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
	HAL063024	A. BUILDING: _____ B. WING _____	05/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on May 4, 5, and 8, 2017.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure hot water temperatures were maintained between a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 19 of 20 fixtures located in the residents rooms and common bathrooms. The findings are: Observations during the initial tour of the facility of water temperatures at fixtures used by residents on the 100 Hall revealed: -At 10:02am, the hot water temperature at the sink in the activity room was 120.2 degrees F. -At 10:12am, the hot water temperature at the bathroom sink in room 103 was 120.4 degrees F. -The hot water flow at the bathroom shower in room 103 stopped after the water had been running for approximately one minute and before	D 113		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

R C Cleveland — 6/7/17 — Executive Director

STATE FORM 6899 M09411 If continuation sheet 1 of 30

Addendum per telephone conversation with Laura Cleveland, Executive Director on June 12, 2017 at 11:45 a.m. — Hope Lorts, RN Licensure Consultant

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the hot water temperature could be obtained.
-At 10:19am, the hot water temperature at the kitchenette sink in room 103 was 122.2 degrees F.
-At 10:34am, the hot water temperature at the kitchenette sink in room 108 was 120.3 degrees F.
-At 10:36am, the hot water temperature at the bathroom sink in room 108 was 120.8 degrees F.
-At 10:43am, the hot water temperature at the kitchenette sink in room 109 was 120.7 degrees F.
-At 10:47am, the hot water temperature at the bathroom sink in room 109 was 120.8 degrees F.
-At 10:49am, the hot water temperature at the shower in room 109 was 118.2 degrees F.
-At 11:00am, the hot water temperature at the kitchenette sink in room 104 was 117.9 degrees F.
-At 11:07am, the hot water temperature at the kitchenette sink in room 105 was 119.6 degrees F.
-At 11:12am, the hot water temperature at the bathroom sink in room 105 was 121.2 degrees F.
-The hot water flow at the bathroom shower in room 105 stopped after the water had been running for approximately one minute and before the hot water temperature could be obtained.

Observations during the initial tour of the facility of water temperatures at fixtures used by residents on the 300 Hall revealed:
-At 10:02 am, the hot water temperature at the bathroom sink in room 308 was 119 degrees F.
-At 10:07 am, the hot water temperature at the bathroom sink in room 310 was 119 degrees F.
-At 10:15 am, the hot water temperature at the shower room sink was 119 degrees F.
-At 10:20 am, the hot water temperature at the shower in the shower room was 118 degrees F.

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D 113	Continued From page 2 -At 10:25 am, the hot water temperature at the bathroom sink in room 306 was 120 degrees F. -At 10:32 am, the hot water temperature at the bathroom sink in room 305 was 119 degrees F. -At 10:38 am, the hot water temperature at the bathroom sink in room 304 was 120 degrees F. -At 10:55 am, the hot water temperature at the kitchenette sink in room 301 was 119 degrees F. Confidential interviews with 9 residents 05/04/2017 revealed: -The hot water was not too hot for them. -Staff assisted them when using the shower. -The residents could adjust the water temperatures. -They liked the water "pretty hot". -They had never gotten burned. -They had not noticed the water was too hot. -The water temperature got "hot and cold". -Residents had not seen anybody checking the water temperatures. -One resident had seen someone checking the water temperatures "a couple days ago". -The water was very hot, but the residents knew how to adjust it. -They had not reported the water being too hot to anyone, because they thought it was "supposed to be that way." -They rather have the hot water very hot than too cold. Interview on 05/04/2017 at 11:25am with the Maintenance Director revealed: -He performed random water temperature checks every morning. -He would turn the thermostat down on the hot water heater that supplied hot water to resident rooms. -The thermostat on the hot water heater was "messed up" 9not working properly).	D 113		

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D 113	Continued From page 3 -He had never noticed the water temperatures being too hot. -The showers were equipped with a safety shut off when the hot water temperature got to 117. The water flow would stop until the water temperature cooled down -No one had reported to him that the water was too hot. Interview with the Executive Director (ED) on 05/04/2017 at 11:50am revealed: -She had no knowledge of the water temperatures being too hot. -The Maintenance Director checked water temperatures in the facility every day. -She had a survey from the Construction Division on 05/03/2017 who looked at the hot water tank and checked water temperatures and did not mention any concerns about the water temperatures. -The thermostat on the hot water tank may have been hit by someone which caused the hot water temperatures. -She would contact a plumber to come to the facility today to service the hot water tank. Review of the water temperature log documentation provided by the ED at 12:05pm on 05/04/2017 revealed: -There were documented water temperatures for 04/24-28/2017 and 05/01-04/2017. -There was no documentation of the fixture checked, the room number of the fixture checked, or the time of the water temperature checks. -The water temperature was 114 degrees on the 100 hall on 05/04/2017. -The water temperature was 114 degrees on the 200 hall on 05/04/2017. -The water temperature was 114 degrees on the 300 hall on 05/04/2017.	D 113		

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-The water temperature was 114 degrees on the 400 hall on 05/04/2017.
-The water temperature was 114 degrees on the Claire Bridge Unit on 05/04/2017.

