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PINECREST GARDENS	1984 OLD US 421 LILLINGTON, NC 27546

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from 10/19/23 through 10/20/23.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure health care referral and follow-up for 1 of 5 sampled residents (#3) related to not scheduling a follow-up appointment with a cardiology provider after a hospitalization with new diagnoses of heart arrhythmia and heart block. The findings are: Review of Resident #3's current FL-2 dated 11/15/22 revealed diagnoses included diabetes mellitus type 2, hypertension, and bipolar disorder. Review of Resident #3's hospital discharge summary dated 05/25/23 revealed: -The resident was admitted to the hospital on 05/23/23 with admission diagnoses of hyponatremia (low sodium level), fall, altered mental status, and closed nondisplaced fracture of the fifth metacarpal bone of the left hand. -The resident's hospital stay was complicated with reported heart arrhythmia for which cardiology was consulted and felt the rhythm was consistent with first-degree AV (atrioventricular) block and an echocardiogram was performed.	D 273	Cardiology provider was contacted and paperwork was sent to schedule an appointment. 10/20/23 Resident Care Coordinator and Primary Care Provider will review and monitor referrals weekly from hospital discharges and any other doctors referral from outside the facility to ensure follow up appointments are made. Resident 10/24/23	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rhonda Lockamy — TITLE: Administrator — (X6) DATE: 11/21/23

Reviewed and Acknowledged SCM 11/30/23

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D 273	Continued From page 1 -The echocardiogram showed normal ejection fraction with mild left ventricular hypertrophy (thickening of the walls of the heart). -The resident was to follow up with an outpatient cardiology provider for placement of a Holter monitor (a portable electrocardiogram that records the electrical activity of the heart continuously over a certain period of time to evaluate the heart and diagnose heart conditions.) Review of Resident #3's physician's order sheet dated 05/30/23 revealed an order for the resident to follow up with cardiology. Review of Resident #3's provider visits notes and facility progress notes dated May 2023 - October 2023 revealed no documentation of the resident following up with a cardiology provider as ordered on 05/25/23 and 05/30/23. Interview with the Resident Care Coordinator (RCC) on 10/20/23 at 3:56pm revealed: -She was responsible for setting up referrals. -Resident #3 had never seen a cardiology provider. -She overlooked the orders for the resident to be seen by an outpatient cardiology provider. -The resident had not complained of any heart symptoms to her knowledge. Interview with Resident #3 on 10/19/23 at 3:49pm revealed: -He did not currently have a cardiology provider. -He did not recall being seen by a cardiology provider recently. -He thought the cardiology provider had "let him go" a long time ago. -He denied any current heart symptoms.	D 273	Care coordinator will review appointment schedule daily to ensure appointments are kept.	

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D 273	Continued From page 2 Telephone interview with Resident #3's primary care provider (PCP) on 10/20/23 at 3:30pm revealed: -Resident #3 was in the hospital in May 2023. -She reviewed the hospital discharge paperwork on 05/30/23 and advised the facility that the resident needed to follow up with an outpatient cardiology provider. -She was not aware the resident had not been seen by a cardiology provider since the May 2023 hospitalization. -She was not aware of the resident having any heart symptom episodes since the hospitalization in May 2023 but she was "really concerned" about the resident not following up with a cardiology provider as ordered. -Heart block could potentially cause the resident to have heart symptoms such as dizziness, lightheadedness, and passing out.	D 273		
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 ensure medications were administered as ordered for 4 of 9 residents (#1, #6, #7, #8) observed during the medication pass including errors with a controlled substance	D 358	All currently employed med techs attended in service training conducted by facility LHPS-RN. All areas of medication administration were discussed	11/4/23

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D 358	Continued From page 3 for anxiety and agitation (#7), an eye drop for glaucoma (#1), lubricant eye drops (#1, #8), a topical gel used for pain and inflammation (#1), and a calcium supplement used to treat and prevent osteoporosis (#6). The findings are: The medication error rate was 24% as evidenced by 6 errors out of 25 opportunities during the 8:00am, 9:00am, and 10:00am medication passes on 10/20/23. a. Review of Resident #1's current FL-2 dated 02/14/23 revealed: -Diagnoses included diabetes mellitus type 2, glaucoma, chronic pain syndrome, neuropathy, restless leg syndrome, peripheral vascular disease, and chronic kidney disease stage 3. -There was an order for Combigan eye drops, instill 1 drop in both eyes twice a day. (Combigan is used to treat glaucoma.) -There was an order for Systane Complete, instill 1 drop in both eyes 4 times a day. (Systane Complete is a lubricant eye drop used to relieve dry eyes.) Review of the facility's undated policy for the administration of eye drops provided on 10/20/23 revealed when two or more different eye drops must be administered at the same time, a 3 to 5-minute period should be allowed between each. Review of Resident #1's October 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Combigan eye drops place 1 drop into each eye twice daily scheduled at 9:00am and 9:00pm. -Combigan eye drops were documented as	D 358	10/23/23 Resident Care coordinator and facility manager began monitoring all med passes daily on both shifts to ensure med techs understood and conducted med passes as ordered on MAR's by physicians. 11/6/23 Resident Care Coordinator will monitor and work with med techs on med passes at least once a week on both shifts to ensure compliance in all medication administration.	

