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
	FCL034015	A. BUILDING: _____ B. WING _____	09/20/2018

NOV 13 2018 ADULT CARE LICENSURE SECTION RALEIGH

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW FAMILY CARE HOME	2778 REYNOLDS PARK ROAD WINSTON-SALEM, NC 27107

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 09/20/18.	C 000		
C 074	10A NCAC 13G .0315(a)(1) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping And Furnishings (a) Each family care home shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the walls, blinds, ceilings and floors were kept clean and in good repair in the living room and 2 of 2 bathrooms. The findings are: Observation of the men's bathroom on 09/20/18 at 7:57 am revealed: -There was an area 8 inches by 4-inches on the left shower wall that was missing 2 tiles, exposing the drywall. -There was an area 18 inches by 12 inches on the back shower wall that had previously been patched in some places and other spots had been scrapped. There was multiple tiny areas with a black substance on it. -There was a split across the right shower wall that had previously been patched and had started cracking. The crack was reddish brown in color and had several tiny areas with a black substance on it. -There was a black substance on the last 8 slats	C 074	In order to correct the missing tiles in the mens bathroom. I will replace them with a one piece surround In the tub area. That will eliminate the tiles altogather. Also a one piece surround will make it easier for cleaning. 1/15/18	

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

Dangela Jones — Manager — 10/25/18

STATE FORM 6899 R2ZI11 If continuation sheet 1 of 28

2018-12-14

Jo Scarlett, RN

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C 074	Continued From page 1 of the mini blind which covered the back shower wall window. The pull strings on the mini blind were also covered with the same black substance. -There was a split in the linoleum at the base of the cabinet's front left corner 3 inches in length; the linoleum flooring was raised on each side of the split. -There was an area 12 inches by 8 inches that had peeled off the ceiling with some of the popcorn texture hanging on the border of the peeled area. Observation of the women's bathroom on 09/20/18 at 8:22 am revealed: -There was a window on the back shower wall in which the paint had peeled from the window frame on all 4 sides. -The window on the back shower wall was covered by a mini blind. The last 20 slats of the mini blind had a black substance on them. The strings of the mini blind was also covered with the same black substance, and the bottom cover of the mini blind was covered with rust. -The ceiling above the shower had a 24 inch crack on it and the popcorn ceiling had started to peel. Observation of the living room floor on 09/20/18 at 4:22 pm revealed: -There were stains in the center of the carpet just beside the area rug. The area was 18 inches in diameter. -There were stains on the carpet on the left side of the room by the right end of the couch and end table. The area measured 24 inches in diameter. Review of the Environmental Health inspection report dated 12/18/17 revealed: -There was documentation the ceiling was	C 074	The Frame around the window will be scraped + painted, and also sealed w/a water proof sealant to protect it From the Steam in the shower. Also I will replace the blinds and hang a water proof curtain to protect the window Frame + Blinds in both bathrooms From water. 12/5/18 The popcorn ceiling over the shower is Peeling, because of the steam in the shower. The popcorn ceiling will be scraped + painted In both bath-Rooms, to eliminate the popcorn ceilings over the showers. It will be a smooth surface. 11/30/18	

Pamela Jones Manager 10/25/18

Division of Health Service Regulation

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C 074	Continued From page 2 damaged in several areas. -There was documentation the paint was chipping from the window seal in the women's bathroom. -There was documentation the blinds were rusted in the women's bathroom. -There was documentation the blinds needed cleaning. (Any demerits deducted for these areas and what was the sanitation score?) Interview with a resident on 09/20/18 at 8:05 am revealed: - The shower tiles in the men's bathroom had not been missing long. -He had not noticed the peeling ceiling in the men's bathroom. Interview with a second resident on 09/20/18 at 8:24 am revealed she had not paid any attention to the black substance or the rust on the mini blind that covered the window in the shower in the women's bathroom. Interview with a third resident on 09/20/18 at 4:20 pm revealed: -The shower tiles in the men's bathroom had been missing for 6 months. -He did not know if the Medication Aide or the Manager knew of the missing shower tiles in the men's bathroom. -He had never told anyone about the missing shower tiles. -He had not noticed the black substance on the mini blind that covered the window in the shower in the men's bathroom. -He did not know how often the mini blind in the men's shower was changed. -The ceiling in the men's bathroom had been peeling for 3 months. Interview with a Medication Aide on 09/20/18 at	C 074	Duplicate SEE above Correction	