Further interview with the Maintenance Director on 05/04/2017 at 12:15pm revealed:
-When he checked water temperatures in the facility, he usually checked rooms at the end of the halls but could not explain why.
-He did not document the fixture checked, room number, or time that the water temperatures were checked.
-Signs were currently being posted to caution staff and residents of the hot water.
-He would be flushing and draining the hot water tank as per instructions from the ED and Corporate Maintenance Director.

The facility thermometer and surveyor's thermometers were calibrated in icy slush water at 12:17pm. The facility thermometer calibrated at 33.5 degrees F. The surveyor's thermometer calibrated at 32.2 degrees F.

Observations with the Maintenance Director on 05/04/2017 of water temperatures at fixtures used by residents on the 100 Hall revealed:
-At 3:51pm, the hot water temperature at the sink in the activity room was 99.0 degrees F.
-At 3:45pm, the hot water temperature at the bathroom sink in room 103 was 100.0 degrees F.
-At 3:47pm, the hot water temperature at the bathroom shower in room 103 was 99.3 degrees F
-At 3:49pm, the hot water temperature at the kitchenette sink in room 103 was 99.3 degrees F.
-At 3:55pm, the hot water temperature at the kitchenette sink in room 108 was 99 degrees F.
-At 3:53pm, the hot water temperature at the

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bathroom sink in room 108 was 99.2 degrees F.

Observations on 05/05/2017 of water temperatures at fixtures used by residents on the 100 Hall revealed:
-At 9:45am, the hot water temperature at the sink in the activity room was 106.6 degrees F.
-At 9:30am, the hot water temperature at the bathroom sink in room 103 was 100.1 degrees F.
-At 9:33am, the hot water temperature at the kitchenette sink in room 103 was 100 degrees F.
-At 9:55am, the hot water temperature at the kitchenette sink in room 108 was 108.5 degrees F.
-At 10:00am, the hot water temperature at the bathroom sink in room 108 was 109.3 degrees F.
-At 9:48am, the hot water temperature at the kitchenette sink in room 109 was 108.0 degrees F.
-At 9:50am, the hot water temperature at the bathroom sink in room 109 was 108.3 degrees F.
-At 9:53am, the hot water temperature at the shower in room 109 was 105.7 degrees F.
-At 9:43am, the hot water temperature at the kitchenette sink in room 104 was 106.7 degrees F.
-At 9:38am, the hot water temperature at the kitchenette sink in room 105 was 106.3 degrees F.
-At 9:40am, the hot water temperature at the bathroom sink in room 105 was 106.5 degrees F.

Observations on 5/08/2017 of water temperatures at fixtures used by residents on the 300 Hall revealed:
-At 9:37 am, the hot water temperature at the bathroom sink in room 308 was 102 degrees F.
-At 9:39 am, the hot water temperature at the bathroom sink in room 310 was 106 degrees F.
-At 9:41 am, the hot water temperature at the

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D 113	Continued From page 6 shower room sink was 105 degrees F. -At 9:43 am, the hot water temperature at the shower in the shower room was 103 degrees F. -At 9:46 am, the hot water temperature at the bathroom sink in room 306 was 105 degrees F. -At 9:49 am, the hot water temperature at the bathroom sink in room 305 was 105 degrees F. -At 9:53 am, the hot water temperature at the bathroom sink in room 304 was 106 degrees F. -At 9:56 am, the hot water temperature at the kitchenette sink in room 301 was 103 degrees F. Interview with the Executive Director (ED) on 05/08/2017 at 4:09pm revealed: -The Plumber came and made all necessary repairs on 05/08/2017. -The water temperatures should be within range since the repairs had been made to the hot water unit. -She and the maintenance worker will develop a system for monitoring the water temperatures.	D 113		
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	D 131		

