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 _____	R 04/24/2017

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 Licensure Section conducted an annual and follow-up survey on April 19, 2017, April 20, 2017, April 21, 2017 and April 24, 2017.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to keep the bathroom floor shared by residents in room #43 and #44 and the electrical equipment on the wall in room #44 clean and in good repair. The findings are: A. Observation in the bathroom between rooms #43 and #44 during the initial tour on 04/19/17 at 11:00am revealed: -The commode had thickly applied caulk at the junction of the commode and tile floor. -The floor around the commode was wet. -When the edge of tiles at the base of the commode were stepped on, a tee-colored liquid oozed out. Interview with a resident who shared the bathroom on 04/19/17 at 11:20am revealed: -The resident had resided in room #43 for [did not remember when] 3 months. -The commode had "leaked ever since he had been here". -They [facility staff] had applied the extra caulk	D 074	Bathroom floor was fixed during survey. Manager will check bathrooms at least twice a month for any evidence of leaking. Housekeeping staff will report daily to manager if issues are noted	4/20/17

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mame D. Lokay, J. TITLE: Administrator (X6) DATE: 6/15/17

STATE FORM 6899 E2QE11 If continuation sheet 1 of 22

Accepted with revisions.
Tinila J. Bowen, RN
06/20/17

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D 074	Continued From page 1 but it didn't "fix" the problem. Interview with the Resident Care Coordinator (RCC) on 04/19/17 at 11:07am revealed: -The RCC was not aware of a problem with the commode. -The RCC did not know if one of the 4 residents had urinated on the floor or if the commode was leaking. -The RCC would have housekeeping mop the floor immediately and check after floor had dried. Second observation of the bathroom between rooms #43 and #44 on 04/19/17 at 1:10pm revealed the tile floor around the base of the commode was still wet; the rest of the bathroom floor was dry. Second interview with the RCC on 04/19/17 at 1:17pm revealed she would have the facility's maintenance man check the commode for possible leaks. Interview with the maintenance man on 04/19/17 at 5:00pm revealed: -He had checked the commode and it appeared to be leaking underneath the recently applied caulk. -He had applied the extra caulk "a few weeks ago" and thought the problem had been solved. -The maintenance man had discussed the issue with the Administrator. -A plumber had been contacted and would be at the facility the next day (04/20/17). Interview with the Administrator on 04/20/17 at 3:20pm revealed: -On 04/20/17, the plumber had "pulled the commode" and had found a blocked pipe underneath the floor.	D 074	While cleaning bathrooms. Manager will follow up with maintenance or plumber immediately upon discovery of leaking commodes in order to insure problem areas are repaired in a timely manner	

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D 074	Continued From page 2 -The blockage had been removed, a new external seal placed between the pipe and commode, the commode replaced and fresh caulk applied around the base. -Floor tiles had been replaced around the commode. -No further leaking had been observed. B. Observation of Room #44 on the initial tour on 04/19/17 at 11:45am revealed: -An air-conditioning unit was mounted at the baseboard on the exterior wall. -The top edge of the air-conditioning unit was partially detached from the wall, leaving a gap approximately 1 inch wide. -The air-conditioning cord, approximately 36 inches long, was looped from the base on the right across the top of the unit with the plug end hanging down on the floor on the left side. -Two electrical outlets, one on either side of the air-conditioning unit, were dangling out of the wall. Observation of the resident in room #44 on 04/19/17 at 11:46pm revealed: -The resident was wheelchair bound. -He was extremely hard of hearing. Based on observation, interview, and record review, the resident in room #44 was not interviewable due to his diagnoses. Interview with the Administrator on 04/19/17 at 1:50pm revealed: -The facility had installed central heating and air about 6 months ago. -The room air-conditioning units were no longer used. -In some rooms, a wooden box had been installed over the air-conditioning units.	D 074	All non working air conditioning units have been removed OR covered Maintenance person will continue to make Repairs when reported to him to ~~insure~~ ensure safety of all residents. Manager will do walk through of building at least twice a month to identify safety issues OR Repairs needed.	6/15/17