Angela Jones Manager 10/25/18

Division of Health Service Regulation

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C 074	Continued From page 3 4:07 pm revealed: -The shower tiles in the men's bathroom had broken and came off 1 week ago. -She knew the men's bathroom ceiling was peeling but unsure how long it had been that way. -The mini blind covering the window in the shower of the men's bathroom had been replaced a couple weeks ago. -The mini blind in the women's bathroom had been there a while but she was unsure when it was last replaced. -The carpet in the living room had not been stained long. -When she noticed anything broken or that needed repairs she verbally reported it to the Manager. -The Manager was responsible for making repairs. Interview with the Manager on 09/20/18 at 4:31 pm revealed: -The shower tiles in the men's bathroom had broken 2-3 weeks ago. -She knew the shower walls in the men's bathroom needed some work. -She would replace the shower walls in the men's bathroom in the next couple weeks. -She replaced the mini blind covering the window in the shower of the men's bathroom 1 year ago. -The moisture from the shower caused the growth of the black substance on the mini blind in the men's bathroom. -She did not know how long the ceiling in the men's bathroom had been peeling. -She did not know the mini blind covering the shower window in the women's bathroom needed to be replaced. -She did not know the ceiling had cracked and started peeling in the women's bathroom. -She had not noticed the stains on the living room	C 074	Duplicate See above Correction I will have the 12/5/ Carpet shampooed in the living room area, and will check for stains monthly.	

Danyela Jones Manager 10/25/18

Division of Health Service Regulation

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C 074	Continued From page 4 carpet. She would get the carpet shampooed. -She observed the home weekly for needed repairs. -She expected staff to report anything broken or needing repairs to her. -She was responsible for ensuring all repairs were completed.	C 074	The air condition is a window unit. It has been taken out and will be replaced by springtime. Since we do not use air-conditioning in the winter months. Also management will ensure the Filter is Cleaned on the new unit as directed by instruction. * Note: All air condition units are removed During the winter months and installed in the spring (window units)	3/5/18
C 102	10A NCAC 13G .0317 (a) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family care home shall be maintained in a safe and operating condition This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure all electrical and mechanical equipment in the facility was maintained in a safe and operating condition related to the air conditioning unit in the window located in the living room. Observation of the window air conditioning unit in the living room on 09/20/18 at 4:19 pm revealed: -There were water droplets and a black substance coming from the window air conditioner unit vents while in operation. -The air condition unit was covered with moisture and a black substance was inside the vents and on the cover of the air conditioning unit. -The air conditioning unit had several areas at the top of the vent which had rusted and multiple	C 102		

Dangela Jones Manager 10/25/18

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C 102	Continued From page 5 small spots of missing enamel on the unit. -The filter had separated from its frame and was not able to be removed from the air conditioning unit. -There were 2 broken vent slats on the front of the air conditioning unit. -The front cover of the air conditioning unit was covered with dust. Interview with a Medication Aide on 09/20/18 at 4:20 pm revealed: -The air conditioning unit was dusty and had a black substance on it. -The air conditioning unit had not been that way long. -She had not reported the air conditioning unit to the Manager but did not indicate a reason why. -She was supposed to report any broken equipment to the Manager. -The Manager was responsible for making repairs. Interview with the Manager on 09/20/18 at 4:31 pm revealed: -She did not know moisture or a black substance was coming out of the the air conditioning unit. -She did not know the air conditioning unit was covered in moisture or had a black substance on the vents. -She did not know the filter had broken and would not come out of the unit. -She had not seen the air conditioning unit. -She did not know how long the air conditioning unit had been that way. -She would replace the air conditioning unit immediately. -She observed the home weekly for needed repairs. -She expected staff to report anything broken or needing repairs to her.	C 102	Duplicate SEE above Correction	

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C 102	Continued From page 6 -She was responsible for ensuring all repairs were completed.	C 102	9/21/18 Management have instructed the med-tech on proper protocal on pulling & administering medications. The medtech was instructed that proper protocal is as follow, while pulling the residence medication, she should check each medication lable against the mar's to ensure the lable & mar's agree. After ensuring that the lable and mar's agree then she can administer the medication to the resident. After the medtech have witness →	
C 335	10A NCAC 13G .1004 (f) (1-4) Medication Administration 10A NCAC 13G .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name: (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section.	C 335		

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C 335	Continued From page 7 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications prepared for administration in advance were kept in a sealed container that identified the name and strength of each medication prepared, identified up to the point of administration and protected from contamination and spillage for 4 of 4 residents (Residents #1, #2, #3, and #4) residing in the home. The findings are: Observation on 09/20/18 at 8:50 am of the 8:00 am medication pass revealed: -The medication aide/Supervisor-in-Charge (MA/SIC) finished preparation of the breakfast for 4 residents. The MA/SIC rolled a medication storage rack from a double locked medication storage area in the hallway of the facility to the SIC office. -The MA/SIC was sitting at a desk in the MA/SIC office and living quarters. She located 4 small paper soufflé cups on a shelf above the desk. -Each paper soufflé cup was labeled with the resident's name and time (8:00 am), but no name or strength of medications. -The MA/SIC prepared medication for 4 residents (Residents #1, #2, #3, and #4) one at a time by reviewing the Medication Administration Record (MAR) for each resident, comparing the medication bottles or bingo cards to the MAR, and placing the medications in the paper soufflé cup labeled with each residents' name and moving to the next resident. -The MA/SIC reviewed the total number of tablets	C 335	the resident taking his or her medication, She is to then sign the mar's. After following those steps she can then move on to the next individual resident and Repeat the above steps. furthermore preparing medications in advance is not allowed by management. Management will observe the med tech administration technique for 90 days to ensure that proper protocal is being followed. Management began the observation immediately after the survey.	