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D 131	Continued From page 7 facility failed to assure 1 of 6 sampled staff (Staff F) was 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: Review of Staff F's personnel file revealed: -Staff F was hired on 02/21/2017 as a Personal Care Aide/Resident Assistant (PCA/RA). -There was documentation of a TB skin test placed on 02/10/2017 and read as negative on 02/13/2017. -There was no documentation of a second step TB skin test for Staff F since her hire date. Interview with the Business Office Manager (BOM) on 05/08/2017 at 4:09 p.m. revealed: -She was new to her position and was trying to establish a system of organization for facility staff files. -It was her responsibility to ensure all staff received TB skin testing as required when hired. -She was not aware Staff F had not had a second step TB skin test upon hire. -She thought if a staff had worked at another facility and had a TB skin test completed, then that TB skin test could be used and was all that was needed for that staff to start employment at the facility. -Staff F was called in on 5/08/17 to the facility to receive a second step TB skin test but did not know who had called her. Interview with the Wellness Director on 05/08/2017 at 9:50 a.m. revealed: -She was not aware Staff F did not have a second step TB skin test. -It was not solely her responsibility to follow-up on	D 131		

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D 131	Continued From page 8 TB skin tests for facility staff. -She was working on creating a tracking system for staff files. Interview with Staff F on 05/08/2017 at 3:20 p.m. revealed: -She had not had a TB skin test completed since hired at the facility. -She had worked at the facility for a little over 2 months. -She worked as a Personal Care Aide at the facility. -She had one TBST (tuberculosis skin test) completed before she was hired at the facility. -She did not remember the date of the TBST she had before being hired to work at the facility. -She received a call from facility management (could not specify who) to come in to the facility to get another TBST "that morning" (05/08/2017). Interview with the Executive Director on 05/08/2017 at 4:15 p.m. revealed: -It was a shared responsibility by facility management to ensure staff completed TB skin testing as required upon hire. -She was not aware Staff F did not have a second step TB skin test completed. -The facility did not have documentation for a second step TB skin test for Staff F. -Staff F was a "fairly new" staff. -She was aware Staff F was asked to report to the facility to have a second step TB skin test administered on 5/08/17. (She did not specify who had asked Staff F to come in to the facility to receive her second step TB skin test). -There was no system currently in place to track or monitor staff TB skin tests. -She expected facility management when hiring staff to follow state requirements regarding TBST. -She would meet with facility management to	D 131		

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D 131	Continued From page 9 establish a system to ensure TB skin tests were administered and completed as required upon hire.	D 131		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the 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, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 3 of 5 residents sampled (#3, #4, #5) were tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: 1. Review of Resident #3's current FL-2 dated 12/06/2017 revealed diagnoses included gait ataxia, urinary tract infection, vitamin D deficiency, aortic stenosis, urinary retention, senile dementia, impaction, hypertension, constipation, cerumex, dyslipidemia, bilateral history of breast cancer with mastectomy, and osteoporosis.	D 234		

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D 234	Continued From page 10 Review of Resident #3's Resident Register revealed an admission date of 10/02/2012. Review of Resident #3's documentation of tuberculosis skin testing revealed: -There was documentation of a TB (tuberculosis) skin test placed on 09/10/2012 and 09/24/2012 and read as 0mm (millimeter). -There was no documentation of the dates the TB skin tests were read. -There was no signature or initials for the administrator of the TB skin test readings. -There was no documentation for a completed 2-step TB skin test. Interview with the Administrator on 05/05/2017 at 11:10am revealed: -She had not been able to locate any additional information regarding TB skin test for Resident #3. -The current information in the resident's record came from the previous facility where the resident had resided. -She had contacted a staff from the previous facility on 05/04/2017 about dates for the TB skin test readings, but the facility did not have any additional information to provide. -The previous Health and Wellness Director (HWD) would have been responsible for reviewing admission TB information on Resident #3 for accuracy when the resident was admitted. Interview with the HWD on 05/05/2017 at 11:20am revealed: -She and the Resident Care Coordinator (RCC) were responsible to review admission TB documentation. -The facility required a TB skin test to be read before admission. -If a resident was admitted without a second step	D 234		

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TB skin test performed, the facility would administer the second step TB skin test and document the results.
-She was not employed at the facility when Resident #3 was admitted.
-She audited resident records and "would probably say audit done monthly".
-She was probably in residents records every day reviewing physician orders.
-She reviewed a resident record when she got an alert that it was time for something in the record to be done like the care plan or Licensed Health Professional Support review.
-She used a spreadsheet when auditing records.
-If there were dates already documented on the spreadsheet for TB skin testing, she did not review the TB skin test document again.
-She looked at the spreadsheet for what was due for the resident.