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D 074	Continued From page 3 -His plan was to cover all the unused units in this manner eventually. -The Administrator could not give a completion date for the repairs. -The Administrator would have the maintenance man immediately reattach the air-conditioning unit and electrical outlets to the wall. Observation of room #44 on 04/19/17 at 4:30pm revealed the air-conditioning unit and outlets were mounted flush against the wall.	D 074		
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 reviews and interviews, the facility failed to assure 2 of 4 sampled staff (Staff B and D) were tested upon hire for Tuberculosis (TB) disease with the two step TB skin test in compliance with TB control measures adopted by the Commission for Health Services. The findings are: 1. Review of Staff B's personnel file revealed: -Staff B was hired 02/17/2017 as a Personal Care	D 131	All staff have a 2 step TB skin test documented at this time. Manager will have all newly hired staff a current TB skin test upon hire and will ensure ~~if sure~~ a 2nd TB test is completed within the time frame required.	6/15/17

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D 131	Continued From page 4 Aide/Medication Aide (PCA/MA). -There was documentation of a TB skin test placed on 02/02/2016 and read as negative on 02/04/2016. -There was no documentation of a second step TB skin test for Staff B since her hire date. Interview with the Administrator-In-Charge (AIC) on 04/21/2017 at 2:40pm revealed: -The facility did not have documentation for a 2nd step TB skin test for Staff B. -Staff B was a "fairly new" staff. Interview with Staff B on 04/24/2017 at 10:20am revealed: -She had not had a TB skin test placed since employed at the facility. -She had worked at the facility for a little over 2 months. -She worked as a Personal Care Aide and Medication Aide at the facility. -She was asked by the Manager before hire if she had been tested for TB. -She had one TBST (tuberculosis skin test) completed before she was employed at the facility. -She did not remember the date of the TBST she had in the past. -She went to get another TBST "this morning" (04/24/2017) because she was told the TBST she had in the past would "expire next month". Interview with the Administrator on 04/24/2017 at 10:45am revealed: -The Manager was responsible to ensure staff TBST were done upon hire. -He expected staff to follow state requirements regarding TBST.	D 131		

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D 131	Continued From page 5 Interview with the Manager on 04/24/2017 at 11:05am revealed: -She was responsible to ensure TBST documentation was in the staff personnel file. -Newly hired staff were supposed to bring a copy of their TBST results to the facility. -She thought if someone worked at another facility and had a TBST completed, then that TBST could be used and was all that was needed for that staff to start employment at this facility. -She thought she only needed to have the staff get another TBST before the current TBST was one year old. -There had been seven newly hired employees, including Staff B and D, at the facility since 11/2016. -There were five of the newly hired employees who had their 2nd step TBST placed on 04/22/2017 and were read on 04/24/2017. -There was one of the seven newly hired employees who had a TBST upon hire and whose documentation of a previous 2-step TBST was being faxed to the facility. 2. Review of Staff D's personnel file revealed: -Staff D was hired 04/12/2017 as a Cook/Kitchen Staff. -There was documentation of a TB skin test placed 05/14/2016 and read as negative on 05/16/20 -There was no documentation of a second step TB skin test for Staff B since her hire date. Observation of meal preparation on 04/20/17 at 4:07pm revealed Staff D was working in the kitchen assisting with meal preparation. Interview with the Staff D, Kitchen on 04/24/2017 at 10:55am revealed: -She had just started working at the facility about	D 131		

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D 131	Continued From page 6 a week ago. -She worked in the kitchen at the facility. -She had worked "maybe 3 days" in the facility kitchen since she was hired. -She was asked by the Manager, before she was hired, to bring documentation of TB skin testing to the facility. -She had a TBST (tuberculosis skin test) completed before she was employed at the facility. -She thought the copy of the 05/14/2016 TBST from her other job was good enough. -She was told the previous TBST was good for one year. -She had not had a TBST placed at the facility until Saturday because she was waiting for someone to come to the facility to perform the TBST. -She had another TBST placed on Saturday (04/22/2017) and had just had the TBST read at the facility today. Interview with the Administrator on 04/24/2017 at 10:45am revealed: -The Manager was responsible to ensure staff TBST were done upon hire. -He expected staff to follow state requirements regarding TBST. Interview with the Manager on 04/24/2017 at 11:05am revealed: -She was responsible to ensure TBST documentation was in the staff personnel file. -Newly hired staff were supposed to bring a copy of their TBST results to the facility. -She thought if someone worked at another facility and had a TBST completed, then that TBST could be used and was all that was needed for that staff to start employment at this facility. -She thought she only needed to have the staff	D 131		

