Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

Parkwood Village

Plan of Correction

Facility License #HAL-098-030

Submission Date: 10-18-21

Pages: 31

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
	HAL098030	A. BUILDING: _____ B. WING _____	R 09/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD VILLAGE	1730 PARKWOOD BLVD WILSON, NC 27895

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on September 16-17, 2021.	D 000	1) 10A NCAC 13F .0306 Housekeeping and Furnishings Adult Care Homes shall be maintained and uncluttered, clean and orderly manner, free of all obstructions and hazards:	
D 079	1DA NCAC 13F .0306(a)(5) Housekeeping and Furnishings 1DA NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to maintain a hazard-free environment related to unsecured oxygen cylinders in two resident rooms. The findings are: Observation of a semi-private resident room on 09/16//21 at 9:53am revealed: -There were two unsecured oxygen (02) cylinders that were 25.5 inches in length sitting upright on the floor in the opened closet area. -The two unsecured 02 cylinders were sitting beside a 02 cylinder rack containing six full 02 cylinders. -There was an unsecured mini-O2 cylinder that was 12 inches in length sitting on top of a portable refrigerator. -There was another unsecured mini-O2 cylinder that was sitting on top of a small chest of drawers.	D 079	a)This rule was not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to maintain a hazard free environment related to unsecured oxygen cylinders in 2 resident rooms. A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action: The oxygen cylinders were placed in crates on 9/16/21 for the 2 residents. B) Other residents potentially affected by the same alleged deficient practice will be identified as follows: All residents with oxygen cylinders were reviewed by the Director of Resident Care and are secured. C)The following systemic changes will be made to ensure compliance with this regulation: a)All Staff will be in-serviced by 10/11/2021 on oxygen storage within the facility. b)Facility policies regarding oxygen storage will be incorporated within new hire orientation for all employees. D)The facility will monitor the corrective actions as follows: The Executive Director and/or designee will complete random room checks ~~for 60 days to~~ ensure oxygen is being properly stored within the facility.	10/11/21 WE amended 10/19/21 amended WE and ongoing 10/19/21 by phone

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITL

E Jaime McGee ED (X6) DATE 10-12-21

STATE FORM 490311 If continuation sheet 1 of 24

Reviewed and acknowledged by WEdwards 10/19/21

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D 079	Continued From page 1 Observation of another resident's room on 09/16/21 at 5:48pm revealed there were ten unsecured 02 cylinders sitting on the floor in the opened closet area. Interview with a personal care aide (PCA) on 09/16/21 at 5:07pm revealed: -She was taught how to exchange and refill the 02 cylinders for the 02 concentrators. -She had not worked for the facility for a long time and she did not know of a storage area for the 02 cylinders. -She did not know where 02 cylinders should be stored. -She had not noticed the unsecured 02 cylinders in the residents' rooms. Interview with a medication aide (MA) on 09/16/21 at 5:10pm revealed: -Each resident had their own 02 supply which was stored in their rooms. -02 cylinders were delivered by a local medical supply company. -She was taught to separate empty 02 cylinders from full 02 cylinders. -There were no racks to store the empty 02 cylinders. -The MAs called the local medical supply company to pick-up empty 02 cylinders. -The local medical supply company would pick up 02 cylinders either the same day or the next day. -She had not noticed there were unsecured 02 cylinders in the residents' rooms. -She knew both residents had an 02 concentrator and portable 0 2. -She had not received any training concerning 02 cylinder storage. -She had not reported there was not a storage rack for the 02 cylinders to other staff or management of the facility.	D 079		

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D 079	Continued From page 2 -She had not contacted the medical supply company to come and pick up the empty cylinders. -After she saw the unsecured 02 cylinders in a resident's room, she saw that the 02 cylinders were at risk for being knocked over resulting in a possible rupture of the cylinder. Interview with the Director of Resident Care (DRC) on 09/16/21 at 5:48pm revealed: -She made rounds through the facility. -When she made rounds, she checked in with staff to determine if there were any hospitalizations or falls. -The MAs conducted resident room sweeps daily. -A room sweep was when a MA checked on the residents and checked to determine if there were items that needed to be removed, like chemicals. -The MAs should report to her if anything was found that should not be in the resident rooms. -She knew there were residents who were using 02 cylinders. -She expected staff to notify her if there were unsecured 02 cylinders. -She was not aware 02 cylinders were unsecured in two residents' rooms. -She expected 02 cylinders to be stored in a storage rack delivered with the 02 cylinders. -She was concerned that the 02 cylinders were unsecured and at risk of being bumped. -Staff had not told her there were unsecured 02 cylinders in two residents' rooms. Telephone interview with the Administrator on 09/17/21 at 5:32pm revealed: -She was told by the DRC on 09/16/21 that two residents had unsecured 02 cylinders. -She expected staff to contact her or the DRC when they noticed unsecured 02 cylinders in a room without an available rack.	D079		

The Physician for residents #8 and #9 were notified on the day of the observation of deficient practice in addition to the vitamin supplement being ordered and delivered from the pharmacy on the day of observation.