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C 335	Continued From page 8 prepared for each resident with the exception prior to stacking the soufflé cups on top of the previous cup. -The MA/SIC completed preparation of the last resident's oral medications and stated she would administer medications to the residents in their rooms. 1. Review of Resident #4 current FL2 dated 04/16/18 revealed: -Diagnoses included major depressive disorder, essential tremor, and superficial bruising. -There were medications orders as follows: Metformin (used to treat elevated blood sugar) 500 mg twice a day, propranolol (used to treat tremors) 80 mg daily, tamsulosin (used to treat decreased urine stream) 0.4 mg daily, vitamin B12 (a vitamin supplement) 1000 micrograms (mcg) daily, and vitamin D3 (a vitamin supplement) 1,000 IU daily. Observation on 09/20/18 at 8:50 am of the 8:00 am medication pass revealed the MA/SIC prepared one tablet/capsule of each oral medication (5 total) in a paper soufflé cup labeled with Resident #4's first name and "8:00 am" and set the cup on the desk in the MA/SIC office. -The MA/SIC initialed the space designated for 09/20/18 administration on the September 2018 MAR. -The MA/SIC moved on to the next resident. Observation on 09/20/18 at 9:41 am revealed the MA/SIC administered 6 oral medications from the cup labeled with the resident's name to Resident #4. Review of Resident #4's September 2018 MAR revealed: -There was an entry for metformin 500 mg twice	C 335	SEE above explanation	

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C 335	Continued From page 9 a day scheduled for administration at 8:00 am and 8:00 pm, and documented as administered at 8:00 am on 09/20/18. -There was an entry for propranolol 80 mg daily scheduled for administration at 8:00 am daily, and documented as administered at 8:00 am on 09/20/18. -There was an entry for tamsulosin 0.4 mg daily scheduled for administration at 8:00 am daily, and documented as administered at 8:00 am on 09/20/18. -There was an entry for vitamin B12 1000 micrograms (mcg) daily scheduled for administration at 8:00 am daily, and documented as administered at 8:00 am on 09/20/18. -There was an entry for vitamin D3 1,000 IU daily scheduled for administration at 8:00 am daily, and documented as administered at 8:00 am on 09/20/18. Interview on 09/20/18 at 12:10 pm with Resident #4 revealed: -He routinely received his medications at the half door leading into the medication room/SIC office. -He only received his medication in his room occasionally, like if he was in the bathroom when the resident received medications and he missed the medications passed at the half-door. -He had not seen the MA/SIC prepare all the medications at one time before. Refer to interview on 09/20/18 at 12:16 pm with the MA/SIC. Refer to interview on 09/20/18 at 5:25 pm with the Manager/Medication Aide . 2. Review of Resident #3's current FL2 dated 12/18/17 revealed diagnoses included schizophrenia, hypertension, irritable bowel	C 335	SEE above explanation	

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C 335	Continued From page 10 syndrome and obesity. Review of Resident #3's current FL2 dated 12/18/17 and signed physician's orders dated 09/14/18 revealed medications orders included. -There was an order for amlodipine (used to treat high blood pressure) 5 mg daily. -There was an order for atenolol (used to treat high blood pressure) 50 mg daily. -There was an order for citalopram (used to mental disorders like depression) 20 mg daily. -There was an order for ferrous sulfate (a iron supplement) 325 mg twice a day. -There was an order for hydrochlorthiazide (used to treat high blood pressure) 12.5 mg daily. -There was an order for vitamin D3 (a vitamin supplement) 1000 IU daily. Observation on 09/20/18 at 8:58 am of the 8:00 am medication pass revealed the MA/SIC prepared one tablet/capsule of each oral medication (6 total) in a paper soufflé cup labeled with Resident #3's first name and "8:00 am" and stacked the soufflé cup on top of Resident #4's cup on the desk in the MA/SIC office. -The MA/SIC initialed the space designated for 09/20/18 administration on the September 2018 Medication Administration Record (MAR). -The MA/SIC moved on to the next resident. Observation on 09/20/18 at 9:41 am revealed the MA/SIC administered 6 oral medications from the cup labeled with the resident's name to Resident #3. Review of Resident #3's September 2018 MAR revealed: -There was an entry for amlodipine 5 mg daily scheduled for administration at 8:00 am, and documented as administered at 8:00 am on	C 335	See above explanation	