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D 131	Continued From page 7 get another TBST before the current TBST was one year old. -There had been seven newly hired employees, including Staff B and D, at the facility since 11/2016. -There were five of the newly hired employees who had their 2nd step TBST placed on 04/22/2017 and were read on 04/24/2017. -There was one of the seven newly hired employees who had a TBST upon hire and whose documentation of a previous 2-step TBST was being faxed to the facility.	D 131		
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 observation and interviews, the facility failed to assure that water was served to residents in the small dining room during two meals observed. The findings are: Observation of the lunch meal service in the small dining room on 04/20/17 at 12:15pm revealed: -The Medication Aide (MA) and a Personal Care Aide (PCA) were serving the residents. -Nine residents were sitting at tables in the dining area. -All nine was served iced tea, milk and coffee. -There were no glasses of water or pitchers of	D 306	All Residents IN both dining areas are served water at each meal Managers and RCC observe both dining areas daily to ~~INSURE~~ ensure JAB cups and water are available at each meal.	6/15/17

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D 306	Continued From page 8 water on any of the 4 dining tables. -Water was not offered to any resident. Interview with the facility's Manager on 04/21/17 at 2:50pm revealed that residents with the diagnosis of dementia or that required additional assistance with activities of daily living ate in the small dining room. Observation of the main dining room during the lunch meal on 04/20/17 at 12:00pm revealed glasses of water at each place setting for the lunch meal along with iced tea and coffee cups. Interview with a PCA on 04/20/17 at 12:20pm revealed: -The food cart was filled in the kitchen, including beverages and beverage containers. -Only MAs were allowed to go to the kitchen for the stocked food cart. -A pitcher of water was usually on the food cart at each meal. -If water was served to the residents at meals it would have to be in Styrofoam cups since there was never enough glasses on the cart to serve water. -The PCA did not think enough glasses were sent to the the small dining room. Interview with the Resident Care Coordinator on (RCC) on 04/20/17 at 3:40pm revealed: -The RCC was aware that each resident should be served water at each meal. -The RCC did not know that the residents served in the small dining area were not receiving water with their meals. -"I'll take care of it". Observation of the breakfast meal service in the small dining area on 04/21/17 at 8:30am	D 306		

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D 306	Continued From page 9 revealed: -Each resident was served approximately 8 ounces of both milk and orange juice as well as coffee. -Water was not served to any of the 10 residents present. Second interview with the RCC on 04/21/17 at 8:55am revealed: -She could not believe the issue had not been corrected. -"I spoke with [the cook] yesterday and told her to send enough glasses to the [small dining area]." -"I will speak with her again". Interview with a second PCA on 04/21/17 10:11am revealed: -She was not aware that water had to be placed on the table at each place setting. -She served water to the residents if they asked for it using the disposable cups. -If the kitchen provided more glasses, the staff would serve the water at each meal. -She denied asking the kitchen staff for more glasses. Interview with the cook on 04/21/17 at 11:50am revealed: -When asked if she was aware that each resident was to get water at each meal, she responded "Si, Si" and picked up a pitcher of water. -When asked how many drinking glasses were going to the small dining room at lunch, she pointed to a clear storage container on top of the food cart which contained approximately forty 9 ounce cups. Interview with the Administrator on 04/24/17 at 12:30pm revealed: -"I am outraged over this water business".	D 306		