B) The following systemic changes will be made to ensure compliance with this regulation:

b) All Med Techs will be in-serviced by 10/11/21 on proper documentation on the MAR for medication not administered and reporting medications not being in the facility that are ordered by the Physician.
c) The Med Tech observed was in-serviced on the day of observation on proper documentation on the MAR for medication not administered and reporting medications not being in the facility that are ordered by the Physician.
d) The Director of Resident Services and/or designee will conduct monthly MAR audits and random Med Pass observations for 60 days to ensure compliance.
e) The Director of Resident Services and/or designee will conduct weekly medication cart audits for 60 days to ensure compliance.

10/11/21 WE amended 10/19/21 by phone

C) The facility will monitor the corrective actions as follows:

The Executive Director and/or designee will complete random MAR audits and random Med Pass Observations ~~for 60 days~~ to ensure compliance

WE

amended 10/19/21 by WE and phone

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D 358	Continued From page 4 -There was a medication order for cholecalciferol (used to treat vitamin O deficiency) 50,000 units one capsule every Friday at 8:00am. Observation of the 9:00am medication pass on 09/17/21 at 8:06am revealed: -The medication aide (MA) administered six oral medications to Resident #8. -There were no cholecalciferol capsules available for administration. Review of Resident #B's September 2021 printed medication administration record (MAR) revealed: -There was an entry for cholecalciferol (vitamin 03) 50,000 units take one capsule every Friday, without a scheduled time of administration. -There was documentation of administration of cholecalciferol on 09/03/21, 09/10/21. -There was documentation of circled staff initials on 09/17/21 and on the reverse side of the MAR was a note indicating vitamin 03 50,000 units "not given on order". Telephone interview with a representative at the facility contracted pharmacy on 09/17/21 at 11:57am revealed: -There was a current order dated 08/19/21 for Resident #S's cholecalciferol for one capsule weekly. -Four tablets of cholecalciferol were dispensed on 07/15/21 and 08/19/21, which was a 28-day supply. Interview with the MA on 09/17/21 at 10:40am revealed: -She filled out a refill form for the pharmacy and faxed the form to the pharmacy. -She had a fax verification form that she had faxed the refill form to the pharmacy. -Resident #B's cholecalciferol should be delivered	D 358		

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D 358	Continued From page 5 during the night shift. -Resident #B's cholecalciferol was supposed to be ordered when there was one tablet remaining in the package. -She was not able to locate documentation that Resident #B's cholecalciferol was ordered on any other date in September. -The night shift staff would sign for the delivered medications and place the medications on the medication cart. -When a medication was not available to administer, the MA initialed and circled the initials. -The MA also documented on the reverse side of the MAR that the medication was not given awaiting pharmacy or awaiting refill. -The MAs were responsible for ensuring refills were done on each shift. -She did not know what would be done concerning Resident #B's cholecalciferol weekly dose for the current week. Interview with the DRC on 09/17/21 at4:16pm revealed: -She began working at the facility on 07/12/21. -She expected the MAs to request medication refills if they noticed a medication had 8 tablets remaining. -She expected staff not to wait until there was one tablet or no medication before requesting a refill. -She was not aware that there was no cholecalciferol to administer to Resident #8. -She expected the MAs to tell her if a medication was omitted from the medication pass because the medication was not available. -She would have to notify the PCP to determine if Resident #B's cholecalciferol could be given on an alternative day. Interview with the Administrator on 09/17/21 at	D 358		

