Interview with the same Supervisor/MA on 2/24/17 at 5:20 p.m. revealed: -There was a staff person who used to work at the facility to file paperwork. -When Effexor order dated 12/12/16 was received, the staff person was supposed to place the order in a certain location so the Supervisor could review it and fax it to the pharmacist. -The staff person filed the order and never put the order in the assigned location for the Supervisor to review and fax. -The Supervisor had never seen the Effexor order dated 12/12/16. -The staff person had not worked at the facility in the last three weeks. Interview with a second MA on 2/24/17 at 5:00 p.m. revealed: -Sometimes Resident #4 may feel happy or sad and sometimes the resident cried. -Resident #4 was on Effexor 75 mg daily. -The MA did not know how long the resident had been receiving the medication. -When the facility received a medication order, the order was faxed to the facility's pharmacy to be added on the electronic MAR. -Resident #4's medications came from another pharmacy. -Every month the Supervisor checked the residents' MARs against the medication orders to make sure it was matching.	D 358		

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D 358	Continued From page 9 Interview with the Administrator on 2/24/17 at 6:08 p.m. revealed: -Resident #4 was sometimes happy and sometimes sad. -She was not sure if Resident #4 was on Effexor or not. -When the facility received a medication order, the order goes in a basket and was reviewed by the MA. -Her expectation was for staff to administer medications as ordered. Based on observation, interview and record review, Resident #4 was not interviewable. Resident #4's primary care physician could not be reached by the end of the survey. 2. Review of Resident #3's current FL-2 dated 12/5/16 revealed: -The resident's diagnoses included cerebral vascular accident, dementia, encephalopathy, and ischemic cardiomyopathy. -There was an order for Potassium Chloride Extended Release (ER) 20 milliequivalents (meq) take one tab three times daily (used to treat or prevent low levels of potassium.) Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 6/23/08. Review of Resident #3's medication orders revealed: -There was a prior order dated 9/29/16 for Potassium Chloride 20 meq take 1 tablet three times daily. -There was an order dated 12/1/16 for Potassium Chloride 20 meq take 1 tablet by mouth daily.	D 358		

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D 358	Continued From page 10 Review of Resident #3's December 2016 electronic Medication Administration Records (MARs) revealed: -Potassium Chloride ER 20 meq take one tablet daily was transcribed on the MAR. -The medication was documented as administered at 8:00 a.m. from 12/1/16-12/31/16. Review of Resident #3's January 2017 electronic MAR revealed: -Potassium Chloride 20 meq was documented as administered at 8:00 a.m., 12:00 p.m. and 8:00 p.m. from 1/1/17-1/5/17 and at 8:00 a.m. and 12:00 p.m. on 1/6/17. Discontinued was transcribed on the MAR and the stop date was 1/6/17 at 12:00 p.m. -Potassium Chloride 20 meq daily was documented as administered at 8:00 a.m. from 1/7/17-1/31/17. Review of Resident #3's February 2017 electronic MAR revealed Potassium Chloride 20 meq daily was documented as administered at 8:00 a.m. from 2/1/17-2/23/17. Review of Resident #3's medications on hand revealed: -Potassium Chloride 20 meq take 1 tablet daily was on the medication label. -The original date of the order was 12/1/16. -A 30 day supply of the medication was last dispensed on 1/25/17. Telephone interview with a Pharmacy Technician from Resident #3's local pharmacist on 2/24/17 at 11:45 a.m. revealed: -The resident had a current order dated 12/1/16 for Potassium Chloride 20 meq give one tablet daily.	D 358		

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-The medication was last dispensed on 2/22/17 and 30 tablets were dispensed.
-The was no subsequent orders dated 12/5/16 for Potassium Chloride at the pharmacy.
-The pharmacy did not receive the order for Potassium Chloride dated 12/5/16 from the facility or the resident's primary care physician.

Review of Resident #4's comprehensive metabolic panel dated 3/8/16 revealed the resident's serum potassium level was 4.5 millimole per liter (mmole/L) and serum chloride level was 103 mmol/L, which was within the normal range. (According the the lab report, the normal therapeutic range for serum potassium is 3.5-5.2 mmol and the normal therapeutic range for serum chloride is 97-108 mmol).

Interview with a Supervisor/Medication Aide (MA) on 2/24/17 at 4:20 p.m. revealed:
-Resident #3 used to take Potassium Chloride at 8:00 a.m., 12:00 p.m. and at 8:00 p.m., but the order had changed.
-Currently, the resident took Potassium Chloride 20 meq daily at 8:00 a.m.
-Resident #3's primary care physician emailed medication orders to Resident #4's local pharmacy.
-When the facility received a medication order, the MA faxed the order including the FL-2 to the facility's pharmacy.
-The facility's pharmacy added the medication order on the electronic MAR by that evening or the next day.

