PRINTED: 01/31/2020
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
	HAL066001	A. BUILDING: _______ B. WING _______	R 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE FOREST REST HOME	3277 HWY 35 WOODLAND, NC 27897

(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 and the Northampton County Department of Social Services conducted a follow-up survey on January 22-23, 2020.	{D 000}	RECEIVED MAR 13 2020 ADULT CARE LICENSURE SECTION RALEIGH	
{D 310}	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure 2 of 3 sampled residents (#3 and #4) with therapeutic diet orders for a no concentrated sweets diet (NCS) were served as ordered. The findings are: Review of the facility's menus and therapeutic diet spreadsheets revealed: -Skim milk was on the NCS therapeutic diet spreadsheet whenever milk was on the regular menu. -Diet chocolate cake, instead of a brownie, was to be served to residents on a NCS diet on 01/22/2020 at supper. -Diet pudding parfait, instead of a regular pudding parfait, was to be served to residents on a NCS diet on 01/23/2020 at supper. -Diet fruit crisp, instead of fruit crisp, was to be served to residents on a NCS diet on 01/24/2020 at lunch. -A cup of fruit, instead of a fluffy fruit dessert, was	{D 310}	We buy skim milk along with our whole milk now. Residents on a NCS diet have a dr's order that they can have concentrated sweets. If they eat NCS, we have all ingredients in house, to make what is on the menu.	2/4/2020

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brooke B Jenkins
TITLE: administrator
(X6) DATE: 3/9/2020

STATE FORM 6899 JU5S12

Reviewed + accepted. [initials] 3-17-20

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{D 310}	Continued From page 1 to be served to residents on a NCS diet on 01/25/2020 at lunch. -Diet pudding, instead of baked custard, was to be served to residents on a NCS diet on 01/25/2020 at supper. Observations in the kitchen on 01/22/2020 at 2:21 pm revealed: -There was a binder that contained the regular menu and the therapeutic diet spreadsheets on a counter across from the food preparation area. -The pantry did not contain any of the ingredients necessary to prepare desserts that were listed on the therapeutic diet spreadsheets. -The refrigerator did not contain any skim milk. Observation of dessert to be served for the supper meal service on 01/22/2020 at 4:58pm revealed homemade brownies were the only dessert available. 1. Review of Resident #3's current FL2 dated 04/09/19 revealed: -Diagnoses included hypertension, diabetes, and chronic ischemic heart disease. -There was an order for glipizide 5mg twice daily (used to treat high blood sugar) and metformin 1000mg twice daily (used to treat high blood sugar). Review of physician's order dated 10/07/19 revealed there was a physician's order for a no added salt (NAS) and no concentrated sweets (NCS) diet. Review of physician's order dated 11/12/19 revealed there was a physician's order to check finger stick blood sugars (FSBS) twice daily at 6:00am and 4:30pm.	{D 310}	Kitchen staff has been in-serviced by administrator of importance of giving menu ordered for resident. They are also well-aware of where all therapeutic menus are located in menu book binder. If a resident refuses to eat NCS ~~diet~~ as ordered by his/her physician, we document and contact doctor for further direction/orders.	2/4/2020

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{D 310}	Continued From page 2	{D 310}		

Review of Resident #3's Medication Administration Record (MAR) for December 2019 revealed:
-FSBS ranged from 91-205 at 6:00am.
-FSBS ranged from 128-370 at 4:30pm.

Review of Resident #3's MAR for January 2020 revealed:
-FSBS ranged from 86-167 at 6:00am.
-FSBS ranged from 104 to 303 at 4:30pm.

Attempted telephone interview with Resident #3's Primary Care Physician (PCP) on 01/23/20 at 11:14am was unsuccessful.

Interview with Resident #3 on 01/22/20 at 1:10pm revealed:
-He was not on a special diet.
-He received the same meals as everyone else.
-He sometimes did not eat meat.

Interview with Resident #3 on 01/23/20 at 10:20am revealed:
-He only had grits for breakfast this morning.
-He ate a brownie last night at dinner; "they tasted like candy."

Observation of the snack provided to Resident #3 on 01/23/20 at 10:33am revealed he was served canned peaches in light syrup and a glass of whole milk.

Refer to interview with the cook on 01/22/20 at 2:57pm.

Refer to interview with the Administrator on 01/23/20 at 10:15am.

2. Review of Resident #4's current FL2 dated

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{D 310}	Continued From page 3	{D 310}		

04/17/19 revealed:
-Diagnoses included hypertension, diabetes, and hyperlipidemia.
-There was an order for Novolog insulin 70/30, inject 40 units subcutaneously every am and pm (used to treat high blood sugar).
-There was an order for metformin ER 500mg, take two tablets daily (used to treat high blood sugar).
-There was an order to check finger stick blood sugars (FSBS) three times daily.
-There was an order for a no added salt (NAS) and no concentrated sweets (NCS) diet.

Review of physician's order dated 10/02/19 revealed there was an order for Novolog insulin 70/30, inject 50 units subcutaneously twice daily at 7:30am and 4:30pm.

Review of physician's order dated 10/07/19 revealed there was an order for a NAS and NCS diet.

Review of Resident #4's Medication Administration Record (MAR) for December 2019 revealed:
-FSBS ranged from 125-257 at 7:00am.
-FSBS ranged from 78-322 at 12:00pm.
-FSBS ranged from 102-309 at 4:00pm.