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D 358	Continued From page 6 5:32pm revealed: -She was not aware that Resident #8 did not have cholecalciferol available to administer for the medication pass. -She expected the MAs to notify the DRC so that the PCP was notified about the missed medication. Attempted telephone interview with Resident #7's PCP on 09/17/21 at 12:26pm was unsuccessful. Refer to the interview with the DRC on 09/17/21 at 11:34am. Refer to the interview with the Administrator on 09/17/21 at 5:32pm. b. Review of Resident #9's current FL-2 dated 10/30/20 revealed diagnoses included cerebrovascular disease, Alzheimer's disease, and atherosclerotic heart disease. Review of Resident #9's subsequent primary care provider (PCP) orders revealed there was an order dated 11/03/20 for Miralax (used to treat occasional constipation) 17grams in 8 ounces (oz) of beverage of choice every other day. Review of Resident #9's six-month physician orders dated 07/01/21 revealed there was an order for Miralax 17 grams in 8 oz of beverage of choice every other day. Review of Resident #9's September 2021 printed medication administration record (MAR) revealed: -There was an entry for Miralax dissolve 17 grams (as marked on the inside of the cap) in 8 oz of beverage of choice every other day, without a scheduled time. -In the column for time, "QOD" (medical	D 358		

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D 358	Continued From page 7 abbreviation for every other day) was printed. -There was documentation of administration of Miralax on 09/01/21, 09/03/21, 09/05/21, 09/07/21, 09/09/21, 09/11/21, 09/13/21, 09/15/21, and 09/17/21. -There was documentation on the reverse side of the MAR that medications were not given from 09/13/21 to 09/15/21 because Resident #9 was not in the facility. Observation of the 9:00am medication pass on 09/17/21 at 9:19am revealed: -The medication aide (MA) did not prepare Miralax for administration for Resident #9. -The MA administered 14 tablets and one liquid supplement to Resident #9. Interview with Resident#9 on 09/17/21 at 9:26am revealed: -He had surgery and was having pain. -He took the medications provided by the MA. Telephone interview with a pharmacist at the facility contracted pharmacy on 09/17/21 at 11:57am revealed: -There was an order dated 11/03/20 for Resident #9 for Miralax 17 grams in 8 oz. -One 510 gram container of Miralax was dispensed on 11/03/20. -There were no other dispense dates for Resident #9's Miralax. -A 510- gram container of Miralax administered every other day should last 45 days. Interview with the MA who completed the medication pass on 09/17/21 at 12:50pm revealed she did not administer Resident #9's Miralax because she forgot to administer it. Interview with the Director of Resident Care	D 358		

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D 358	Continued From page 8 (DRC) on 09/17/21 at 4:16pm revealed: -She expected the MAs to use the six "Rs" for medication administration; the right resident, the right medication, the right dose, the right time, the right route, and the right documentation. -She was not aware that Resident #9's container of Miralax was dispensed 11/03/20. -Because Resident #9's Miralax was dispensed 11/03/20, staff were falsifying documentation for Resident #9's Miralax. -The MAs were responsible for administering medications as ordered. Interview with the Administrator on 09/17/21 at 5:32pm revealed: -She was not aware that Resident #9 was not receiving Miralax as ordered. -She expected the MAs to administer medications as ordered. -If the MAs were having difficulty with obtaining a medication after a refill request was made, she expected the MAs to notify the DRC. -The MAs should not document that a medication was administered if it was not administered. Attempted telephone interview with Resident #7's PCP on 09/17/21 at 12:26pm was unsuccessful. Refer to the interview with the DRC on 09/17/21 at 11:34am. Refer to the interview with the Administrator on 09/17/21 at 5:32pm. Interview with the DRC on 09/17/21 at 11:34am revealed: -She began working at the facility in July 2021. -She and the newly hired Wellness Coordinator (WC) were responsible for the medication cart audits.	D 358		

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D 358	Continued From page 9 -The Licensed Practical Nurse (LPN) completed audits on all three medication carts in August 2021. -Medication cart audits included checking the cleanliness and tidiness of the carts, ensuring the medication aides (MA) were keeping the carts locked, removing expired and discontinued medications, checking the opened dates on creams and drops, making sure all medications were labeled, keeping liquids separate from tablets, and making sure over the counter medications provided by a resident's family matched the primary care provider's (PCP) order. -Her goal was to complete one cart audit each week. -She performed "random" spot checks of the medication carts. -The MA was responsible for requesting refills of medications from the pharmacy. -She was responsible for contacting the PCP if a new order was needed. -The WC was responsible for making sure all ordered medications were available for administration. -In September 2021, she implemented a daily checklist for the MAs. -The MAs were to complete a daily audit on the medication carts during "down time" on their shifts. -The MAs were supposed to remove expired medications from the cart and make sure all medication was available for administration to the residents. -She was ultimately responsible for the administration of medication. Interview with the Administrator on 09/17/21 at 5:32pm revealed the MAs was responsible for administering medications as ordered and the DRC was responsible for oversight of medication	D 358		