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C 335	Continued From page 11 09/20/18. -There was an entry for atenolol 50 mg daily scheduled for administration at 8:00 am daily, and documented as administered at 8:00 am on 09/20/18. -There was an entry for citalopram 20 mg daily scheduled for administration at 8:00 am daily, and documented as administered at 8:00 am on [illegible]. -There was an entry for ferrous sulfate 325 mg twice a day scheduled for administration at 8:00 am and 8:00 pm, and documented as administered at 8:00 am on 09/20/18. -There was an entry for hydrochlorthiazide 12.5 mg daily scheduled for administration at 8:00 am daily, and documented as administered at 8:00 am on 09/20/18. -There was an entry for vitamin D3 1,000 IU daily scheduled for administration at 8:00 am daily, and documented as administered at 8:00 am on 09/20/18. Interview on 09/20/18 at 5:30 pm with Resident #3 revealed: -She routinely received her medications at the [illegible] office. -She only received her medication in her room occasionally, if she did not get up for the medication pass. -She did not watch the MA/SIC prepare medications. Refer to interview on 09/20/18 at 12:16 pm with the MA/SIC. Refer to interview on 09/20/18 at 5:25 pm with the Manager/Medication Aide. 3. Review of Resident #1's current FL2 dated	C 335	SEE above Statement + Explanation	

Angela Jones Manager 10/25/18

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C 335	Continued From page 12	C 335	SEE above Statement & Explanation	

05/21/18 revealed diagnoses included schizophrenia, hypertension, and major depression.

Review of Resident #1's current FL2 dated 05/21/18 revealed medications orders included:
-There was an order for amlodipine (used to treat high blood pressure) 10 mg daily.
-There was an order for aspirin (used to treat circulation) 81 mg daily.
-There was an order for atorvastatin (used treat high cholesterol) 40 mg daily.
-There was an order for fluoxetine (used to treat mental disorders like major depression) 40 mg daily.
-There was an order for carvedilol (used to treat high blood pressure) 25 mg two times daily.
-There was an order for chlorthalidone (used to treat high blood pressure) 25 mg daily.
-There was an order for hydroxyzine (used to treat mental disorders) 50 mg two times daily.
-There was an order for losartan (used to treat high blood pressure) 100 mg daily.
-There was an order for metformin (used to treat elevated blood sugar) 500 mg twice a day.
-There was an order for omeprazole (used to treat acid reflux) 20 mg daily.
-There was an order for oxcarbazepine (used to treat mental disorders) 300 mg twice a day.

Review of Resident #1's record revealed:
-There was a physician's order dated 09/05/18 for chlorpromazine (used to treat mental disorders like psychosis) 25 mg twice daily and 2 at bedtime.
-There was a physician's order dated 07/22/17 to change metformin to 1,000 mg twice a day.

Observation on 09/20/18 at 8:58 am of the 8:00 am medication pass revealed the MA/SIC

Jangela Jones Manager 10/25/18

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
	FCL034015	A. BUILDING: _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW FAMILY CARE HOME	2778 REYNOLDS PARK ROAD WINSTON-SALEM, NC 27107

(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
C 335	Continued From page 13 prepared one tablet/capsule of each oral medication (12 total) in a paper soufflé cup labeled with Resident #1's first name and "8:00 am", and stacked the soufflé cup on top of Resident #3's cup on the desk in the MA/SIC office. -The MA/SIC initialed the space designated for 09/20/18 on the September 2018 Medication Administration Record (MAR). -The MA/SIC moved on to the next resident. Observation on 09/20/18 at 9:32 am revealed the MA/SIC administered 12 oral medications from the cup labeled with the resident's name to Resident #1 in his room. Review of Resident #1's September 2018 MAR revealed: -There was an entry for amlodipine 10 mg daily scheduled for administration at 8:00 am daily, and documented as administered at 8:00 am on 09/20/18. -There was an entry for aspirin 81 mg daily scheduled for administration at 8:00 am daily, and documented as administered at 8:00 am on 09/20/18. -There was an entry for atorvastatin 40 mg daily scheduled for administration at 8:00 am daily, and documented as administered at 8:00 am on 09/20/18. -There was an entry for fluoxetine 40 mg daily scheduled for administration at 8:00 am daily, and documented as administered at 8:00 am on 09/20/18. -There was an entry for carvedilol 25 mg two times daily scheduled for administration at 8:00 am and 8:00 pm daily, and documented as administered at 8:00 am on 09/20/18. -There was an entry for chlorthalidone 25 mg daily scheduled for administration at 8:00 am	C 335	SEE above Statement & Explanation	