Interview with a second MA on 2/24/17 at 5:00 p.m. revealed:
-Currently, Resident #3 was on Potassium Chloride 20 meq at 8:00 a.m.
-When the facility received a medication order,

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D 358	Continued From page 12	D 358		

the order was faxed to the facility's pharmacy to be added on the electronic MAR.
-Resident #4's medications came from another pharmacy.
-Every month the Supervisor checked the residents' MARs against the medication orders to make sure it was matching.

Interview with the Administrator on 2/24/17 at 6:08 p.m. revealed:
-She was not aware staff had administered Potassium Chloride to Resident #3 once daily versus three times daily.
-If she had been aware the medication had been administered wrong, she would have told staff to administer it accurately.
-When the facility received a medication order, the order goes in a basket and was reviewed by the MA.
-Her expectation was for staff to administer medications as ordered.

Based on observations, interviews and record review, Resident #3 was not interviewable.

Resident #3's primary care physician could not be reached by the end of the survey.

3. Review of Resident #1's current FL-2 dated 06/21/2016 revealed diagnoses included schizophrenia, lower back pain arthropathy multisites, and dementia.

Review of physician's orders for Resident #1 revealed a physician's order dated 01/10/2017 to apply Lac-Hydrin Lotion to feet daily (skin moisturizer).

Review of the January 2017 electronic Medication Administration Records (eMARs) for Resident #1

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PINE VALLEY ADULT CARE HOME	3522 CAMDEN ROAD FAYETTEVILLE, NC 28306

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D 358	Continued From page 13 revealed: -There were printed instructions to the eMARs for Ammonium Lac Lotion 12% apply to feet every day at 8:00am. -There was documentation of administration for the Lac-Hydrin Lotion application to feet daily beginning 01/12/2017. Review of the February 2017 electronic Medication Administration Records (eMARs) for Resident #1 revealed: -There were printed instructions to the eMARs for Ammonium Lac Lotion 12% apply to feet every day at 8:00am. -There was documentation of administration for the Lac-Hydrin Lotion application to feet daily from 02/01/2017 through 02/23/2017. Observation of the Ammonium Lac Lotion 12% for Resident #1 on hand on 02/24/2017 revealed: -There was a sealed 14-ounce bottle of Ammonium Lac Lotion 12% with a pharmacy labeled dispense date of 01/11/2017. -There were printed instructions on the medication label to apply to feet every day. Interview with the Medication Aide (MA) on 02/24/2017 at 3:10pm revealed: -If she documented administration of the lotion on the electronic medication administration record (eMAR) and the cream was not opened, then she did not administer the medication. -She scanned her medications before she administered them to the resident. -It was busy in the facility in the morning. -She usually took residents to the bathroom to apply any topical medication. -The residents would leave the medication cart after taking their medications by mouth and go to breakfast.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026048	A. BUILDING: _____ B. WING _____	02/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 14 -She did not know how she had missed applying the lotion as ordered, and did not know how applying the lotion as ordered "got by me, but it did". Interview with a second Medication Aide (MA) on 02/24/2017 at 3:30pm revealed: -She had not been applying the lotion to Resident #1's feet. "Just a mistake, just a mishap". -She normally compared the medications to the eMAR before administering the medications. -She checked the medication off on the eMAR before she administered the medications. -The eMAR was not signed until the MA clicked "submit or enter". -She noticed the lotion for Resident #1 was on the medication cart on 02/19/2017 when she was cleaning the medication cart. -She had initialed the lotion as administered because she was "not paying attention". Interview with Resident #1 on 02/24/2017 at 3:15pm revealed: -The lotion had not been applied to her feet. -She did not know about the lotion. -Her heels were sore. -When she saw the foot doctor there were thick scabs on her heels that were removed by the doctor. Observation of Resident #1's feet on 02/24/2017 at 3:15pm revealed: -The skin on the resident's right heel was dry and cracked in multiple areas across the heel. -The skin on the resident's left heel was dry. Interview with the MA on 02/24/2017 at 3:15pm revealed Resident #1's right heel felt harder than the resident's left heel.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 15 Interview with the Owner/Administrator on 02/24/2017 at 4:15pm revealed: -She did not know about the lotion to be applied to Resident #1's feet that had been prescribed by the doctor. -The MA's were responsible to administer medications. -"Sometimes things slip through the cracks". -Resident #1 had not complained to the Owner/Administrator about her feet, and the Owner/Administrator was in the facility every day. -If Resident #1 had complained, the Owner/Administrator would have inquired into it. -The Owner/Administrator expected the MA's to "click off on the medication as you do it - if they do that, then would pretty much be on line with what they're supposed to do. Tell them all the time to click off on the med as they give it. That's what they're supposed to do". -There used to be an assistant who was responsible to check physician orders and the medication cart to ensure medications were in house, but that person no longer worked at the facility. -The Owner/Administrator needed to hire another medication aide.	D 358		