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D 358	Continued From page 10 administration process.	D 358		
D 376	10A NCAC 13F .1005 (b) Self-Administration Of Medications 10A NCAC 13F .1005 Self-Administration Of Medications (b) When there is a change in the resident's mental or physical ability to self-administer or resident non-compliance with the physician's orders or the facility's medication policies and procedures, the facility shall notify the physician. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure compliance with the facility's policies and procedures for self-administration of medications for 1 of 1 sampled resident (#7) with orders to self-administer medications. The findings are: Review of the facility's policies and procedures for self-administration for medications revealed: -If a resident wished to self-administer his/her medica tion, the Director of Resident Care (DRC) (or designee) would assess the resident's ability to participate by completing a Self-Administration of Medication Assessment. The assessment must be completed upon move-in and at the	D 376	**3) 10A NCAC 13F .1005 Self Administration of Medications: When there is a change in the resident's mental or physical ability to self-administer or resident noncompliance with the physician's orders or the facillty's medications policies and procedures, the facility shall notify the physician. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications.** **a) This rule was not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure compliance with the facility's policies and procedures for self-administration of medications for 1 of 1 sampled resident (#7) with orders to self-administer.** **A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:** The Physician for resident #7 was notified of her refusal of the medication Nexium and requested from the Physician to please advise. All medications for resident #7 were reviewed and compared to the facility's medication record for	

resident #7 by the DRC and medications were placed in a lock box in the resident room.

B) The following systemic changes will be made to ensure compliance with this regulation:

b) All Med Techs will be in-serviced by 10/11/21 on proper documentation on the MAR for Self Administration of Medication Residents and the facility's Self Administration of Medication Policy.

c) The Med Tech observed was in-serviced on the day of observation on proper documentation on the MAR for Self Administration of Medication Residents and the facility's Self Administration of Medication Policy.

10/11/21 amended on 10/19/21 WEdwards by phone

d) The Director of Resident Services and/or designee will conduct monthly MAR audits and random room checks for Self Administration residents ongoing for ~~60 days~~ to ensure compliance. WE

amended on 10/19/21 by WE by phone

C) The facility will monitor the corrective actions as follows:

The Executive Director and/or designee will complete random MAR audits and random room checks for 60 days for Self Administration residents to ensure compliance.

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D 376	Continued From page 11 resident 's request. -The DRC would interview the resident to determine their ability to identify, prepare and administer medications/treatments. -Based on the assessment, a decision was made as to whether or not the resident was a candidate for self-administration. This would be recorded on the assessment tool. -A valid written physician's order must be obtained for each resident conducting self-administration of medications/treatments. -The DRC would assess accuracy and compliance of self-administration by periodic observation. -Storage of self-administered medications/treatments will comply with state/federal and community requirements for medication storage. -If the DRC determined that a resident was unwilling/unable to take medications as prescribed, he/she would meet with the resident concerning the need for possible assistance with medications. The DRC would contact the resident's healthcare provider regarding questions, concerns and observations related to the resident's medications. -The self-administration of medications would be documented on the resident's service plan. -An update list of the resident's medications would be maintained in the resident record/file. If the resident is not self-administering all of his/her medications, mark the medication administration record (MAR) to identify individual medications that are self-administered by the resident. -The DRC (or designee) would document communication with the resident and his/her healthcare provider in the resident's record/file. Review of Resident #*l's* current FL-2 dated 12/12/20 revealed:	D 376		