Telephone interview with a state TB Nurse on 05/08/2017 at 4:05pm revealed:
-When a TB skin was read, there should be documentation of the nurse's signature, the millimeters reading, and date and time of the TB skin test reading.
-If the date or millimeter reading was not documented for a TB skin test reading, the reading was invalid.
-If the information was invalid, there would need to be at least one more TB skin test performed.

Further interview with the HWD on 05/08/2017 at 6:20pm revealed she was hired at the facility on 04/25/2015.

Based on record review and observation of Resident #3 on 05/04/2017 and 05/05/2017, the resident was determined not to be interviewable due to senile dementia.

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2. Review of Resident #4's current FL-2 dated 08/24/2016 revealed diagnoses included history of pelvic fracture, history of falls, hyperlipidemia, esophageal reflux, essential hypertension, cerebrovascular accident, dementia with behaviors, anxiety, and depression.

Record review revealed documentation that Resident #4 was admitted to the facility on 05/05/2015.

Review of Resident #4's documentation of tuberculosis skin testing revealed:
-There was documentation of a TB (tuberculosis) skin test administered on 04/14/2015 and read as 0mm (millimeter).
-There was no documentation of the date the TB skin test was read.
-There was documentation of a completed TB skin test administered on 05/04/2015 and read as 0mm (negative) on 05/07/2015.
-There was no documentation of a completed 2-step TB skin test.
-There were TB Surveillance Questionnaire's completed on 05/13/2015 and 08/10/2016 which documented no resident unprotected exposure to anyone with active TB within the last 12 months and no symptoms of TB were exhibited.

Interview with the Administrator on 05/05/2017 at 11:10am revealed:
-The information in the resident's record for the TB skin test placed on 04/14/2015 was received in the facility as part of the admission information.
-The Health and Wellness Director (HWD) would have been responsible for reviewing admission TB information on Resident #4 for accuracy when the resident was admitted.

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BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 234	Continued From page 13	D 234		

Interview with the HWD on 05/05/2017 at 11:20am revealed:
-She and the Resident Care Coordinator (RCC) were responsible to review admission TB documentation.
-The facility required a TB skin test to be read before admission.
-If a resident was admitted without a second step TB skin test performed, the facility would administer the second step TB skin test and document the results.
-She was not employed at the facility when Resident #3 was admitted.
-She audited resident records and "would probably say audit done monthly".
-She was "probably" in residents records every day reviewing physician orders.
-She reviewed a resident record when she got an alert that it was time for something in the record to be done like the care plan or Licensed Health Professional Support review.
-She used a spreadsheet when auditing records.
-If there were dates already documented on the spreadsheet for TB skin testing, she did not review the TB skin test document again.
-She looked at the spreadsheet for what was due for the resident.

Telephone interview with a state TB Nurse on 05/08/2017 at 4:05pm revealed:
-When a TB skin was read, there should be documentation of the nurse's signature, the millimeters reading, and date and time of the TB skin test reading.
-If the date or millimeter reading was not documented for a TB skin test reading, the reading was invalid.
-If the information was invalid, there would need to be at least one more TB skin test performed.

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D 234	Continued From page 14 Further interview with the HWD on 05/08/2017 at 6:20pm revealed she was hired at the facility on 04/25/2015. Based on record review and observation of Resident #4 on 05/04/2017 and 05/05/2017, the resident was determined not to be interviewabledue to diagnosis of dementia. 3. Review of Resident #5's current FL-2 dated 3/16/16 revealed diagnoses included dementia, hypertension, bipolar disorder, and diabetes. Review of Resident #5's Resident Register revealed the resident was admitted to the facility on 4/06/15. Review of Resident #5's tuberculosis (TB) skin testing documentation on 5/04/17 revealed: -There was no documentation of a TB skin test being completed. -There was no documentation to indicate a second step TB skin test had been completed since Resident #5 was admitted to the facility. Interview with the Health and Wellness Director (HWD) on 5/08/17 at 9:50 a.m. revealed: -She did not have a current TB skin test since admission for Resident #5. -The only documentation she had available was noted in Resident #5's record. -She was responsible for ensuring the residents had TB skin testing completed as required. -She ensured all residents had a first TB skin test completed upon admission to the facility. -She would conduct the second TB skin test following admission. -She was unaware Resident #5 did not have the first or second TB skin test completed because	D 234		

