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 02/29/2024

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 02/29/24.	C 000		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents (#1) regarding an order to discontinue calcium carbonate. The findings are: Review of Resident #1's current FL-2 dated 07/19/23 revealed diagnoses included Pica and undifferentiated schizophrenia. Review of Resident #1's after-visit summary dated 01/19/24 revealed there was a physician's order for calcium carbonate 600 mg (a calcium supplement used to treat low calcium levels) to be discontinued. Review of Resident #1's January 2024 Medication Administration Record (MAR)	C 330		

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C 330	Continued From page 1	C 330		

revealed:
-There was an entry for calcium carbonate 600mg and scheduled to be administered at 8:00am.
-Calcium carbonate was documented as administered at 8:00am from 01/01/24 to 01/31/24
-There was no entry on the MAR to discontinue calcium carbonate.

Review of Resident #1's February 2024 MAR revealed:
-There was an entry for calcium carbonate 600mg and scheduled to be administered at 8:00am.
-Calcium carbonate was documented as administered at 8:00am from 02/01/24 to 02/29/24.

Observation of Resident #1's medications on hand on 02/29/24 at 12:25pm revealed:
-Calcium carbonate 600mg was on the medication cart and available for administration.
-There was a bubble pack of calcium carbonate 600mg which had been dispensed on 02/13/24.

Interview with Resident #1 on 02/29/24 at 12:45pm revealed he was not aware his primary care provider (PCP) had discontinued the calcium carbonate for use on 01/19/24.

Telephone interview with the facility's contracted pharmacy consultant on 02/29/24 at 1:00pm revealed:
-She was not aware Resident #1's PCP had discontinued the calcium carbonate on 01/19/24.
-She had an active order for Resident #1's calcium carbonate, and she last dispensed 30 tablets of calcium carbonate 600mg on 02/13/24.
-She expected the facility to follow-up with her

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C 330	Continued From page 2 when orders were changed by the PCP. Telephone interview with Resident #1's PCP on 02/29/24 at 1:30pm revealed: -He had ordered Resident #1's calcium carbonate to be discontinued on 01/19/24 and ordered an alternative medication to treat Resident #1. -He expected the facility to follow up with his office related to questions or concerns with medication orders. -The PCP expected the facility to follow his orders to discontinue Resident #1's calcium carbonate and the PCP would expect possible diarrhea and possible dehydration if the facility failed to follow his order. Interview with the medication aide/Supervisor-in-Charge (MA/SIC) on 02/29/24 at 3:00pm revealed: -She was not aware Resident #1's calcium carbonate was discontinued on 01/19/24. -She had not reviewed any of the PCP after-visit summaries for Resident #1 and she had continued to administer calcium carbonate to him. -The Administrator was responsible for reviewing the PCP after-visit summaries for medication changes that were ordered by the PCP. Interview with the Administrator on 02/29/24 at 2:30pm revealed: -She was responsible for reviewing the PCP after-visit summaries for medication changes and she was responsible for providing the medication changes ordered to the pharmacy. -She and the MAs were responsible for adding and for removing medications from the MAR based on PCP orders. -She was not aware Resident #1's PCP had discontinued the calcium carbonate on the 01/19/24 on the after-visit summary and she had	C 330		

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C 330	Continued From page 3 overlooked that detail. -She knew she should have reviewed the PCP after-visit summary and she should have changed the MAR, but it was an oversight.	C 330		
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 administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 3 sampled residents (Resident #3) including inaccurate documentation for an antibiotic medication.	C 342		

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C 342	Continued From page 4 The findings are: Review of Resident #3's current FL2 dated 10/12/23 revealed diagnoses included hypertension, multiple sclerosis, and epilepsy. Review of Resident #3's urology after visit summary dated 02/26/24 revealed there was an order for cephalexin 500mg 1 capsule 4 times daily for 7 days. Review of Resident #3's medication administration record (MAR) for February 2024 revealed there was not an entry for cephalexin 500mg 1 capsule 4 times daily for 7 days. Review of Resident #3's record revealed there was no documentation cephalexin had been administered to Resident #3. Observation of medications available to Resident #3's on 02/29/24 at 10:45am revealed: -There was a bottle of cephalexin 500mg 1 capsule 4 times daily for 7 days was available on the medication cart. -Cephalexin was dispensed to the facility on 02/26/24 with a quantity of 28 capsules. -It could not be determined how many capsules of cephalexin were remaining. Telephone interview with the facility's contracted pharmacy on 02/29/24 at 11:04am revealed cephalexin 500mg 1 capsule 4 times daily for 7 days was dispensed to the facility on 02/26/24 with a quantity of 28 capsules. Interview with a medication aide (MA)/supervisor-in-charge (SIC) on 02/29/24 at 11:28am revealed: -She had been administering cephalexin to	C 342		

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C 342	Continued From page 5 Resident #3 four times daily at 8:00am, 12:00pm. 4:00pm, and 8:00pm. -She did not document administration of cephalexin to Resident #3 on the MAR. -She was not on duty when cephalexin was delivered to the facility by the pharmacy on 02/26/24, and she had not thought about entering cephalexin to the MAR when she returned to work on 02/28/24. -MARs were delivered to the facility monthly for each resident. -If a resident received physician's orders for a new medication after the MARs were delivered, she and the Administrator were responsible for writing new medications onto the resident's MAR. Interview with the Administrator on 02/29/24 at 11:48am revealed: -She and the MA/SIC were responsible for writing new medication orders on the paper MARs. -She did not realize cephalexin was not written on Resident #3's February MAR and she may have just overlooked entering the order entry on the MAR. -Cephalexin had been administered to Resident #3 four times daily since 02/26/24.	C 342		
C 381	10A NCAC 13G .1009(b) Pharmaceutical Care 10A NCAC 13G .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by:	C 381		

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Based on interviews and record reviews, the facility failed to ensure that action was taken in response to the quarterly pharmaceutical review recommendation for 2 of 3 sampled residents (#1 and #3) related to blood work for a medication (#1) and blood pressure monitoring and a low salt diet (#3).