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D 306	Continued From page 10 -"I mean water is free, come on". -"I expect it to be served to each resident at each meal and it will be".	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 (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 assure medications were administered as ordered by the prescribing practitioner for 2 of 8 residents (#7, #8) observed during the medication pass including errors with a psychotropic medication (Resident #8) and a stool softener (Resident #7) and for 1 of 5 residents sampled (Resident #2) for record review with a physician's order for a medication used to treat high blood pressure according to prescribed parameters. The findings are: 1. The medication error rate was 7% as evidenced by observations of 2 errors out of 26 opportunities during the 12noon, 3pm, and 5pm medication passes on 04/19/2017, and the 9am medication pass on 04/20/2017.	D 358	4/20/17 All med techs were given a review class by the RN Consultant Regarding Medication administration. RCC requested the pharmacy add the complete order to the MAR, not just times of administration in order for med techs to understand medications that need to be taken with food, or medications to be taken on an empty stomach.	

The above mission was discussed with Rhonda Lackamy, Administrator on 06/20/17 at 1:15 pm.
T. Bowen, RN

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D 358	Continued From page 11 A. Review of Resident #8's current FL-2 dated 12/29/2016 revealed: -Diagnoses included seizure disorder, hypertension, insulin dependent diabetes mellitus, hyperlipidemia, and adjustment disorder. -There was a physician's order for Geodon (used to treat mood disorder) 60mg twice a day with meals. Review of a subsequent physician's order dated 01/11/2017 revealed: -There was an order to discontinue Geodon 60mg twice daily. -There was a physician's order to start Geodon 80mg twice daily with breakfast and dinner. -The physician noted with the order that the Geodon 80mg "needs to be with food to be effective". Observation of the medication pass on 04/19/2017 at 4:27pm revealed: -Resident #8 was outside on the back porch of the facility. -The Medication Aide (MA) prepared and administered three pills to Resident #8 with water, including Geodon 80mg one capsule. -The resident was not offered any food with the medication. -The resident remained outside on the back porch after the medication was administered. Observation of Resident #8 on 04/19/2017 at 4:45pm revealed Resident #8 remained outside on the back porch of the facility. Observations in the facility dining room on 04/19/2017 at 4:45pm revealed: -The kitchen staff were placing glasses of water and silverware on the dining room tables. -The supper meal delivery to residents had not	D 358	In addition, the RN Consultant went over documentation and proper procedures for blood pressures as well as facility policy regarding parameters for med techs to notify physician. IF physician orders B/P outside of facility policy- The physician should determine parameters JB RCC will schedule additional trainings for Review at least twice annually or upon hire of new staff.	4/20/17

The above revision was discussed via telephone call with Rhonda Lackamp, Adm. on 06/20/17 at 1:15 pm. J. Bauer, RN

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D 358	Continued From page 12 begun.	D 358		

Observation of the same MA on 04/20/2017 at 4:35pm during the medication pass revealed:
-The MA removed Resident #8's Geodon 80mg blister pack of medication from the medication cart.
-The MA stated she was getting ready to administer Resident #8 her medication.

Interview with the MA on 04/20/2017 at 4:35pm revealed:
-The residents would be served supper at 5:00pm.
-If a medication was supposed to be given with food, the resident would be administered the medication when the resident was in the dining room eating.
-She administered the Geodon to Resident #8 before dinner.
-There would be instructions on the resident's Medication Administration Records (MARs) to administer the medication with food if the medication was supposed to be administered with food.
-She administered medications to residents according to the instructions on the MARs.
-There were no instructions on the MARs to administer the Geodon with food.
-The MARs were printed by the pharmacy.
-The MARs were reviewed by the Resident Care Coordinator (RCC) for accuracy.
-She had an hour before the scheduled time of administration or an hour after the scheduled time of administration to administer medications to residents.
-She did not administer the Geodon with food on 04/19/2017 to Resident #8.
-Resident #8 went to eat supper "about 15 minutes later" on 04/19/2017.

