

PRINTED: 09/13/2024
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	DX1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL079079	DX2) MAILING INFORMATION: A. MAILING ADDRESS: B. PHONE: C. FAX:	DX3) DATE SURVEY COMPLETED 09/05/2024
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NAME OF PROVIDER OR SUPPLIER PINE FORREST HOME FOR THE AGED	STREET ADDRESS, CITY, STATE, ZIP CODE 312 BROAD STREET REIDSVILLE, NC 27320
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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 000	Initial Comments The Adult Care Licensure Section conducted an annual survey from 09/04/24 to 09/05/24.	D 000	"Please see attached"	
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 observations, interviews, and record review, the facility failed to administer medications as ordered for 1 of 5 sampled residents (Resident #2) related to an eye drop used to treat glaucoma. The findings are: Review of Resident #2's current FL-2 dated 08/09/24 revealed: -Diagnoses included dementia and glaucoma. -There was an order for Lumigan (an eye drop used to treat glaucoma) 0.01% one drop in each eye at bedtime. Review of Resident #2's July 2024 medication administration record (MAR) revealed: -There was an entry for Lumigan 0.01% instill one drop in each eye with a scheduled administration time of 8:00pm. -There was documentation Lumigan 0.01% one drop in each eye at bedtime was administered	D 358		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Judy Blackwell Administrator

TITLE:

(X8) DATE

10/9/2024

STATE FORM

48FH11

Revised July 2019

"Reviewed and Acknowledged" CPP October 17, 2024

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL079079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/05/2024
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D 358	<p>Continued From page 1</p> <p>from 07/01/24 to 07/31/24 at 8:00pm.</p> <p>Review of Resident #2's August 2024 MAR revealed:</p> <ul style="list-style-type: none"> -There was an entry for Lumigan 0.01% instill one drop in each eye with a scheduled administration time of 8:00pm. --There was documentation Lumigan 0.01% one drop in each eye at bedtime was administered from 08/01/24 to 08/31/24 at 8:00pm. <p>Review of Resident #2's September 2024 from 09/01/24 to 09/03/24 MAR revealed:</p> <ul style="list-style-type: none"> -There was an entry for Lumigan 0.01% instill one drop in each eye with a scheduled administration time of 8:00pm. --There was documentation Lumigan 0.01% one drop in each eye at bedtime was administered from 09/01/24 to 09/03/24 at 8:00pm. <p>Observation of Resident #2's medications on hand on 09/04/24 at 2:50pm revealed:</p> <ul style="list-style-type: none"> -There was one bottle of Lumigan 0.01% eye drops available for administration. -The dispensed date on the bottle of Lumigan 0.01% eye drops was 08/07/24. -The bottle had not been opened; the plastic seal was still intact. <p>Telephone interview with the facility's contracted Pharmacist on 09/04/24 at 3:04pm revealed:</p> <ul style="list-style-type: none"> -One bottle of Lumigan 0.01% eye drops was dispensed to the facility on 05/08/24, 06/10/24, 07/10/24, and 08/07/24. -One bottle of Lumigan 0.01% eye drops would last between 25-30 days. -Resident #2's Lumigan eye drops were not part of the facility's cycle fill medications; someone from the facility would have to call the pharmacy and order them. 	D 358		

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D 358	<p>Continued From page 2</p> <p>-The facility had not requested Lumigan eye drops for Resident #2 since August 2024. -Lumigan was used for glaucoma, it helped keep intraocular pressure down.</p> <p>Based on observations, record review, and interviews, it was determined that Resident #2 was not interviewable.</p> <p>Interview with Resident #2' primary care provider (PCP) on 09/05/24 at 9:10am revealed: -Resident #2 was non-complaint so she would not be surprised if he refused his eye drops. -She had no concerns with Resident #2's vision. -Resident #2 did not report any problems with his vision to her. -The staff had not notified her that Resident #2 had episodes of eye drop refusals. -If Resident #2 did not receive the Lumigan eye drops as ordered, his intraocular pressure could go up and he would have difficulty seeing.</p> <p>Interview with Resident #2's eye doctor on 09/05/24 at 10:30am revealed: -She saw Resident #2 regularly in the facility. -Resident #2 was blind in the left eye and had significant vision loss in his right eye. -Resident #2 had open angle glaucoma and was prescribed eye drops to keep his intraocular pressure down. -She saw Resident #2 in the facility on 08/27/24 and his intraocular pressure was good. -It was incredibly important for Resident #2 to receive the eye drops as ordered to keep what vision he had. -She thought he must be receiving some eye drops since his intraocular pressure was normal; if the intraocular pressure was elevated, she would be more concerned that he had not received his eye drops as ordered.</p>	D 358		

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D 358	<p>Continued From page 3</p> <p>Interview with the Medication Aide (MA) on 09/04/24 at 3:20pm revealed: -She just threw out the previous bottle of Lumigan eye drops for Resident #2 last night and would open the new bottle tonight, 09/04/24. -Resident #2 sometimes refused his eye drops. -She administered Resident #2's Lumigan eye drops at night when she worked. -If Resident #2 refused his eye drops, she would document on the MAR. -Resident #2 did not complain of blurred vision or headaches.</p> <p>Interview with the Administrator on 09/05/24 at 10:15 revealed: -She did complete audits of the medication carts to make sure the residents had the medications ordered. -She did not look at dispense dates for eye drops as part of her medication cart audit. -If Resident #2 refused his eye drops, she expected that to be documented on the MAR and the physician notified. -She was concerned that the facility needed to do better and give medications as ordered.</p>	D 358		

**PROVIDERS PLAN OF CORRECTION
PINE FORREST HOME FOR THE AGED**

RESPONSE TO STATEMENT OF DEFICIENCIES

REGARDING RULE 10A NCAC 13F .1004 – MEDICATION ADMINISTRATION

Corrective Action Plan and Facility's Response and Progress (Plan to correct deficiency)	Expected Completion
<p>The problem cited was discussed with all supervisors and medication staff. The medication staff is currently consistently administering the medication and documenting the administration as ordered by the physician. Any refusal by the resident is appropriately documented on the MAR.</p> <p>The administrator and supervisory staff and medication staff have been made aware of the importance of administering all medications including eye drops as order.</p> <p>The Medication administration policy has been updated to require removal of the previous bottle from the medication cart when a new bottle is received, checked for correctness, and stored in the medication cart.</p> <p>The administrator, supervisory, and medication staff will receive additional Medication Administration training by a Register Nurse on November 04, 2024. The training will include receiving medication into the facility, stocking the medication cart, administration medication to each resident as ordered by the physician, and proper documentation of medication administered.</p> <p>We have and will continue to make every effort to provide quality care for the residents of Pine Forrest Home for the Aged.</p>	<p align="center">11/05/2024</p>
<p>Monitoring System put in place to assure continued compliance (Preventing reoccurrence)</p>	<p align="center">11/05/2024</p>
<p>The area identified in the "Statement of Deficiencies" have been corrected and steps have been put in place through our on-going Quality Assurance and Improvement and Staff Training program to ensure that all medication is administered and documented as ordered by the physician and there is no reoccurrence of the problem cited.</p>	<p align="center">11/05/2024</p>
<p>Completion date by which the plan of correction will be completed</p>	<p align="center">11/05/2024</p>

Administrator Signature: *Judy J. Blalock* Date: 10/9/2024