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 _____	R 02/14/2023

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 a follow-up survey on February 14, 2023.	C 000		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled residents (#1) had completed tuberculosis (TB) testing upon admission. The findings are: Review of Resident #1's current FL2 dated 08/30/22 revealed diagnoses included severe bipolar affective disorder, schizoaffective disorder, and history of seizures. Review of the Resident Register for Resident #1 revealed an admission date of 09/09/21. Review of Resident #1's immunization records revealed there was documentation of a negative tuberculosis (TB) skin test dated 09/03/21.	C 202		

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 _____	R 02/14/2023

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 202	Continued From page 1 Interview with Resident #1 on 02/14/23 at 3:05pm revealed she was not sure if she had two TB skin tests completed upon admission. Interview with the Supervisor-in-Charge (SIC) on 02/14/23 at 2:10pm revealed: -Resident #1 did not have her second TB skin test completed. -She was aware that residents were required to have two TB skin tests on admission, but she had forgotten about the second TB test. -It was her responsibility to ensure residents' TB testing was completed.	C 202		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication	C 342		

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 _____	R 02/14/2023

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 342	Continued From page 2 administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the accuracy of Medication Administration Records (MARs) for 1 of 3 sampled residents (#1) related to documentation for administration of a stool softener. The findings are: Review of Resident #1's current FL2 dated 08/30/22 revealed: -Diagnoses included severe bipolar affective disorder, schizoaffective disorder, and history of seizures. -There was an order for docusate sodium 100mg twice daily (a medication used to prevent constipation). Review of Resident #1's February 2023 MAR from 02/01/23 to 02/14/23 revealed: -The MARs were a mixture of typed and hand-written medication order entries. -There was a hand-written entry for docusate sodium 100mg take 1 capsule twice daily. -There was a hand-written time entry space for docusate sodium to be administered for an 8:00am administration time. -There was not a second time entry space for docusate sodium written on the MAR. Observation of Resident #1's medications on hand on 02/14/23 at 3:03pm revealed there was a medication bubble pack labeled docusate sodium 100mg take one capsule twice daily with a dispensed date of 02/03/23 with 40 of 60 capsules remaining.	C 342		

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 _____	R 02/14/2023

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 342	Continued From page 3 Telephone interview with a representative from the facility's contracted pharmacy on 02/14/23 at 3:32pm revealed: -There was an active order on file for docusate sodium 100mg tablets twice daily for Resident #1. -Docusate sodium 100mg tablets were dispensed for Resident #1 on 02/03/23 for a quantity of 60 tablets. -If Resident #4's docusate sodium 100mg capsules were administered as ordered, there would be about 40 capsules remaining. Interview with Resident #1 on 02/14/23 at 3:05pm revealed she thought she was getting all her medications as ordered, including docusate sodium. Interview with the Supervisor-in-Charge (SIC) on 02/14/23 at 2:15pm revealed: -The pharmacy normally placed order entries and time slots on the MARs, but sometimes she had to manually write orders and time slots on the MAR. -She had administered Resident #1's docusate sodium to her twice a day as ordered. -She did not know why she did not add the 8:00pm time slot for docusate sodium to the MAR.	C 342		