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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 358	Continued From page 13 -She had never administered the Geodon to Resident #8 with food. Review of Resident #8's Medication Administration Records (MARs) for 04/2017 revealed: -There was an entry for Ziprasidone (generic for Geodon) 80mg capsule twice a day. -The Geodon 80mg capsule was scheduled for 8am and 5pm daily. -There were no instructions printed on the MARs for the Geodon to be administered with breakfast and dinner or with food. Interview with the Resident Care Coordinator (RCC) on 04/20/2017 at 4:50pm revealed: -The pharmacy provider printed the MARs every month. -New orders were sent to the pharmacy by e-script from the physician and she faxed a copy of new orders to the pharmacy. -The instructions for the Geodon to be given with food should have been printed on the MAR according to the physician's order. Observation of the meal service on 04/20/2017 revealed: -Resident #8 was served her meal at 5:20pm. -The MA administered two pills to Resident #8 at 5:22pm, including Geodon 80mg capsule. Interview with the RCC on 04/21/2017 at 9:45am revealed: -She was responsible for reviewing the MARs for accuracy each month before the MARs were placed in the notebook for the MAs use for documenting administration of medications. -When she reviewed the MARs, she compared the current MAR to the upcoming month's MAR. -If she had a concern about the accuracy of the	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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINECREST GARDENS	1984 OLD US 421 LILLINGTON, NC 27646

(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 MAR she would look in the resident's record for clarification of the order. -When she saw a medication scheduled for 8am and 5pm, she thought the medication was supposed to be given with food because those were scheduled meal times at the facility. -The MAs did not review physician orders and did not go through resident records unless there was a need. Telephone interview with the Pharmacy Representative (PR) on 04/21/2017 at 10:30am revealed: -The PR was responsible for printing the facility MARs. -The current order on file for Resident #8's Geodon was dated 01/11/2017 with instructions for Geodon 80mg two times a day with breakfast and dinner. -Most of the time the PR printed all of the physician ordered instructions on the MAR. -The PR knew the meal times at the facility were 8am and 5pm, so she printed the instructions for the Geodon to be administered at that time. Telephone interview with the Pharmacist on 04/21/2017 at 10:40am revealed: -Geodon was absorbed about 60% when given with food. -Food helped the absorption of the Geodon. -The pharmacy could add instructions to Resident #8's MAR if the medication needed to be given with food. Interview with Resident #8 on 04/24/2017 at 12:25pm revealed. -She felt calm. -She was prescribed a "psychotropic". -She recognized her medications by color but did not know the names.	D 358		

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

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D 358	Continued From page 15 -She was administered medication by the MAs. B. Review of Resident #7's current FL-2 dated 12/22/2016 revealed: -Diagnoses included diabetes mellitus, hypertension, lower back pain, lumbar radiculopathy, spinal stenosis, coronary artery disease, arthritis, and constipation. -There was a physician's order for Colace (used to treat constipation) 100mg capsule three times a day. Observation of the medication pass on 04/19/2017 at 2:53pm revealed: -Resident #7 was in his room. -The Medication Aide (MA) prepared and administered two pills to Resident #7, including Docusate Sodium (Colace) 100mg one capsule. Review of Resident #7's Medication Administration Records (MARs) for 04/2017 revealed: -There was an entry for Docusate Sodium 100mg (generic for Colace) take one capsule three times a day. -The Colace was scheduled at 7am, 1pm, and 7pm daily. Interview with the MA on 04/19/2017 at 3:00pm revealed: -She was the only MA responsible for medication administration on the first shift. -Resident #7 was difficult to administer medications to on occasions. Interview with the Manager on 04/19/2017 at 3:45pm revealed: -The MAs had been trained to administer medications within one hour of the time the medication was scheduled for administration.	D 358		