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D 234	Continued From page 15 Resident #5 was admitted to the facility prior to her getting her position. -She would follow-up with Resident #5's former placement to see if she could obtain a first and a second TB skin test. -She was not sure if Resident #5 had a positive TB skin test in the past. -She would ensure Resident #5's TB skin testing was updated. Interview with the HWD on 5/08/17 at 10:40 a.m. revealed: -Resident #5 came from a hospital out of state and due to her diagnosis of Dementia, a chest x-ray was administered on 4/01/15. -Resident #5 had no prior record of a positive PPD test. -She thought a negative chest x-ray "trumped" not having a first and a second TB skin test for Resident #5. -The chest x-ray was ordered to have Resident #5 immediately admitted to the facility and not because of a positive TB skin test. Interview with the Executive Director on 5/08/17 at 5:25 p.m. revealed: -She was not aware Resident #5 did not have documentation of a first TB skin test upon admission to the facility. -She did not know Resident #5 did not have a second TB skin test completed. -She would follow-up with the HWD to update TB skin testing for Resident #5.	D 234		
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:	D 306		

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D 306	Continued From page 16 (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 special care unit (SCU) during meals. The findings are: Observation of the breakfast meal in the Special Care Unit (SCU) dining room on 05/05/17 at 7:55 a.m. revealed: -The Personal Care Aides (PCA) were serving the residents. -Eight residents were sitting at tables in the dining area. -All eight residents were served 8 ounces milk and 8 ounces cranberry juice. -There were no glasses of water or pitchers of water on any of the 4 dining tables. -Water was not offered to any resident. Interview with a PCA in the SCU on 5/05/17 at 8:14 a.m. revealed: -Water was only served during the lunch and supper meals. -She was not sure why water was not served during breakfast but it had "always been that way." (She did not specify a timeframe). -The residents could get water or any other beverages if they asked for it but they could not because they were not mentally able to do so. Interview with a second PCA in the SCU on 5/05/17 at 9:12 a.m. revealed:	D 306		

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-None of the residents had received water during breakfast.
-If the residents requested more to drink, including water, they could receive it but none had asked that she could recall.
-All residents were served water during their lunch and dinner meals.
-She was not sure why water was not ever served with the breakfast meal.
-Sometimes a resident might ask for water or more to drink, and she gave it to them.

Observation of the lunch meal in the SCU dining area on 05/05/17 at 12:00 p.m. revealed each resident was served approximately 8 ounces of pink lemonade and 8 ounces of water.

Interview with a Cook on 5/05/17 at 11:44 a.m. revealed:
-Water was only served during the lunch and supper meals.
-She could not explain why water was not served during breakfast but said that was their "common practice."
-If a resident wanted more milk or juice, they could have it.
-If water was required to be served at breakfast, then she would ensure the residents received it.

Interview with the Dietary Manager on 5/05/17 at 11:51 a.m. revealed:
-The residents received water at their lunch and supper meals because it was a common practice to do so.
-She thought only 8 ounces of water were required a day and they tried to make sure they met that requirement.
-The residents received water during morning medication pass and morning snack times.
-All residents could have any beverage, at any

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D 306	Continued From page 18 time, if they wanted it. Interview with the Medication Aide (MA) on 5/05/17 at 11:55 a.m. revealed: -She had not observed water been served at any time during the breakfast meal. -She offered water to the residents who received morning medications after their breakfast meals. -She was not sure why water was not offered during breakfast. -The residents she offered water to drank the water well without any prompting. -She thought water was important for all the SCU residents to receive during meals. Interview with the Health and Wellness Director (HWD) on 5/08/17 at 2:50 p.m. revealed: -She did not know residents should be served water three times daily with meals. -All residents received water at medication passes and snack times. -She thought residents served juice should substitute for water not being served for breakfast. -She would follow-up with the Dietary Manager regarding serving water three times daily with all three meals. Interview with the Executive Director on 5/08/17 at 5:25 p.m. revealed: -Water should be served three times a daily with meals. -She thought "colored" or "flavored" water was being served at each meal. -She was not aware water was not being offered during the breakfast meal. -Water was offered during medication passes and during snack times. -She would inservice the kitchen staff regarding serving water during all three meals to the	D 306		

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D 306	Continued From page 19 residents.	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 7 residents (#1, #6) observed during the medication pass including errors with an extended release medication (Resident #1) and a vitamin supplement (Resident #6). The findings are: 1. The medication error rate was 7% as evidenced by observations of 2 errors out of 28 opportunities during the 4pm medication pass on 05/04/2017, and the 8am medication pass on 05/05/2017. A. Review of Resident #6's current FL-2 dated 01/10/2017 revealed: -Diagnoses included Alzheimer's disease, chronic urinary tract infection, transient ischemic attack, hypertension, and hypercholesterolemia. -There was a physician's order for Calcium-D	D 358		