Danyala Jones Manager 10/25/18

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
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C 335	Continued From page 14 daily, and documented as administered at 8:00 am on 09/20/18. -There was an entry for hydroxyzine 50 mg two times daily scheduled for administration at 8:00 am and 8:00 pm daily, and documented as administered at 8:00 am on 09/20/18. -There was an entry for losartan 100 mg daily scheduled for administration at 8:00 am daily, and documented as administered at 8:00 am on 09/20/18. -There was an entry for metformin 1,000 mg twice a day scheduled for administration at 8:00 am and 8:00 pm daily, and documented as administered at 8:00 am on 09/20/18. -There was an entry for omeprazole 20 mg daily, scheduled for administration at 8:00 am daily, and documented as administered at 8:00 am on 09/20/18. -There was an entry for oxcarbazepine 300 mg twice a day scheduled for administration at 8:00 am and 8:00 pm daily, and documented as administered at 8:00 am on 09/20/18. -There was an entry for chlorpromazine 25 mg twice daily and 2 at bedtime schedule for administration at 8:00 am, 2:00 pm, and 8:00 pm daily, and documented as administered at 8:00 am on 09/20/18. Interview on 09/20/18 at 12:00 pm with Resident #1 revealed: -He routinely received his medications at the half-door leading into the medication room/SIC office. -He had not seen the MA/SIC prepare all the medications at one time before. -He did not know why the residents received their medications in their rooms today. Refer to interview on 09/20/18 at 12:16 pm with the MA/SIC.	C 335	SEE above Statement & Explanation	

Angela Jones Manager 10/25/18

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
	FCL034015	A. BUILDING: _____ B. WING _____	09/20/2018

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C 335	Continued From page 15 Refer to interview on 09/20/18 at 5:25 pm with the Manager/Medication Aide. 4. Review of Resident #2's current FL2 dated 08/26/18 revealed diagnoses included schizophrenia, hypertension, dyslipidemia, hypothyroid, and osteoarthritis and rheumatoid arthritis. Review of Resident #1's current FL2 dated 08/26/18 revealed medications orders included: -There was an order for acetaminophen (used to treat mild pain) 325 mg 3 times daily. -There was an order for levothyroxine (used to treat thyroid) 137 mg daily. -There was an order for losartan (used to treat high blood pressure) 100 mg daily. -There was an order for omeprazole (used to treat acid reflux) 40 mg daily. -There was an order for potassium chloride (used supplement potassium) 20 mg daily. -There was an order for Geri-kot (used to treat constipation) 8.6 mg 2 tablet twice daily. -There was an order for amlodipine (used to treat high blood pressure) 10 mg daily -There was an order for furosemide (used to treat high blood pressure) 40 mg daily. -There was an order for haloperidol (used to treat mental disorders) 10 mg in the morning and 20 mg at bedtime. -There was an order for ferrous sulfate (used to supplement iron) 325 mg 3 times a day. -There was an order for diazepam (used to treat anxiety) 0.5 mg 2 times a day. -There was an order for hydrocodone 5-325 acetaminophen (used to pain) twice a day. -There was an order for Incruse Ellipta 62.5 mg inhaler (used to treat breathing problems) one puff orally each day.	C 335	SEE above Statement & Explanation	

Angela Jones Manager 10/25/18

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
	FCL034015	A. BUILDING: _____ B. WING _____	09/20/2018

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C 335	Continued From page 16 Review of Resident #2's record revealed physician's order dated 09/06/18 as follows: -There was an order for Retaine eye drops (used to treat dry eyes) one drop in each eye 3 times a day. -There was an order for Maxitrol eye drops (used to treat eye irritations) one drop in each 4 times a day in each eye for 3 weeks. Observation on 09/20/18 at 9:11 am of the 8:00 am medication pass revealed the MA/SIC prepared one tablet/capsule of each oral medication (12 total) in a paper soufflé cup labeled with Resident #1's first name and "8:00 am", and stacked the soufflé cup on top of Resident #1's cup on the desk in the MA/SIC office. -The MA/SIC initialed the space designated for 8:00 am 09/20/18 on the September 2018 Medication Administration Record (MAR). -The MA/SIC moved on to the next resident. Observation on 09/20/18 at 9:35 am revealed the MA/SIC administered 12 oral medications from the cup labeled with the resident's name to Resident #2 in his room. The MA/SIC also administered one puff of Incruse Ellipta 62.5 mg inhaler, one drop of Retaine in each eye, and waited 3 minutes from previous eye drops, and administered one drop of Maxitrol eye drops in each eye. Review of Resident #2's handwritten September 2018 MAR revealed 8:00 am administration was documented on 09/20/18 for the following medications: -There was an entry for acetaminophen 325 mg 3 times daily schedule for 8:00 am, 12 noon, and 8:00 pm daily.	C 335	SEE above Statement + Explanation	

Angela Jones Manager 10/25/18

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
	FCL034015	A. BUILDING: _____ B. WING _____	09/20/2018