The findings are:

1. Review of Resident #3's current FL2 dated 10/12/23 revealed:
-Diagnoses included hypertension.
-There was an order for a medication used to treat hypertension.
-Resident #3 was to be served a regular diet.
-There were no orders for blood pressure monitoring.

Review of Resident #3's quarterly pharmacy review dated 11/23/23 revealed:
-There was a recommendation to monitor Resident #3's blood and to use a low salt diet.
-There was no documentation Resident #3's primary care provider (PCP) had reviewed or responded to the pharmacist's recommendations.

Review of Resident #3's medication administration records (MARS) for December 2023, January 2024, and February 2024 revealed there was no documentation of any blood pressure readings for Resident #4.

Review of the facility's undated therapeutic diet list revealed Resident #3 was to be served a regular diet.

Telephone interview with the facility's contracted pharmacy consultant on 02/29/24 at 11:04am revealed:

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C 381	Continued From page 7 -She made the recommendation on 11/23/23 to monitor Resident #3's blood pressure and for her to use a low salt diet due to her diagnoses of hypertension. -She expected the facility to follow-up with Resident #3's PCP regarding her recommendations, but she did not know if the facility had followed up or not. Interview with the medication aide/Supervisor-in-Charge (MA/SIC) on 02/29/24 at 11:28am revealed: -The Administrator was responsible for reviewing the quarterly pharmacy reviews for recommendations. -She had not reviewed any of the quarterly pharmacist reviews and was not aware of the pharmacist recommendations for Resident #3. Interview with the Administrator on 02/29/24 at 11:20am revealed: -She was responsible for reviewing the quarterly pharmacy reviews for recommendations and for following up on them. -She had not followed up with Resident #3's PCP about the pharmacist's recommendations from the quarterly pharmacy review on 11/23/23. -During one of Resident #3's visits, her blood pressure was high, but his PCP did not say anything about checking her blood pressures; she just put Resident #3 on a medication used to treat high blood pressure. -She knew she should have followed up with Resident #3's PCP regarding the pharmacist's recommendations, but it must have been an oversight. Attempted telephone interview Resident #3's PCP on 02/29/24 at 12:01pm was unsuccessful.	C 381		

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2. Review of Resident #1's current FL2 dated 07/19/23 revealed:
-Diagnosis included undifferentiated schizophrenia.
-There was an order for Depakote ER 250mg for 3 tablets to be given before bedtime. (used to treat schizophrenia).

Review of Resident #1's quarterly pharmacy review dated 02/017/24 revealed:
-There was a recommendation to obtain Resident #1's bloodwork for Depakote.
-There was no documentation Resident #1's primary care provider (PCP) had reviewed or responded to the pharmacist's recommendations.

Review of Resident #1's January 2024 medication administration records (MARs) revealed:
-There was an entry for Depakote ER 250mg scheduled to be administered at bedtime.
-Depakote was documented as administered from 01/01/24 to 01/31/24.
-There was no documentation on completed bloodwork for Resident #1.

Review of Resident #1's February 2024 medication administration records (MARs) for 02/17/24 through 02/29/24, revealed:
There was a entry for Depakote ER 250 mg scheduled to be administered at bedtime.
-Depakote was documented as administered from 02/01/24 to 02/28/24.
-There was no documentation on completed bloodwork for Resident #1.

Interview with Resident #1 on 02/29/24 at 12:45pm revealed:
-He was not aware of any recommendations to get bloodwork completed recently.

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-He had not attended any appointments for bloodwork recently and was not aware if the facility had an appointment scheduled for bloodwork.

Telephone interview with the facility's contracted pharmacy consultant on 02/29/24 at 1:00pm revealed:
-She made the recommendation on 02/17/24 to obtain Resident #1's bloodwork for Depakote related to his diagnosis of schizophrenia.
-She expected the facility to follow-up with Resident #1's primary care physician (PCP) regarding her recommendations.
-She had not received follow-up documentation from Resident #1's PCP or from the facility which had clarified results for the resident's completed bloodwork.

Telephone interview with Resident #1's PCP on 02/29/24 at 1:30pm revealed:
-The PCP was not aware of the pharmacists' recommendations on 2/14/24 to obtain Resident #1's bloodwork for Depakote.
-The PCP expected the facility to follow-up with the pharmacists' recommendations for Resident #1 to his office in a timely manner.

Interview with the medication aide/Supervisor-in-Charge (MA/SIC) on 02/29/24 at 3:00pm revealed:
-The Administrator was responsible for reviewing the quarterly pharmacy reviews for recommendations.
-She had not reviewed any of the quarterly pharmacist reviews and was not aware of the pharmacy recommendations for Resident #1.

Interview with the Administrator on 02/29/24 at 2:30pm revealed:

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C 381	Continued From page 10 -She was responsible for reviewing the quarterly pharmacy reviews for recommendations and for following on those recommendations with the PCP. -She was aware of the pharmacy's recommendations to obtain Resident #1's bloodwork for Depakote, but she had not followed up with Resident #1's PCP about the pharmacist's recommendations from the quarterly pharmacy review on 02/17/24. -She should have followed up with Resident #1's PCP regarding the pharmacy's recommendations, but it must have been an oversight.	C 381		