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D 358	Continued From page 20 600mg-400mg (vitamin supplement) twice a day with meals. Observation of the medication pass on 05/04/2017 at 4:03pm revealed: -The Medication Aide (MA) removed a blister pack of medication from the medication cart. -The MA placed one tablet of the medication in a medication cup. Observation of the blister pack of medication on 05/04/2017 at 4:03pm revealed: -The blister pack of medication was pharmacy labeled for Resident #6. -The instructions printed on the label were for Calcium 600mg - Vitamin D3 400mg twice daily with meals. Interview with the MA on 05/04/2017 at 4:05pm revealed: -The residents would be served supper at 5:00pm. -She administered medications one hour before or one hour after the scheduled time of administration. -She could not administer medications in the dining room. -She was trained to administer medications scheduled with meals right before the resident went into the dining room. -The MA was requested to check with her Supervisor before administering the medication. -The MA stated she was not going to administer the medication right then until after she had checked with her Supervisor. Observation of the MA on 05/04/2017 at 4:07pm revealed: -The MA approached the Health and Wellness Director (HWD).	D 358		

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D 358	Continued From page 21 -The MA showed the HWD the blister pack of Calcium 600mg - D3 400mg tablets. -The HWD reviewed the printed instructions on the medication label with the MA. Interview with the HWD on 05/04/2017 at 4:07pm revealed if the instructions on the medication label were to give the medication with a meal, the medication was to be given just before the resident went into the dining room for the meal. Review of Resident #6's electronic Medication Administration Records (eMARs) for 05/2017 revealed: -There was an entry for Calcium/D tablet 600-400 one tablet two times a day for vitamin insufficiency with meals printed on the eMAR. -The Calcium/D tablet was scheduled for 8am and 5pm daily. Telephone interview with the Pharmacist on 05/08/2017 at 12:25pm revealed: - The current order on file for Resident #6's Calcium/D was 600-400mg two times a day with meals. -Calcium could be aggravating to the stomach. -It was suggested to take the Calcium/D with a meal because of the possibility of stomach discomfort of pain, or heartburn. -Calcium could be administered without it being with a meal. -The Calcium/D should be administered 15-30 minutes before eating or up to one hour after a meal. Interview with Resident #6 on 05/08/2017 at 3:00pm revealed: -She denied any stomach upset or discomfort. -She could not remember if she was administered	D 358		

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Calcium/D.
-Whoever was on duty administered her medication.
-She always took the medication that was given to her.
-She did not remember if she took any medication with food or was offered food with her medication.
-She did not remember if she was administered medication around supper time.

2. Review of the current FL-2 dated 3/02/17 for Resident #1 revealed:
-Diagnoses included hypertension, anemia, memory loss, hypocalcemia and joint pain.
-There was a physician's order for Diltiazem Extended Release (ER)180mg 1 tablet daily to treat hypertension.

A subsequent order dated 3/07/17 included the resident's medications could be crushed.

Observation on 5/05/17 at 8:17 a.m. of the medication pass to Resident #1 in the special care unit revealed:
-The medication label on the Diltiazem ER 180mg capsule bubble card revealed it was not to be crushed.
-The medication aide (MA) put one Diltiazem 180mg ER in capsule into the crusher plastic bag with the resident's other medications.
-All of the resident's medications were then placed into the crusher and crushed.
-When the medications were crushed, the MA took the smashed Diltiazem capsule without any medication in it out of the crushed medications in the plastic bag.
-All of the resident's medications were poured into a small medication cup filled with apple sauce.

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D 358	Continued From page 23 -Small beads of the Diltiazem medication were observed to be in the crushed medications poured into the applesauce for administration. -The MA went to Resident #1's room to administer the medications. -She was not able to get the resident to sit up and take the medications. -She went out of the resident's room and came back with the Health & Wellness Director (HWD) to assist with the resident so the medications could be administered. -The resident refused to take the medications. -The MA left the room with the HWD and disposed of the resident's medications and documented them as refused on the electronic medication administration record. Interview with the MA on 5/05/17 at 8:19 a.m. revealed: -The resident had a may crush medication order. -She had prepared the resident's medications, including the crushed Diltiazem ER in the capsule and was going to administer them as she had prepared them. -She was not aware a "Do not crush" medication sheet was available to be used as a guide for medications not to be crushed. -She did not know to not crush a whole capsule in the crusher. -She was not aware if it was possible to open the Diltiazem capsule and sprinkle the medication beads over the applesauce. -She thought all of the the resident's medications including the capsules that were extended release could be crushed. Review of the electronic printed MAR for Resident #1 revealed: -Cardizem LA Extended Release 24 hour 180mg (Diltiazem HCL ER coated beads.), give 1 tablet	D 358		