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D 376	Continued From page 12 -Diagnoses included hypertension and dysrhythmia. -There was a medication order for aspirin 81mg daily as needed for headaches. -There was a medication order for metoprolol succinate 25 mg at bedtime. Review of Resident #7's six-month physician's orders revealed there was an order for Resident #7 to self-administer medications signed by her primary care provider (PCP) on 02/03/21. Review of Resident #7's physician visit forms revealed: -There was a physician visit form dated 06/03/21. -Resident #7 was seen for dysphagia and the physician suggestion was a proton-pump inhibitor medication. -There was no date documented for another appointment. Review of Resident #7's physician orders revealed there was an order dated 07/22/21 for Nexium (used to treat certain stomach and esophageal problems and a proton-pump inhibitor) 40mg take one packet daily mixed with foods. Review of Resident #7's six-month physician's orders revealed: -The PCP signed the orders on 09/05/21. -There was an order for Resident #7 to self-administer medications. -There was an order for aspirin 81mg take one tablet daily as needed for headaches. -There was an order for metoprolol 25 mg take one tablet at bedtime. -There was an order for Nexium 40mg take one packet daily mixed with food.	D376		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098030	A. BUILDING: _____ B. WING _____	R 09/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 376	Continued From page 13 Review of Resident #7's July 2021 printed medication administration record (MAR) revealed: -There was a handwritten entry for Nexium 40mg oral packet take one packet daily with meals. -There was an entry to check MAR and medications weekly, without a scheduled time or shift time. -There were lines drawn indicating or highlighting the dates of 07/03/21, 07/10/21, 07/17/21, 07/24/21, and 07/31/21. -There was documentation that the MAR and medications were checked on 07/03/21. -There was no documentation that the MAR and medications were checked on 07/10/21, 07/17/21, 07/24/21, and 07/31/21. Review of Resident #7's August 2021 MAR revealed: -There was a handwritten entry for Nexium 40mg oral packet take one packet daily with meals. -There was an to check MAR and medications weekly, without a scheduled time or shift time. -There were lines drawn indicating or highlighting the dates of 08/07/21, 08/14/21, 08/21/21 and 08/28/21. -There was documentation that the MAR and medications were checked on 08/14/21. -There was no documentation that the MAR and medications were checked on 08/07/21, 08/21/21, and 08/28/21. Review of the Medication Self-Administration Assessment Form for Resident #7 revealed: -The resident's initial assessment was done on 04/13/19. -The resident was reassessed for medication self-administration on 07/06/19, 09/14/19, 12/07/19, 02/22/20, 05/16/20, 08/08/20, 10/24/20, 01/16/21, 04/10/21 and 07/03/21. -There was a checkmark underneath the column	D 376		

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D 376	Continued From page 14 labeled "fully able" beside each of the questions on the forms for all assessment dates. -No issues or concerns were documented on the assessment form. Interview on 09/17/21 at 5:21pm with the facility nurse who did the self-administration assessments revealed she assessed Resident #7 on 07/03/21 and she was not refusing any medications at that time. Interview with Resident#7 on 09/17/21 at 3:38 p.m. revealed: -She self-administered all of her medications, but she did not take many medications. -The medication aides (MA) at the facility did not administer any medications to her. -She was currently self-administering aspirin and metoprolol. -She had a bubble package of metoprolol in her top right dresser drawer. -She took metoprolol at 9:00pm each night. -She had an old pill bottle that previously had metoprolol dispensed in it and now she refilled the bottle by popping out the metoprolol tablets from the bubble package. -She kept the pill bottle containing metoprolol on her bathroom counter near her aspirin bottle. -She took aspirin once daily when she needed because of pain. -She did not take her Nexium. -She took Nexium for a short period of time and stopped. -She was unsure of how long it had been since she last took Nexium. -She read the drug information insert inside her box of Nexium and the instructions confused her.. -She no longer took the Nexium, because she tried to take it at 10:00am on an empty stomach as the insert instructed.	D 376		

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D 376	Continued From page 15 -She had a box of Nexium that she kept on a storage cart in her bathroom. -She had not asked the MAs or the DRC any questions about her Nexium. -The MAs had not come to check her medications in her room. -She did not recall if any staff at the facility had asked her what medications she was taking. -She told the MAs when she needed a medication refill. -She had not told the MAs that she was not taking her Nexium. Observation of Resident #7's medications in her room on 09/16/21 at 9:50 am revealed: -There was a bubble package of metoprolol in the top right drawer of Resident #7's chest of drawers. -There were 8 tablets remaining in the bubble package which was dispensed on 08/30/21. -There was a small over the counter bottle of aspirin on the bathroom sink counter. -There was a larger over the counter bottle of aspirin in the medication cabinet. -There was a box of Nexium 40mg packets in a storage cart in the bathroom. -There were 17 packets remaining in the box of Nexium which was dispensed on 07/22/21. Interview with a MA on 09/16/21 at 5:17 p.m. revealed: -She did not normally check with Resident #7 for compliance with self-administration of her medications. -She usually did not check with any resident who self-administered medications. -She did not ask Resident #7 if she was taking the medications listed on her MAR. -She had not documented on Resident #7's MARs because Resident #7 administered her	0376		