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C 335	Continued From page 17 -There was an entry for levothyroxine 137 mg daily scheduled for 8:00 am. -There was an entry for losartan 100 mg daily scheduled for 8:00 am. -There was an entry for omeprazole 40 mg daily scheduled for 8:00 am. -There was an entry for potassium chloride 20 mg daily scheduled for 8:00 am. -There was an entry for Qeri-tet 8.6 mg 2 tablets at 8:00 am and 2 tablets at 8:00 pm daily.. -There was an entry for amlodipine 10 mg daily scheduled for 8:00 am. -There was an entry for furosemide 40 mg daily scheduled for 8:00 am. -There was an entry for haloperidol 10 mg in the morning scheduled for 8:00 am. -There was an entry for ferrous sulfate 325 mg 3 times a day, scheduled for 8:00 am, 12 noon, and 8:00 pm. -There was an entry for clonazepam 0.5 mg 2 times a day, scheduled for 8:00 am and 8:00 pm. -There was an entry for hydrocodone 5-325 acetaminophen twice a day, scheduled for 8:00 am and 8:00 pm. -There was an entry for Incruse Ellipta 62.5 mg inhaler one puff orally each day scheduled for 8:00 am. -There was an entry for Retaine eye drops, one drop in each eye 3 times a day scheduled for 8:00 am, 2:00 pm, and 8:00 pm daily. -There was an entry for Maxitrol eye drops, one drop in each 4 times a day in each eye scheduled for 8:00 am, 12 noon, 4:00 pm and 8:00 pm daily. Interview on 09/20/18 at 12:00 pm with Resident #2 revealed: -She routinely received her medications in her room because it was hard for her to get up and down from her chair.. -She had not seen the MA/SIC prepare all the	C 335	SEE above Statement + Explanation	

Angela Jones Manager 10/25/18

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
	FCL034015	A. BUILDING: _____ B. WING _____	09/20/2018

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C 335	Continued From page 18 medications at one time before. Refer to interview on 09/20/18 at 12:16 pm with the MA/SIC. Refer to interview on 09/20/18 at 5:25 pm with the Manager/Medication Aide. Interview on 09/20/18 at 12:16 pm with the MA/SIC revealed: -She did not routinely prepare resident's medication all at one time like she had done today. -She routinely prepared each residents' medications, called the resident to come to the half door separating the medication room from the dining room, and administered the residents' medications. -Today (09/20/18) she had misunderstood when she was asked to be observed preparing and administering residents' medications. -She assumed she was to be observed preparing each medication and then administering the medications. -The paper soufflé cups labeled with a resident's name and 8:00 am were used to prepare the medication today, but the medications were routinely taken directly to the residents at the half-door for administration (one resident at a time). -She routinely documented administration of the medication when she prepared each medication, prior to observing the medications being administered. -She did not know she was supposed to observe the resident receive a medication, then document administration prior to administering the next resident's medication. She was nervous about being observed during the medication pass.	C 335	SEE above Statement + Explanation	

Angela Jones Manager 10/25/18

Division of Health Service Regulation

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C 335	Continued From page 19 Interview on 09/20/18 at 5:25 pm with the Manager revealed: -She did not know why the MA/SIC prepared all residents' medications before administering each resident their medications. -She had never observed the MA/SIC do that before. ~~She was present today (09/20/18) when the~~ MA/SIC prepared the medications and stacked the cups. -She did not stop the staff or question her for what she was doing because she was being observed. -The Manager had spoken with the MA/SIC regarding preparing and administering one resident's medication before going to the next resident at lunch today (09/20/18) to make sure she did not repeat the error again.	C 335	As Stated I had never seen the medtech prepare or pull all the residents meds before giving them to the residents. Because that is not how we administer medications. As I stated it was miss Communication.	
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .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 assure pre-charting	C 341	* SEE above Correction Statement + Explanation	

Pamela Jones Manager 10/25/18

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C 341	Continued From page 20 was prohibited regarding administration of medications for 4 of 4 residents (Residents #1, #2, #3, and #4) observed during the 8:00 am medication pass on 09/20/18. The findings are: Observation on 09/20/18 at 8:50 am of the 8:00 am medication pass revealed: -The medication aide/Supervisor-in-Charge (MA/SIC) finished preparation of the breakfast for 4 residents. The MA/SIC rolled a medication storage rack from a double locked medication storage area in the hallway of the facility to the SIC office. -The MA/SIC was sitting at a desk in the MA/SIC office and living quarters. -She located 4 small paper soufflé cups on a shelf above the desk. -Each paper soufflé cup was labeled with the resident's name and time (8:00 am), but no name or strength of medications were included. -The MA/SIC prepared medications for 4 residents (Residents #1, #2, #3, and #4) one at a time by reviewing the Medication Administration Record (MAR) for each resident, comparing the medication bottles or bingo cards to the Medication Administration Record (MAR), and placing the medications in the paper soufflé cup labeled with each residents' name and moving to the next resident. -The MA/SIC counted the total number of tablets prepared for each resident with the surveyor prior to stacking the soufflé cups on top of the previous cup. -The MA/SIC documented each medication was administered on the corresponding MAR as she prepared the medications, prior to observing administration of the medication. -The MA/SIC completed preparation of the last	C 341	SEE above Statement + Explanation	