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administered from 10/01/23 - 10/20/23.
-There was an entry for Systane Complete eye drops, place 1 drop into each eye 4 times a day scheduled at 9:00am, 1:00pm, 5:00pm, and 9:00pm.
-Systane Complete eye drops were documented as administered from 10/01/23 - 10/20/23.

Observation of the 9:00am medication pass on 10/20/23 revealed:
-The medication aide (MA) instilled 1 drop of Systane Complete eye drops into each of Resident #1's eyes at 8:22am.
-Thirty seconds later, the MA instilled 1 drop of Combigan eye drops into each of Resident #1's eyes.
-The eye drops ran back down the resident's face and the full dosage of the eye drops administered were not absorbed.

Interview with Resident #1 on 10/20/23 at 11:57am revealed:
-She usually received more than one eye drop every day and usually at the same time.
-The eye drops usually run out of her eyes and down her face.
-Her eyes hurt but she thought the eye drops helped some.

Interview with the MA on 10/20/23 at 12:20pm revealed:
-For the administration of two different eye drops, she usually counted from 15 to 20 between the two different eye drops.
-She was not aware of the facility's policy on how long to wait between the administration of different eye drops.

Interview with the Resident Care Coordinator (RCC) on 10/20/23 at 12:55pm revealed:

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D 358	Continued From page 5 -The MAs should wait at least 10 to 15 minutes between the administration of two different eye drops. -The MAs were taught during MA classes to wait between the administration of two different eye drops. Interview with the facility Manager on 10/20/23 at 1:24pm revealed: -She could not recall the facility's written policy for the administration of eye drops. -She thought the MAs should wait 10 to 15 minutes between different eye drops. -If the MAs did not wait between the different eye drops, the eye drops would not work as well because they were not administered the correct way. Telephone interview with Resident #1's primary care provider (PCP) on 10/20/23 at 3:30pm revealed: -For the administration of two different eye drops, the MAs should wait at least 5 minutes between the eye drops. -Administering the Combigan and Systane Complete too close together could wash out the eye drops. -Not getting the full dose of Combigan eye drops could prevent the resident from getting the full effect of the medication which could worsen the resident's glaucoma. -Not getting the full dose of Systane Complete eye drops could affect the resident's dry eye syndrome and cause eye discomfort. b. Review of Resident #1's physician's order dated 10/10/23 revealed an order for Voltaren Gel 1%, apply 2 grams to left shoulder daily. (Voltaren Gel is a topical ointment used to treat pain and inflammation. Voltaren Gel is supplied	D 358		

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D 358	Continued From page 6 with a plastic dosing card with markings for 2 gram and 4 grams that should be used to measure the proper dose.) Review of Resident #1's October 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Voltaren Gel 1%, apply 2 grams topically to left shoulder once daily scheduled for 9:00am. -Voltaren Gel 1% was documented as administered from 10/11/23 - 10/20/23. Observation of the 9:00am medication pass on 10/20/23 revealed: -The medication aide (MA) first stated she used a plastic medication measuring cup to measure Resident #1's Voltaren Gel 1%. -When asked if there were markings for grams on the plastic medication cup, the MA then stated she used the plastic dosing card to measure the dose. -After looking at the plastic dosing card, the MA stated she did not see any markings on the dosing card so she would use the plastic medication cup. -The MA squeezed a quarter-sized amount of Voltaren Gel into the plastic medication cup which had no markings for measuring grams. -The MA then asked the Resident Care Coordinator (RCC) if that looked like 2 grams to her and the RCC agreed that it looked like 2 grams. -The MA then applied the unmeasured Voltaren Gel to the resident's left shoulder, across the top of the back just below the neckline and to the right shoulder, instead of the left shoulder as ordered at 8:39am. Observation of Resident #1's medications on	D 358		