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

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D 358	Continued From page 16 -She would contact the Licensed Health Professional Support (LHPS) Nurse to come to the facility to provide a medication review for the MAs. Interview with Resident #7 on 04/24/2017 at 12:15pm revealed: -He was administered a "little red gel cap three times a day" to help with constipation. -He usually had a bowel movement every three days. -He denied having any episodes of loose stools. 2. Review of Resident #2's current FL-2 dated 02/01/2017 revealed: -Diagnoses included hypertension, neurocognitive disorder/vascular, depression, and wheezing. -There was an order for blood pressure checks two times a day. -There was an order for Clonidine (used to treat high blood pressure) 0.1mg tablet two times a day as needed for systolic blood pressure (SBP) greater than 160 or diastolic blood pressure (DBP) greater than 100. Interview with the Medication Aide (MA) on 04/19/2017 at 10:40am during the initial facility tour revealed: -She had just checked Resident #2's blood pressure. -The blood pressure reading obtained was 204/96. (According to the National Institute of Health, a person is considered hypertensive if the systolic blood pressure is 140 or higher and diastolic is 90 or higher.) -She would recheck Resident #2's blood pressure in 30 minutes. -The facility policy was to give the resident 15 - 30 minutes, then recheck the blood pressure. If the blood pressure was still high, then the physician	D 358		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 17 would be notified. -The MA did not mention the administration of the Clonidine to Resident #2 due to the systolic blood pressure being greater than 160. Review of the February 2017, March 2017, and April 2017 Medication Administration Records (MARs) for Resident #2 revealed: -There was documentation for blood pressure checks during the 7a -3p shift and 3p 11p shift. -Clonidine 0.1mg tablet take one tablet twice daily as needed for SBP greater than 160 or DBP greater than 100 was printed on the MARs. Further review of the February 2017 MARs revealed there were three occasions on the 7a-3p shift when Resident #2's systolic blood pressure was documented as greater than 160 as follows: -On 02/07/2017 Resident #2's SBP was documented as 165. -On 02/21/2017 Resident #2's SBPwas documented as 183. -On 02/27/2017 Resident #2's SBP was documented as 162. -There was no documentation of administration of Clonidine for February 2017. Further review of the March 2017 MARs revealed there were five occasions during the 7a-3p shift and 3p-11p shift when Resident #2's SBP was documented as greater than 160 and one occasion when Resident #2's DBP was documented as greater than 100 as follows: -On 03/05/2017 Resident #2's SBP was documented as 162. -On 03/05/2017 Resident #2's DBP was documented as 138. -On 03/09/2017 Resident #2's SBPwas documented as 163.	D 358		

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D 358	Continued From page 18 -On 03/24/2017 Resident #2's SBP was documented as 164. -On 03/30/2017 Resident #2's SBP was documented as 171. -On 03/31/2017 Resident #2's SBP was documented as 164. -There was no documentation of administration of Clonidine for March 2017. Further review of Resident #2's April 2017 MARs revealed: -On 04/13/2017 during the 7a-3p shift, Resident #2's SBP was documented as 164. -There was no documented blood pressure obtained on 04/19/2017 during the 7a-3p shift or 3p-11p shift for Resident #2. -There was documentation of a blood pressure recheck refused on 04/19/2017. -There was no documentation of administration of Clonidine for April 2017. Interview with the MA on 04/20/2017 at 10:45am revealed: -She documented resident blood pressure rechecks on the back of the MAR. -She did not recheck Resident #2's blood pressure on 04/19/2017 because the resident refused. -She documented the resident's refusal on the back of the MAR. -She had not documented the results of the first blood pressure reading obtained on 04/19/2017 for Resident #2 on the MAR but had written it on a separate piece of paper. -When she got a high blood pressure reading, she would notify the RCC or Manager and they would tell her if the physician needed to be contacted or if the resident needed to be sent to the hospital. -She thought she had informed the RCC about	D 358		

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D 358	Continued From page 19 the blood pressure reading for Resident #2. -She had not administered any additional blood pressure medication to Resident #2 except the medication the resident routinely was administered every morning. -She knew there was Catapres (brand name for Clonidine) in the medication cart for Resident #2. -She had never administered the Catapres medication to Resident #2. -She was not aware of the physician's order for Catapres nor was she aware of the blood pressure parameters for when the Catapres was to be administered. -She had not checked Resident #2's blood pressure for 04/20/2017 as of yet. Observation of Resident #2 on 04/20/2017 at 11:25am revealed: -The resident was in her room laying on her bed. -The MA placed the digital blood pressure cuff on the resident's left upper arm and checked the resident's blood pressure. -The blood pressure reading was obtained as 135/61. Interview with Resident #2 after the blood pressure was obtained on 04/20/2017 at 11:25am revealed: -She had a stroke about four years ago. -She was administered "about 5 -6 pills" but did not know the names of the pills. -Sometimes she got a headache. -Sometimes she felt dizzy. -She was having stomach pain, but was feeling better. Further interview with the MA on 04/20/2017 at 11:25am revealed: -She was not aware of a written policy on blood pressures.	D 358		