Angela Jones Manager 10/25/18

Division of Health Service Regulation

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C 341	Continued From page 21 resident's oral medications and stated she would administer medications to the residents in their rooms. 1. Review of Resident #4 current FL2 dated 04/16/18 revealed: -Diagnoses included major depressive disorder, essential tremor, and superficial bruising. There were medications orders as follows: Metformin (used to treat elevated blood sugar) 500 mg twice a day, propranolol (used to treat tremors) 80 mg daily, tamsulosin (used to treat decreased urine stream) 0.4 mg daily, vitamin B12 (a vitamin supplement) 1000 micrograms (mcg) daily, and vitamin D3 (a vitamin supplement) 1,000 IU daily. Observation on 09/20/18 at 8:50 am of the 8:00 am medication pass revealed the MA/SIC prepared one tablet/capsule of each oral medication (5 total) in a paper soufflé cup labeled with Resident #4's first name and "8:00 am" and sat the cup on the desk in the MA/SIC office. -The MA/SIC initialed the space designated for 8:00 am on 09/20/18 administration on the September 2018 Medication Administration Record (MAR). -The MA/SIC moved on to the next resident. Observation on 09/20/18 at 9:41 am revealed the MA/SIC administered 6 oral medications from the cup labeled with the resident's name to Resident #4. Refer to interview on 09/20/18 at 12:16 pm with the MA/SIC. Refer to interview on 09/20/18 at 5:25 pm with the Manager .	C 341	SEE above Statement + Explanation	

Jangela Jones Manager 10/25/18

Division of Health Service Regulation

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C 341	Continued From page 22 2. Review of Resident #3's current FL2 dated 12/18/17 revealed diagnoses included schizophrenia, hypertension, irritable bowel syndrome, and obesity. Review of Resident #3's current FL2 dated 12/18/17 and signed physician's orders dated 09/14/18 revealed medications orders included: -There was an order for amlodipine (used to treat high blood pressure) 5 mg daily. -There was an order for atenolol (used to treat high blood pressure) 50 mg daily. -There was an order for citalopram (used to mental disorders like depression) 20 mg daily. -There was an order for ferrous sulfate (a iron supplement) 325 mg twice a day. -There was an order for hydrochlorthiazide (used to treat high blood pressure) 12.5 mg daily. -There was an order for vitamin D3 (a vitamin supplement) 1000 IU daily. Observation on 09/20/18 at 8:58 am of the 8:00 am medication pass revealed the MA/SIC prepared one tablet/capsule of each solid dose oral medication (6 total) in a paper soufflé cup labeled with Resident #3's first name and "8:00 am" and stacked the soufflé cup on top of Resident #4's cup on the desk in the MA/SIC office. -The MA/SIC initialed the space designated for 8:00 am on 09/20/18 on the September 2018 MAR. -The MA/SIC moved on to the next resident's medications. Observation on 09/20/18 at 9:41 am revealed the MA/SIC administered 6 solid dose oral medications from the cup labeled with the resident's name to Resident #3.	C 341	SEE above Statement + Explanation	

Jacqueda Jones Manager 10/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 341	Continued From page 23 Refer to interview on 09/20/18 at 12:16 pm with the MA/SIC. Refer to interview on 09/20/18 at 5:25 pm with the Manager. 3. Review of Resident #1's current FL2 dated 05/21/18 revealed diagnoses included schizophrenia, hypertension, and major depression. Review of Resident #1's current FL2 dated 05/21/18 revealed medication orders included: -There was an order for amlodipine (used to treat high blood pressure) 10 mg daily. -There was an order for aspirin (used to treat circulation) 81 mg daily. -There was an order for atorvastatin (used treat high cholesterol) 40 mg daily. -There was an order for fluoxetine (used to treat mental disorders like major depression) 40 mg daily. -There was an order for carvedilol (used to treat high blood pressure) 25 mg two times daily. -There was an order for chlorthalidone (used to treat high blood pressure) 25 mg daily. -There was an order for hydroxyzine (used to treat mental disorders) 50 mg two times daily. -There was an order for losartan (used to treat high blood pressure) 100 mg daily. -There was an order for metformin (used to treat elevated blood sugar) 500 mg twice a day. -There was an order for omeprazole (used to treat acid reflux) 20 mg daily. -There was an order for oxcarbazepine (used to treat mental disorders) 300 mg twice a day. Review of Resident #1's record revealed: -There was a physician's order dated 09/05/18 for chlorpromazine (used to treat mental disorders	C 341	SEE above Statement + Explanation	