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D 358	Continued From page 24 in the morning. -The medication was listed for administration at 8 a.m. Interview on 5/05/17 at 8:30 a.m. with the HWD revealed: -There was a Do Not Crush list on each med cart including in the special care unit. -She was not aware the MA did not know there was a Do Not Crush sheet for guidance in administration. -She was not aware the time release capsule had been crushed and attempted to be administered for Resident #1 by the MA. -She would ensure medication staff were aware that extended release medications were not to be crushed. Review of the facility's Do Not Crush List located on the medication cart in the special care unit revealed Diltiazem extended release was not to be crushed. Interview on 5/05/17 at 9:21 a.m. with the pharmacist revealed: -The Diltiazem ER was not to be crushed as it could give a high dose of medication all at once instead of being extend over a longer period of time. -This could cause the side effect of lowering the blood pressure too much. -The Diltiazem capsule could be opened and sprinkled over the applesauce for administration.	D 358		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training	D 468		

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D 468	Continued From page 25 The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 3 of 3 sampled staff (Staff D, Staff E, Staff F), assigned to perform duties in the special care unit, received 6 hours of orientation training within the first week of employment and completed 20 hours of special care unit training within 6 months of employment.	D 468		

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D 468	Continued From page 26	D 468		

The findings are:

1. Review of the employee record for Staff D revealed:
-Staff D was hired on 7/13/15.
-Staff D was hired as a resident assistant in the special care unit.
-There was no documentation Staff D completed 6 hours of orientation training within the first week of employment or 20 hours of training for the special care unit within six months of hire.

Review of the facility work schedule for the week of 05/04/2017 through 05/08/2017 revealed Staff D was scheduled to work in the special care unit on 05/06/17.

No further documentation of the 6 hours or the 20 hours of special care unit training was provided by the end of the survey for Staff D.

Refer to Interview with the Business Office Manager on 5/08/17 at 4:45 p.m.

Refer to interview with the Executive Director on 5/08/17 at 5:25 p.m.

Attempted interview with Staff D was unsuccessful prior to survey exit.

2. Review of the employee record for Staff E revealed:
-Staff E was hired on 7/27/16.
-There was documentation Staff E completed the 4.8 hours of orientation to the special care unit within the first week of employment.
-There was no documentation of any additional special care unit orientation or training completed.

Review of the facility work schedule for the week

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	HAL063024	A. BUILDING: _____ B. WING _____	05/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 468	Continued From page 27 of 05/04/2017 through 05/08/2017 revealed Staff E was scheduled to work in the special care unit on 05/07/17. No further documentation of the remaining 6 hours or 20 hours of special care unit training was provided by the end of the survey for Staff E. Refer to Interview with the Business Office Manager on 5/08/17 at 4:45 p.m. Refer to the interview with the Executive Director on 1/15/15 at 2:50pm. Attempted interview with Staff E was unsuccessful prior to survey exit. 3. Review of the employee record for Staff F revealed: -Staff F was hired on 2/21/17. -Staff F was hired as a resident assistant on SCU. -There was documentation Staff F had completed 1 hour and 36 minutes of the 6 hours within the first week of employment. -There was no additional documentation of the remaining 6 hours of special care unit training for Staff F. Interview with Staff F on 05/08/2017 at 3:20 p.m. revealed there was no additional special care training provided that she was aware of since hired at the facility. Review of the facility work schedule for the week of 05/04/2017 through 05/08/2017 revealed Staff F was scheduled to work in the special care unit on 05/06/17. No further documentation of the 6 hours of	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	05/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PINEHURST	17 REGIONAL DRIVE PINEHURST, NC 28374