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D376	Continued From page 16 own medication. -Resident #7 did not tell her she was not taking some of her medications or refusing any medications. -She thought a resident who self-administered medications did not need to be checked on by the **MA** -She thought because a resident was assessed to be competent that the MA did not have to check to verify compliance or refusals. -Resident #7 told her when she needed a medication refill. Interview with a second MA on 09/17/21 at 10:40am revealed: -She assumed because residents who self-administered their own medications that they took the medications. -The entry to check the MAR and medications on Resident #7's MARs meant that the MAs should take the MAR and compare it to the medications in Resident #7's room. -She did not know which shift should complete the check of the resident's MARs and medications. -If there was a blank area on the MAR for the entry to check Resident #7's MAR and medications, then it was not done. -The MAs were responsible for doing Resident #7's MAR and medication checks. -Resident #7 had not told her she was not taking her Nexium. -Resident #7 told her when she needed a refill of medication. Interview with the DRC on 09/17/21 at 4:16pm revealed: -Residents who self-administered medications had an order to self-administer medications. -There was a facility nurse who completed the	D376		

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D376	Continued From page 17 self-administration of medication quarterly assessments. -The quarterly assessments were done to verify that the resident was competent to self-administer medications. -She had seen the entry check MAR and medications on the MAR of residents who self-administered medications. -She thought the entry meant the MAs were supposed to ask the residents if there were any changes to their medications. -The first shift MAs were supposed to address this entry on the MARs. -She expected the residents to tell the MAs if they were not taking their medications or if their PCP discontinued a medication. -She expected the facility nurse to tell her if a resident was refusing or did not take a medication. -No one had reported that Resident #7 was no longer taking her Nexium. -She would prefer to know that Resident #7 was no longer taking a medication earlier than quarterly. Interview with the Administrator on 09/17/21 at 5:32pm revealed: -She was not aware that Resident #7 had stopped taking her Nexium. -She expected the MAs to verify the residents' medications completed the weekly check of the resident's MAR and medications. -The MAs were supposed to take the MAR and compare it to the medications in the resident's room. -She was not aware that the MAs were not completing Resident #7's MAR and medication checks for self-administration of medications with the residents weekly. -The MAs were responsible for completing these	D376		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(Xi) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 376	Continued From page 18 checks so that the resident's PCP could be notified if a medication was refused or not taken as ordered. Attempted telephone interview with Resident #7's PCP on 09/17/21 at 12:26pm was unsuccessful.	D 376		
D612	10ANCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility's IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to the screening of residents for COVID-19 signs and symptoms.	D612	**4) 10A NCAC 13F .1801 Infection Prevention and Control Program (temp): When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility's IPCP, related to policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infection disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility.** **This rule was not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure recommendations and guidance established by the CDC, and NCDHHS were implemented and maintained to provide protection of the residents during the global COVID19 pandemic as related to the screening of residents for COVID19 signs and symptoms.**	

A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:

All resident temperatures were taken immediately and The Director of Resident Services immediately in serviced Med Techs that all residents were required to be screened for COVID19 symptoms and temperatures taken daily and logged in the binder that is located at the nurse's station in Assisted Living and Memory Care.

B) The following systemic changes will be made to ensure compliance with this regulation:

a) All Clinical staff will be in-serviced by 10/11/21 on the facility's current COVID19 policy and requirements for screening residents.
b) The Director of Resident Services implemented a schedule for daily screening of residents. The screening is logged in a binder located at the nurse's station in Assisted Living and Memory Care.
c) The Director of Resident Services and/or designee will complete weekly random checks ~~for 60 days~~ to ensure compliance with the daily screening logs

C) The facility will monitor the corrective actions as follows:

The Executive Director and/or designee will complete random audits for 60 days to ensure compliance with the daily screening logs.

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D 612	Continued From page 19 The findings are: Observation upon entrance to the facility on 09/16/21 at 8:40am revealed: -Staff offered screening after entrance was allowed and completed a screening log. -Staff completed the screening at the front desk, which included a temperature check. Review of the Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes and Long Term Facilities dated 09/10/21 revealed: -Staff should ask residents to report if they feel feverish, any symptoms consistent with COVID-19 or acute respiratory infection. -Staff should actively monitor all residents daily for fever and symptoms consistent with COVID-19. Review of the Centers for Disease Control and Prevention (CDC) Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities dated 03/29/21 revealed all residents and staff should screen daily for symptoms consistent with COVID-19 (fever or chills, cough, shortness of breath or difficulty of breathing, fatigue, headache, body aches, loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting and diarrhea. Review of the NC Department of Health and Human Services COVID-19 Long Term Care (LTC) Infection Control Assessment and Response Tool for local health department (LHD) dated 10/2020 revealed staff and residents should be screened daily for fever, signs and symptoms of COVID-19.	D 612		