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D 358	Continued From page 7 hand on 10/20/23 at 12:21pm revealed: -There was a tube of Voltaren Gel 1% dispensed on 10/10/23. -Instructions were to apply 2 grams topically to left shoulder once daily **use dosing card to measure**. -There was a flat plastic dosing card in the box with the Voltaren Gel tube that had markings for 2 grams and 4 grams. Interview with Resident #1 on 10/20/23 at 11:57am revealed: -She usually had pain in her left shoulder and down her left arm. -Sometimes both of her shoulders hurt. -The MA usually applied Voltaren Gel to both of her shoulders. Interview with the MA on 10/20/23 at 12:20pm revealed: -There used to be a plastic dosing card with markings for 2 grams and 4 grams. -She overlooked the marking on the plastic dosing card for 2 grams and 4 grams today. -She thought she could estimate 2 grams correctly using the plastic medication cups. -Resident #1 had always complained of pain in both shoulders so that was the reason she applied Voltaren Gel to both shoulders. -She was aware she needed an order to apply Voltaren Gel to both shoulders but she had not contacted the PCP about the resident's complaints of pain in both shoulders. -She gave no explanation as to why she had not contacted the PCP. Interview with the RCC on 10/20/23 at 12:55pm revealed: -Voltaren Gel 1% came with a plastic dosing card to measure the correct dosage.	D 358		

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D 358	Continued From page 8 -The facility's nurse had gone over this with the MAs when they were being trained upon hire. -The facility did not have a plastic medication measuring cup that was marked with grams. -When the MA asked her during the medication pass that morning if the amount of Voltaren Gel looked like 2 grams, she told the MA yes because she thought the MA had used the dosing card to measure it before putting it in the cup. -The Voltaren Gel should be applied where it was ordered to be applied. -The MA should report to her or the primary care provider (PCP) and should not apply the Voltaren Gel to another area without an order. Interview with the facility's Manager on 10/20/23 at 1:24pm revealed: -The MAs knew Voltaren Gel came with a plastic measuring strip. -The MA should have used the plastic measuring strip to measure the Voltaren Gel for Resident #1. -If the resident complained of pain in both shoulders, the MA should have contacted the resident's PCP to get an order to apply the gel to both shoulders. Telephone interview with Resident #1's PCP on 10/20/23 at 3:30pm revealed: -Applying Voltaren Gel to an area it was not ordered to be applied was overuse of the medication. -The resident only needed the Voltaren Gel applied to her left shoulder. -She was not aware of any problems with the resident's right shoulder. -Not measuring the Voltaren Gel could cause the resident to receive too much or too little of the medication, which could prevent the medication from being as effective.	D 358		

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D 358	Continued From page 9 c. Review of Resident #6's current FL-2 dated 02/14/23 revealed: -Diagnosis included osteoporosis. -There was an order for Oyster Shell Calcium 500mg take 1 tablet twice a day with food. (Oyster Shell Calcium is used for osteoporosis. Oyster Shell Calcium is absorbed better with food on the stomach.) Review of Resident #6's October 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Oyster Shell Calcium 500mg take 1 tablet twice a day with food scheduled at 8:00am and 5:00pm. -Oyster Shell Calcium was documented as administered from 10/01/23 - 10/20/23. Observation of the 8:00am medication pass on 10/20/23 revealed: -The medication aide (MA) prepared and administered Oyster Shell Calcium 500mg to Resident #6 at 7:53am. -The resident was in bed and had not eaten breakfast. -Oyster Shell Calcium was not administered with food as ordered. Observation of Resident #6 on 10/20/23 revealed the resident was served breakfast at 8:51am. Observation of Resident #6's medications on hand on 10/20/23 at 12:34pm revealed: -There was a supply of Oyster Shell Calcium 500mg tablets dispensed on 09/23/23. -The instructions were to take 1 tablet twice a day with food. Interview with Resident #6 on 10/20/23 at 11:46am revealed:	D 358		