(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 468	Continued From page 28 special care unit training was provided by the end of the survey for Staff F. Refer to Interview with the Business Office Manager on 5/08/17 at 4:45 p.m. Refer to the interview with the Executive Director on 1/15/15 at 2:50pm. _____ Interview with the Business Office Manager on 5/08/17 at 4:45 p.m. revealed: -She had only been in her position for a year and was trying to "work through the staff files she was left." -She was not aware Staff D, E, and F had not completed SCU training. -She did not know 6 hours of SCU training was required for staff within the first week of hire. -She was aware 20 hours of traing was required within 6 months of hire. -She was trying to organize the staff files to monitor training. Interview with the Executive Director on 5/08/17 at 5:25 p.m. revealed: -She was not aware Staff D, E, and F had not had SCU training. -She was unaware 6 hours of special care training was required within the first week of employment. -She thought 20 hours of training was required within 1 year of employment. -It was a shared responsibility of facility management to ensure all staff received their required training. -The facility did not have a system in place to ensure training occurred as required. -She would follow-up with facility management to	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063024	A. BUILDING: _____ B. WING _____	05/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 468	Continued From page 29 develop a system for tracking and monitoring staff training.	D 468		

The following is a summary of the Plan of Correction for Brookdale Pinehurst. This Plan of Correction is in regards to the Statement of Deficiencies dated 5/8/2017. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies or any related sanction or fine. Rather, iti is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors.

Addendum per telephone conversation with Laura Cleveland, Executive Director on June 12, 2017 at 1145pm. - Hope Lentz Sr Licensure Consultant

1. **10A NCAC 13F .0311(d) Other Requirements**

Date of completion will be June 21, 2017

- Maintenance Director/Designee will check water temperatures throughout the facility to include resident rooms and common areas daily to maintain a water temperature between 100 degrees Fahrenheit and 116 degrees Fahrenheit.
- Maintenance Director/Designee will maintain a tracking form with daily water temperatures and reviewed by the Executive Director/Designee quarterly.

2. **10A NCAC 13F .0406(a) Test For Tuberculosis**

- Tracking form has been completed by the Health and Wellness Director/Resident Care Coordinator/Designee

Date of completion will be June 21, 2017

- All admissions will be verified for date given, date read, and results of Tuberculosis Test for 1st step prior to being admitted. The 2nd step Tuberculosis will be administered to residents if not already administered by the facility with the state's guideline.
- Tracking form will be updated by Health and Wellness Director/Resident Care Coordinator/Designee on admissions and discharges.
- Tracking form will be monitored by the Health and Wellness Director/Resident Care Coordinator/Designee monthly and quarterly by the Executive Director/Designee.
- Brookdale Senior Living's addendum to FL-2 has been updated under the section titled Communicable Disease Screening to include date Tuberculosis was given date read, and Result.

3. **10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizations**

- An audit has been completed on associate files by the Business Office Coordinator.

Date of completion will be June 21, 2017

- Identified employees missing documentation was checked and records were obtained for 1st step Tuberculosis Test and 2nd step Tuberculosis Test administered at facility. Documentation was placed in their employee files.
- A tracking system has been put into place for tracking compliance by the Business Office Coordinator/Executive Director/Health Wellness Director/Designee.

- Tracking system will be checked at least monthly by the Business Office Coordinator/Health Wellness Director and quarterly by the Executive Director/Designee for compliance.

4. **10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service**

Date of completion will be June 21, 2017.

- Staff including dietary have been re-trained to serve water to each resident at each meal, in addition to other beverages.
- Health and Wellness Director/Resident Care Coordinator/Dietary Manger/Executive Director/Designee to monitor at meal time daily for 4 weeks that water is being served at meals. Monitoring to continue monthly therafter.

5. **10A NCAC 13F .1004(a) 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 residents record; and

(2) Rules in this section and facility's policies and procedures

Date of completion will be June 21, 2017.

- Staff has been re-trained that they are required to seek clarification for any orders that are incomplete or unclear.
- Staff has been re-trained to follow what the prescriber orders for when a medication should be given and if should be given with a meal.
- Medication Techs have been re-trained on what meds can be crushed and that there is a list of what medications that can't be crushed on the medication cart.
- Health and Wellness Director/Resident Care Coordinator/Designee will observe medication passing techniques with medication techs to make sure orders are being following appropriate. This will take place for 4 weeks, then monthly thereafter.

6. **10A NCAC 13F .1309 Special Care Unit Staff Orientation and Training**

(a) Each staff person at an adult care home shall

Date of completion will be June 21, 2017.

- An audit has been completed on associate files for special care training by Business Office Coordinator.
- A tracking system was put in place for tracking compliance by the Business Office Coordinator.
- The identified employees with missing training have been trained and checked off and documentation was placed in their employee file.
- The tracking system will be checked at least monthly by the Business Office Coordinator and quarterly by the Executive Director/Designee for compliance.

L Cleveland 6/7/17

Addendum per telephone conversation with Laura Cleveland, Executive Director on June 12, 2017 at 11:45 am. - Hope Lasley, RN Licensure Consultant