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D 612	Continued From page 20 Review of the facility's COVID-19 policy revealed: -There was no date on the document. -There were guidelines for screening, visitation, face masks, dining room, activities, transportation, admissions, leave of absence, suspected COVID-19 exposure and confirmed COVID-19 for residents. -The guidelines for screening were that all staff should obtain their temperatures at the beginning of their shifts. -Residents should be screened when returning from a temporary leave of absence such as a medical appointment. -Visitors, vendors and contractors should be screened. -The facility should have one entrance and a method to determine to screen all Assisted Living (AL) residents or identify the AL residents who should be screened. Review of two residents' July 2021, August 2021, and September 2021 medication administration records (MARs) revealed there was no documentation of daily temperatures or COVID-19 signs and symptoms. Review of the Assisted Living (AL) residents' temperature logs revealed: -The temperature logs were for dates in August 2021 and September 2021. -There were temperature logs dated 08/13/21, 08/16/21, 08/17/21, 08/19/21, 08/23/21, 08/25/21, 08/26/21, 08/31/21, from 09/03/21 to 09/05/21, 09/07/21, 09/08/21 and 09/10/21. -There were no resident temperature logs for July 2021 and the week of 09/12/21 to 09/17/21. Review of the Special Care Unit (SCU) residents' temperature logs revealed: -The temperature logs were in a binder.	D 612		

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D 612	Continued From page 21 -There were temperature logs for each SCU resident from 08/13/21 to 08/27/21 and 08/29/21. -There were no temperature logs for July 2021, 08/28/21, and September 2021. Interview with a resident on 09/16/21 at 9:40am revealed: -Staff checked his temperature daily. -She doesn't remember any staff ever asking if she had symptoms like shortness of breath or cough. Interview with a second resident on 09/16/21 at 9:21am revealed: -She had her temperature checked monthly. -She could not remember the last time staff took her temperature. Interview with a third resident on 09/17/21 at 3:38pm revealed: -Staff checked her blood pressure and temperature monthly. -Staff have never asked if she had symptoms like coughing. Interview with a medication aide (MA) on 09/17/21 at 8:00am revealed: -The Administrator provided updates to staff concerning COVID-19 and held a staff meeting in August 2021. -She did not monitor the residents' temperatures daily when she worked. -When residents were quarantined, their temperatures were taken daily until the quarantin·e ended. -There was a thermometer for use at the facility. -She documented the resident's temperatures on a temperature log. -The residents' temperature logs were kept in a binder.	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 612	Continued From page 22 -She screened herself when she worked by taking her temperature and documented her temperature on the screening log at the front desk. -She did not know the residents' temperatures needed to continue to be obtained daily. -There were no residents' temperatures obtained *for* September 2021 because there were no residents on quarantine. Interview with another MA on 09/17/21 at 11:35am revealed: -Residents' temperatures were obtained monthly. -When residents were on quarantine, the MAs obtained residents' temperatures daily. -The MAs no longer obtained residents temperatures daily because they were no longer on quarantine. Interview with the Director of Resident Care (DRC) on 09/17/21 at 4:16pm revealed: -She expected residents' temperatures to be obtained daily. -She read portions of the CDC guidelines concerning COVID-19 but had not completed the guidelines yet. -She knew residents' temperatures were supposed to be monitored daily. -She had noticed that the temperatures documented were not daily, and she sent a group message to all staff. -She had also told staff verbally to obtain residents' temperatures daily. -She was not able to locate any other residents' temperatures *for* September 2021. -The facility's regional nurse told them that the documentation of the residents' temperatures obtained in July 2021 did not have to be saved. -She was not able to provide any documentation that residents' temperatures were obtained in July	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 612	Continued From page 23 2021. -She was not aware that staff stopped obtaining residents' temperatures for September 2021. -She held the MAs and PCAs responsible for screening the residents for COVID-19 by obtaining residents' temperatures. Interview with the Administrator on 09/17/21 at 5:32pm revealed: -The facility had a COVID-19 policy. -Due to the increase in COVID-19 cases within the community, the facility required staff to wear a KN-95 face mask, visitors and staff were screened daily. -Two residents tested positive for COVID-19, and all the residents were tested but none were positive. -The local health department (LHD) nurse provided guidance on how long to quarantine staff and residents. -She expected staff to obtain the residents' temperatures daily. -She knew the current CDC COVID-19 guidelines for long term care facilities related to screening for residents. -She held a staff meeting in August 2021 and provided updates for staff concerning COVID-19. -The MAs were responsible for ensuring the daily temperatures and monitoring of COVID-19 signs and symptoms for residents were completed.	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 079	Continued From page 3 -She or the DRC would contact the local medical supply company to pick up the empty 02 cylinders. -She, the MAs, the PCAs, and the DRC were responsible for ensuring oxygen cylinders were stored securely in a rack or crate.	D 079		
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 administer medications as ordered for 2 of 3 residents (#8 and #9) observed during the medication pass including errors with the unavailability of a vitamin supplement scheduled for administration during the medication pass (#8), and not administering a laxative (#9). 1. The medication error rate was 7.4% as evidence by the observation of 2 errors out of 27 observations during the 9:00am medication pass on 09/17/21. a. Review of Resident #S's current FL-2 dated 07/13/21 revealed: -Diagnoses included major depressive disorder, dementia, and hypertension.	D 358	**2) 10A NCAC 13F .1004(a) Medication Administration: An Adult Care Home shall assure that the preparation and administration of medications, prescription and non-perscription, and treatments by staff are in accordance with: orders by a licensed prescribing practitioner which are maintained in the resident's record; and rules in this section and the facility's policies and procedures.** **a) This rule was not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 2 of 3 residents (#8 and #9) observed during the medication pass including errors with the unavailability of a vitamin supplement scheduled for administration during the medication pass (#8), and not administering a laxative (#9).** **A) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:**	