Pamela Jones Manager 10/25/18

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C 341	Continued From page 24 like psychosis) 25 mg twice daily and 2 at bedtime. -There was a physician's order dated 07/22/17 to change metformin to 1,000 mg twice a day. Observation on 09/20/18 at 8:58 am of the 8:00 am medication pass revealed the MA/SIC prepared one tablet/capsule of each oral medication (12 total) in a paper soufflé cup labeled with Resident #1's first name and "8:00 am", and stacked the soufflé cup on top of Resident #3's cup on the desk in the MA/SIC office. -The MA/SIC initialed the space designated for 8:00 am on 09/20/18 on the September 2018 Medication Administration Record (MAR). -The MA/SIC moved on to the next resident's medications. Observation on 09/20/18 at 9:32 am revealed the MA/SIC administered 12 oral medications from the cup labeled with the resident's name to Resident #1 in his room. Interview on 09/20/18 at 12:00 pm with Resident #1 revealed: -He routinely received his medications at the half-door leading into the medication room/SIC office. -He had not seen the MA/SIC prepare all the medications at one time before. -He did not know why the residents received their medications in their rooms today. Refer to interview on 09/20/18 at 12:16 pm with the MA/SIC. Refer to interview on 09/20/18 at 5:25 pm with the Manager/Medication Aide.	C 341	SEE above Explanation	

Tanjela Jones Manager 10/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL034015	A. BUILDING: _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 341	Continued From page 25 4. Review of Resident #2's current FL2 dated 08/26/18 revealed diagnoses included schizophrenia, hypertension, dyslipidemia, hypothyroid, and osteoarthritis and rheumatoid arthritis. Review of Resident #1's current FL2 dated 08/26/18 revealed medication orders included: -There was an order for acetaminophen (used to treat mild pain) 325 mg 3 times daily. -There was an order for levothyroxine (used to treat thyroid) 137 mg daily. -There was an order for losartan (used to treat high blood pressure) 100 mg daily. -There was an order for omeprazole (used to treat acid reflux) 40 mg daily. -There was an order for potassium chloride (used supplement potassium) 20 mg daily. -There was an order for Geri-kot (used to treat constipation) 8.6 mg 2 tablet twice daily. -There was an order for amlodipine (used to treat high blood pressure) 10 mg daily -There was an order for furosemide (used to treat high blood pressure) 40 mg daily. -There was an order for haloperidol (used to treat mental disorders) 10 mg in the morning and 20 mg at bedtime. -There was an order for ferrous sulfate (used to supplement iron) 325 mg 3 times a day. -There was an order for clonazepam (used to treat anxiety) 0.5 mg 2 times a day. -There was an order for hydrocodone 5-325 acetaminophen (used to pain) twice a day. -There was an order for Ipratropium Albuterol 0.5-2.5 mg inhaler (used to treat breathing problems) one puff orally each day. Review of Resident #2's record revealed physician's order dated 09/06/18 as follows: -There was an order for Retaine eye drops (used	C 341	SEE above Explanation	

Angela Jones Manager 10/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 341	Continued From page 26 to treat dry eyes) one drop in each eye 3 times a day. -There was an order for Maxitrol eye drops (used to treat eye irritations) one drop in each 4 times a day in each eye for 3 weeks. Observation on 09/20/18 at 9:11 am of the 8:00 am medication pass revealed the MA/SIC prepared one tablet/capsule of each solid dose oral medication (12 total) in a paper soufflé cup labeled with Resident #1's first name and "8:00 am", and stacked the soufflé cup on top of Resident #1's cup on the desk in the MA/SIC office. -The MA/SIC initialed the space designated for 8:00 am 09/20/18 on the September 2018 Medication Administration Record (MAR). -The MA/SIC moved on to the next resident. Observation on 09/20/18 at 9:35 am revealed the MA/SIC administered 12 oral medications from the cup labeled with the resident's name to Resident #2 in his room. The MA/SIC also administered one puff of Incruse Ellipta 62.5 mg inhaler, one drop of Retaine in each eye, and waited 5 minutes apart from previous eye drops, and administered one drop of Maxitrol eye drops in each eye. Refer to interview on 09/20/18 at 12:16 pm with the MA/SIC. Refer to interview on 09/20/18 at 5:25 pm with the Manager. Interview on 09/20/18 at 12:16 pm with the MA/SIC revealed: -She did not routinely prepare resident's medication all at one time like she had done today.	C 341	See above Explanation	

Angela Jones Manager 10/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 341	Continued From page 27 -She routinely prepared each residents' medications, called the resident to come to the half door separating the medication room from the dining room, and administered the resident's medication. -She routinely documented administration of the medication when she prepared each medication, prior to observing the medication being administered. -She did not know she was supposed to observe the resident receive a medication, then document administration prior to administering the next resident's medication. Interview on 09/20/18 at 5:25 pm with the Manager revealed she did not know the MA/SIC routinely documented on the residents' MARs when she was preparing the medications not after she observed administration and prior to administering medications to the next resident.	C 341	SEE above Explanation	

Angela Jones Manager 10/25/18