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D 358	Continued From page 10 -He usually received his morning medication before he ate breakfast. -He denied any symptoms with stomach issues when he received his medication on an empty stomach. Interview with the MA on 10/20/23 at 12:32pm revealed: -Resident #6 lived on the back hall and those residents usually ate breakfast around 8:30am, after the front hall residents had eaten. -If a medication was ordered with food, it should be administered with food while the resident was eating. -She was "off her game today" and should have administered Resident #6's Oyster Shell Calcium with food. Interview with the Resident Care Coordinator (RCC) on 10/20/23 at 12:55pm revealed: -Resident #6's Oyster Shell Calcium should be administered with a meal or with crackers if it was not at meal time. -The resident had not complained of any stomach issues to her knowledge. Interview with the facility's Manager on 10/20/23 at 1:22pm revealed: -If a medication was ordered with food, the MA should wait and administer the medication at meal time. -Resident #6 had not complained of any stomach issues to her knowledge. Telephone interview with Resident #6's primary care provider (PCP) on 10/20/23 at 3:30pm revealed: -The main reason Oyster Shell Calcium should be administered with food was to avoid stomach irritation.	D 358		

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-The resident should be monitored to see if he had any gastrointestinal symptoms.

d. Review of Resident #7's current FL-2 dated 05/02/23 revealed:
-Diagnosis included vascular dementia.
-There was an order for Lorazepam 0.5mg take 1 tablet 2 times a day with meals. (Lorazepam is a controlled substance used to treat anxiety and agitation.)

Review of Resident #7's October 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Lorazepam 0.5mg take 1 tablet 2 times a day with meals scheduled at 8:00am and 5:00pm.
-Lorazepam 0.5mg was documented as administered from 10/01/23 - 10/20/23.

Observation of the 8:00am medication pass on 10/20/23 revealed:
-The medication aide (MA) prepared and administered one Lorazepam 0.5mg tablet to Resident #7 at 8:04am.
-The resident was in the common area and had not eaten breakfast.
-The Lorazepam was not administered with the meal as ordered.

Observation of Resident #7 on 10/20/23 revealed the resident's breakfast was served at 8:16am.

Observation of Resident #7's medications on hand on 10/20/23 at 12:39pm revealed:
-There was a supply of Lorazepam 0.5mg tablets dispensed on 09/23/23.
-The instructions were to take 1 tablet 2 times a day with meals.

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D 358	Continued From page 12 Interview with Resident #7 on 10/20/23 at 11:50am revealed: -He received his medications everyday before he ate breakfast. -His medications did not hurt his stomach. Interview with the MA on 10/20/23 at 12:40pm revealed: -She usually administered Resident #7's medication with the meal, once the resident had started eating. -She had no explanation for not administering the Lorazepam with the meal that morning on 10/20/23. Interview with the Resident Care Coordinator (RCC) on 10/20/23 at 12:55pm revealed: -Medications ordered with meals should be administered with the meal while the resident was eating. -The MA should push the medication cart to the dining room and administer the medication while the resident was eating. -Resident #7 had not complained of stomach issues to her knowledge. Interview with the facility's Manager on 10/20/23 at 1:23pm revealed: -If a medication was ordered with meals, the MA should wait until the resident was eating the meal and then administer the medication. -Resident #7 had not complained of any stomach issues to her knowledge. Telephone interview with Resident #7's primary care provider (PCP) on 10/20/23 at 3:30pm revealed: -It was not a major indication for Lorazepam to be administered with a meal. -It was usually administered with meals to avoid	D 358		

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D 358	Continued From page 13 gastrointestinal irritation. e. Review of Resident #8's current FL-2 dated 05/02/23 revealed: -Diagnosis included vascular dementia. -There was an order for Artificial Tears apply warm washcloth compress topically to both eyes for 1 minute then instill 2 drops into both eyes 4 times a day. (Artificial Tears are used to treat dry eyes.) Review of Resident #8's October 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Artificial Tears apply warm washcloth compress topically to both eyes for 1 minute then instill 2 drops into both eyes 4 times a day scheduled at 6:00am, 10:00am, 2:00pm, and 6:00pm. -Artificial Tears were documented as administered from 10/01/23 - 10/20/23. Observation of the 10:00am medication pass on 10/20/23 revealed: -The medication aide (MA) administered Artificial Tears, 2 drops into each of Resident #8's eyes at 10:28am. -The MA did not apply a warm washcloth compress prior to administering the Artificial Tears as ordered. Observation of Resident #8's medications on hand on 10/20/23 at 12:42pm revealed: -There was a bottle of Artificial Tears dispensed on 09/22/23. -The instructions were to apply warm washcloth compress topically to both eyes for 1 minute then instill 2 drops into both eyes 4 times a day. Interview with Resident #8 on 10/20/23 at	D 358		

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	HAL043022	A. BUILDING: _____ B. WING _____	R 10/20/2023