Review of Resident #4's MAR for January 2020 revealed:
-FSBS ranged from 152-353 at 7:00am.
-FSBS ranged from 211-404 at 12:00pm.
-FSBS ranged from 160-332 at 4:00pm.

Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable.

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Interview with Resident #4's Primary Care Physican's nurse on 01/23/20 at 12:06pm revealed:
-Resident #4 had diabetes and therefore had an order for a NCS diet.
-She was not aware that the facility did not provide a NCS diet as ordered.
-She expected the facility to provide the NCS diet as ordered.
-The resident was at risk of developing the long term complications related to diabetes if his blood sugars were not controlled.

Refer to interview with the cook on 01/22/20 at 2:57pm.

Refer to interview with the Administrator on 01/23/20 at 10:15am.

Interview with the cook on 01/22/20 at 2:57pm revealed:
-She referred to the regular menu spreadsheet when she prepared meals.
-She did not know there were therapeutic diet spreadsheets in the binder for reference.
-When she had diet desserts she served them to residents who had orders for a NCS diet.
-She served all the residents the same food.
-She was not responsible for ordering any of the food used in the facility.
-The Administrator was responsible for food purchases.
-She served water, unsweetened tea, whole milk, coffee or juice at meals to anyone on a NCS diet.

Interview with the Administrator on 01/23/20 at 10:15am revealed:
-She was aware that the binder in the kitchen contained the menu as well as the therapeutic

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{D 310}	Continued From page 5 diet spreadsheets -The cook should have known the spreadsheets were available as she had been told they were in the binder -The cook knew to give diet desserts to residents ordered a NCS diet. -She was responsible for ordering food for the kitchen. -She routinely ordered sugar free gelatin and applesauce but the kitchen was currently out and the items were scheduled to be delivered next week. -In the past she ordered and the cook served diet desserts as the menu specified but she stopped ordering the food because the residents did not like the items and they were just throwing it out. -The diet foods were too expensive to just throw away so she did not purchase the items anymore. -All resident received the same foods in the dining room, by resident choice. -The cook should not have served the brownie to everyone at supper the previous night as there was fruit available in the pantry to serve instead of diet chocolate cake.	{D 310}		
{D 338}	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on interviews the facility failed to ensure Resident #5 was treated with consideration, dignity and respect related to Staff B, Medication Aide (MA) going into Resident #5's pocketbook without permission to retrieve medication.	{D 338}	Administrator conducted Stand-up meeting with Staff about privacy and how to handle resident property with dignity and respect.	2/4/2020

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(D 338)	Continued From page 6 The findings are: Review of Resident #5's current FL2 dated 12/31/19 revealed: -Diagnoses included hypertension, generalized osteoarthritis, anxiety, restless leg syndrome and atrial fibrillation. -There was an order for meclizine 25 mg to be given twice a day as needed for dizziness. -There was an order for tylenol 650 mg to be given every 6 hours as needed for pain. Review of Staff B's personnel record revealed she was hired as a Medication Aide (MA) in 2007. Interview with Resident #5 on 01/22/2020 at 3:10pm revealed: -Staff B, MA, entered Resident #5's room on 01-19-2020 while the resident was at breakfast and took 2 medications, meclizine and tylenol, out of her pocketbook. -Staff B told Resident #5 that she had taken the medication because she knew she was not allowed to have medication in her room. -Resident #5 was very upset that someone had entered her room and gone through her pocketbook without her permission. -Resident #5 did not know how the staff knew the medication was in her pocketbook. -Resident #5 knew she was not supposed to have medication in her room and had forgotten to give it to them when she had come back to the facility. -Resident #5 contacted the Administrator and told her about the incident. -The Administrator told Resident #5 she was not allowed to have medication in her room and did not appear to be concerned that a staff had gone through her pocketbook without permission. Interview with the Administrator on 01/23/2020 at	(D 338)	Administrator met with resident #5 and assured her we respected her and her belongings. We will start adding reviewing resident rights to our monthly staff meetings. Each employee got a copy of the resident rights and signed them acknowledging they have read and understand them fully. All questions and concerns made by staff were answered and cleared by administrator.	

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{D 338}	Continued From page 7	{D 338}		

9:28am revealed:
-She was aware of the incident which Resident #5 referred to.
-Residents were not allowed to have medications in their rooms and therefore the staff needed to go in the room and get it.
-She nor any of the other staff ever gave Resident #5 an opportunity to turn in the medication before going through her pocketbook.
-The staff should have asked Resident #5 for the medication and if she refused to turn it in they should have had Resident #5 present when they went through her pocketbook.

Interview with Staff B on 01/23/2020 at 9:38am revealed:
-She worked at the facility as a Medication Aide (MA).
-Residents were not allowed to have any medications in their rooms.
-The night shift MA had reported to her that she had seen tylenol and meclizine (a medication to treat dizziness) in Resident #5's room.
-On her way to breakfast that morning Resident #5 asked Staff B about the side effects of taking meclizine.
-Because she was concerned that Resident #5 might have taken too much meclizine, she went into Resident #5's pocketbook to get the medication.
-Resident #5 became very upset when she was told Staff B had gone into her pocketbook, telling Staff B that she had no right to do that without her permission.
-Staff B did not give the resident an opportunity to turn in the medication, ask permission or have the resident present when she went through Resident #5's pocketbook.