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D 358	Continued From page 20 -Most of the time blood pressure orders were written on the resident's MAR. Interview with the RCC on 04/20/2017 at 11:40am revealed: -When the MA told her about the 04/19/2017 blood pressure reading, she told the MA she would contact the physician. -The physician started Resident #2 on Hydralazine 50mg daily (used to treat high blood pressure). -The Hydralazine would be in the facility tonight (04/20/2017). -She did not instruct the MA to administer the Catapres because she assumed the MA knew the Catapres order was on the MAR. Interview with the Manager on 04/20/2017 at 11:50am revealed: -If a MA had administered Catapres to Resident #2, it would be documented on the front and back of the resident's MAR. -Of the three MAs who documented blood pressure readings outside the physician ordered parameters, one of the MAs no longer worked at the facility, and one of the MAs had not worked as a MA at the facility since 04/8/2017. Interview with the RCC on 04/21/2017 at 9:45am revealed: -She was responsible for reviewing the MARs for accuracy each month before the MARs were placed in the notebook for the MAs use for documenting administration of medications. -When she reviewed the MARs, she compared the current MAR to the upcoming month's MAR. -If she had a concern about the accuracy of the MAR she would look in the resident's record for clarification of the order. -The MAs did not review physician orders and did	D 358		

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D 358	Continued From page 21 not go through resident records unless there was a need. Telephone interview with the Pharmacy Representative (PR) on 04/21/2017 at 10:40am revealed: -The PRR was responsible for printing the facility MARs. -The physician's order for the Clonidine was printed on the MAR. -The Clonidine should have been administered according to the physician's order. -A blood pressure over 200 was considered high and a person could have a stroke. Telephone interview with Resident #2's physician on 04/21/2017 at 11:35am revealed: -She was aware of Resident #2's blood pressure readings. -When she saw the resident at the facility, she checked the resident's blood pressures. -The resident's blood pressures had stayed controlled. -She was considering discontinuing the as needed order for Clonidine. -The Clonidine could make the resident dizzy. -She would rather control the resident's blood pressure with scheduled medications. -She would expect the facility to call her if the resident's blood pressure was high and administer the Clonidine if the blood pressure was above 160 if unable to get up with her. -She considered a blood pressure over 200 to be "very high". -She would expect the facility staff to recheck the resident's blood pressure to determine if the blood pressure had gone down. -She encouraged the facility to call her and not to just depend on the ordered parameters.	D 358		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

MARK PAYNE
DIRECTOR

May 24, 2017

15 working days
June 16

Marion G. Lockamy, Jr.
Senior Management Inc
Pinecrest Gardens
P.O. Box 1913
Lillington, NC 27546

e-mail address: senior.management2@ymail.com

Re: Annual and Follow-up Survey completed April 24, 2017 (E2QE11)

Facility:	**Pinecrest Gardens**
Licensure Number:	**HAL-043-022**
County:	**Harnett**

Dear Mr. Lockamy:

Thank you for the cooperation and courtesy extended during the survey completed 04/24/17 staff with the Adult Care Licensure Section.

As a result of the follow up survey, it was determined that some of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

Enclosed you will find all violations/deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with the state regulations. You must provide an acceptable Plan of Correction for each violation/deficiency cited in the left column. In the spaces to the right of the form, state your plan for correcting the problem and the completion date by which you will correct each violation/deficiency identified and return it to our office within 15 working days of receipt of this letter. Below you will find what to include in the Plan of Correction for all deficiencies; and, if violations were identified, details of the type of violation(s) and the time frame(s) for compliance are also provided below.