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D 358	Continued From page 14 11:52am revealed: -He received eye drops for dry eyes every day. -There had not been any warm washcloth compresses applied to his eyes prior to receiving the eye drops. -The eye drops helped "a little". Interview with the MA on 10/20/23 at 12:42pm revealed: -She forgot to apply a warm washcloth compress prior to administering Resident #8's Artificial Tears that morning. -The morning medication passes were so close together and she was trying to stay within in the time frame for administering medications. Interview with the Resident Care Coordinator (RCC) on 10/20/23 at 12:55pm revealed the MA should have applied a warm washcloth compress to Resident #8's eye prior to administering the Artificial Tears, exactly as it was ordered. Interview with the facility's Manager on 10/20/23 at 1:32pm revealed the MA should have followed the order and applied a warm washcloth compress to Resident #8's eyes for 1 minute prior to administering the Artificial Tears. Telephone interview with Resident #8's primary care provider (PCP) on 10/20/23 at 3:30pm revealed: -The warm washcloth compress helped with eye discomfort. -Without applying the warm compresses for 1 minute to Resident #8's eyes prior to administering the Artificial Tears, the resident would not get the full effects of the medication which could lead to unresolved eye discomfort.	D 358		

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D 366	Continued From page 15	D 366		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication aide (MA) documented the administration of medications immediately following the administration and observation of the residents actually taking the medications for 3 of 3 residents (#4, #8, #9) observed in the back hall unit during the morning medication pass on 10/20/23. The findings are: Observation of the back hall unit on 10/20/23 from 10:15am - 10:30am revealed: -The medication aide (MA) went into the back hall unit to administer medications. -The MA did not bring the laptop computer with the electronic medication administration records (eMARs) to the medication cart in the back hall. -At 10:15am, the MA prepared and administered one controlled substance used for moderate to severe pain to Resident #4 without using the eMAR or entering documentation of administration after observing Resident #4 take the medication and prior to going to the next	D 366	Resident Care Coordinator and facility Manager met with med techs and explained proper procedures regarding recording of medications on Emars laptop when internet service was spotty. 10/20/23 Resident Care Coordinator will monitor at least weekly and on both shifts med passes especially on back hall to ensure Emars are used during administration of medications and are synced correctly after med	

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D 366	Continued From page 16 resident. -At 10:28am, the MA prepared and administered lubricant eye drops to Resident #8 without using the eMAR or entering documentation of administration of the eye drops to the resident and prior to going to the next resident. -At 10:30am, the MA prepared and administered an inhaler for breathing problems to Resident #9 without using the eMAR or entering documentation of administration of the inhaler to the resident. -The MA left the back hall unit and went back to the medication cart on the assisted living (AL) back hall. Interview with the MA on 10/20/23 at 10:33am revealed: -The internet did not always work well in the back hall unit of the facility. -She knew the medications the residents took because she had been administering medications for a long time so she could administer the medications by memory. -She would enter documentation information for the medications she administered to residents in the back hall unit once she returned to the AL side of the facility. Observation of the MA on 10/20/23 at 10:33am revealed: -She documented the administration of medications for Resident #4, Resident #8, and Resident #9 on the October 2023 eMAR at 10:33am. Review of Resident #4's October 2023 eMAR revealed the instructions for Resident #8's lubricant eye drops indicated a warm washcloth compress should have been applied to both of the resident's eyes for 1 minute prior to	D 366	passes are completed. In service training was conducted by LHPS-RN on medication administration which included charting of each medication as it was administered. 11/6/23	

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D 366	Continued From page 17 administering the eye drops, but this was not observed to be done during the morning medication pass on 10/20/23. Interview with the Resident Care Coordinator (RCC) on 10/20/23 at 12:55pm revealed: -The MAs were expected to use the eMARs for guidance when administering medications. -If the internet was not working in the back hall unit, the MAs still had access to pull up the eMARs on the screen and enter the medications as administered on the eMAR. -Once the MAs came back into the AL side of the facility, the eMARs would automatically sync the information in the computer system. -The MAs should document the administration of medications in the eMAR system after observing the resident take the medication and prior to going to the next resident. Interview with the facility Manager on 10/20/23 at 1:34pm revealed: -The MAs were supposed to use the eMARs all the time. -The MAs should look at every eMAR for every resident. -The MAs should document the administration of medications in the eMAR system after observing the resident take the medication and prior to going to the next resident. -If the internet was not working in the back hall unit, the MAs could still enter information on the eMAR system and it would sync once the MA came back into the AL side of the facility.	D 366		