Parkwood Village & The Landing
Oxygen Management
9-17-21

Print	Signature
Letha Archie	
Sara Clark	
Zabrecya Labatte Rouse	
Sharon Daniel	
Brianna Olson	
Ginger Jones	
Kristella Applewhite	
Amanda Vincent	
Tiffany Holland	
Stacy Newsome	
Tricia Joyner	
Legacy Tatman	
Jennifer Sharp	
Emma Rodgers	
Brianna Olson	
Shakira Knight	
Chantanc Hamlett	
Sharon Daniel	
Sara Clark	
Carolina A. McNeil	
Alexis Taylor	
Talentha Fuller	
Autumn Bright	

Parkwood Village & The Landing

In-service on proper documentation on MARs for medications not administered & reporting medications not available in community.

10-11-2021

Print	Signature
Letha Archie	
Sara Clark	
Gabaeha Tabatha Rouse	
Sharon Daniel	
Brianna Olson	
Ginger Jones	
Rashelda Applewhite	
Amanda Vincent	
Tiffany Hallard	
Stacy Newsome	
Tricia Joyner	
Legacy Eatmon	
Cindy Sharp	
Emma Rodgers	
Brianna Olson	
Shakira Knight	
Constance Hamlett	
Sharon Daniel	
Sara Clark	
Carolina A. McNeil	
Alexis Taylor	
Taleatha Fuller	
Antwan Bright	
Erin Green	

Parkwood Village & The Landing

In-service on proper documentation on MARs related to Self Administration of Medication & Self Administration Medication Policy.

10-11-2021

Print	Signature
Letha Archie	
Sara Clark	
Galeatha Tabatha Rouse	
Sharon Daniel	
Brianna Olson	
Ginger Jones	
Rashetta Applewhite	
Amanda Vincent	
Tiffany Holland	
Stacy Nemsome	
Tricia Joyner	
Legacy Latrhon	
Cornet Sharp	
Emma Rodgers	
Brianna Olson	
Shakira Knight	
Constance Hamlett	
Sharon Daniel	
Sara Clark	
Caroline A. McNeil	
Alexis Taylor	
Taleatha Fuller	
Autumn Bristol	
Curtin Green	

Edwards, Wanda A

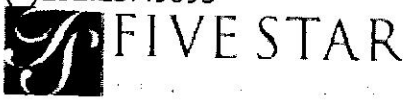
From: Waters, Jaime <JWATERS@5SSL.COM>
Sent: Tuesday, October 19, 2021 11:01 AM
To: Edwards, Wanda A
Subject: [External] Parkwood Village POC
Attachments: ParkwoodPOC10-18-21.pdf

See attached. Let me know if you need anything else.

Thank you,

Jaime Waters
Executive Director

Parkwood Village and The Landing
1730 Parkwood Blvd.
Wilson, NC 27893
(O)252.237.9050
(M)252.294.8071
(F)252.237.9093



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