What to include in the Plan of Correction

- Indicate what measures will be put in place to correct the deficient area of practice (i.e. changes in policy and procedures, staff training, changes in staffing patterns, etc.)
- Indicate what measures will be put in place to prevent the problem from occurring again
- Indicate who will monitor the situation to ensure it will not occur again

- Indicate how often the monitoring will take place
- Completion dates by which the plan of correction will be completed. The completion dates must be acceptable to the State.
- Sign and date the bottom of the first page of the State Form.

Return the signed and dated Statement of Deficiencies form within 15 working days from the date of receipt of this letter. We are unable to accept faxed reports at this time; therefore, a copy must be mailed to our office or e-mailed to the survey team leader. Please make sure the copy you mail or e-mail to us is SIGNED AND DATED or it will not be accepted. A response to the plan of correction will be sent ONLY if the plan of correction is not accepted. Please retain a copy for your files.

Informal Dispute Resolution

In accordance with G.S. § 131D-2.11(a2), you have one opportunity to question cited deficiencies through an informal dispute resolution (IDR) process. You may also contest the severity of noncompliance that resulted in a violation determination. To be given such an opportunity, you are required to send your written request identifying the specific deficiencies being disputed postmarked by **June 14, 2017**. An explanation of why you are disputing those deficiencies (or why you are disputing the severity of noncompliance that resulted in a violation determination) along with any supporting documentation must be sent and postmarked by **June 14, 2017**. You must submit 2 copies of material and highlight or use some other means to identify written information pertinent to the disputed deficiency(ies). Additional written material that does not meet these requirements will not be reviewed. This information should be sent to: IDR Coordinator, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action. IDR Procedures can be accessed at: http://www.ncdhhs.gov/dhsr/acls/idr.html.

If you have questions about the enclosed Statement of Deficiencies or the violations, please contact me at 910-990-0045. A follow up survey will be conducted to determine compliance in all areas cited. If this agency can be of any assistance in providing consultation relative to licensure rules, please let us know.

Sincerely,

Twila J. Bowen, RN

Twila J. Bowen, RN, Licensure Consultant
Adult Care Licensure Section
Division of Health Service Regulation

Enclosures: Statement of Deficiencies
Revisit Report

cc: Edwin Bass, Supervisor, Harnett County DSS
Bridget Rackley, RN, Team Supervisor, Region 6, Adult Care Licensure Section
Facility File

Please note information regarding Customer Service Survey below.

In an ongoing effort to improve the inspection process with the providers we serve, we would like you to complete a Customer Service Survey. The Survey can be accessed at the web site below. Your opinion is important to us, and will assist us in developing new and better ways to do our job.

Please note: Because the survey is confidential, your identity will not be known to the Division of Health Service Regulation or the North Carolina Department of Health and Human Services.

Thank you for participating in this confidential survey as we strive to improve the services we provide to licensed health care providers across the state of North Carolina. Should you wish to have a confidential discussion regarding this survey or your interaction with the Division of Health Service Regulation, please feel free to contact Mark Payne, Director, Division of Health Service Regulation, at 919-855-3750.

Customer Service Survey web site: **http://www2.ncdhhs.gov/dhsr/customerservice.html**
(Survey Max does not work well with all browsers, please access survey with Internet Explorer)

ADULT CARE LICENSURE SECTION
www.ncdhhs.gov
TEL 919-855-3765 • FAX 919-733-9379
LOCATION: BROWN BUILDING • 801 BIGGS DRIVE • RALEIGH, NC 27603
MAILING ADDRESS: 2708 MAIL SERVICE CENTER • RALEIGH, NC 27699-2708
AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
HAL043022 Y1	A. Building B. Wing Y2	4/24/2017 Y3

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

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix D0283 Reg. # 10A NCAC 13F .0904(a)(2) LSC	Correction Completed 04/24/2017	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR: Tamela J. Bower, RN	DATE: 5/24/17
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
11/13/2015	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO