FORM APPROVED

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 07/25/2024

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 and Wilson County Department of Social Services conducted a follow-up survey on July 24, 2024 and July 25, 2024.	D 000		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .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 ensure the medication aide (MA) observed 1 resident (#1) take her medications before documenting the medication was administered as evidenced by 3 tablets of Resident #1's medication found in the resident's room unsupervised and unsecure from other residents with dementia and wandering behavior. The findings are: Review of Resident #1's current FL-2 dated 03/18/24 revealed diagnoses included Alzheimer's disease, muscle weakness, difficulty walking, and asthma. Review of physician orders for Resident #1 revealed:	D 366		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jamme Wa[illegible] TITLE: ED (X6) DATE: 8-20-2[illegible]

STATE FORM 6899 PRLC11

Received via email August 20, 2024.
Reviewed and Acknowledged August 22, 2024. [illegible], R

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D 366	Continued From page 1 -There was an order for Mirtazapine F/C (generic for Remeron and used to treat insomnia) 15mg tablet at bedtime. -There was an order dated 05/14/24 to begin Seroquel (used to treat mood disorders) 100mg twice a day. -There was a subsequent order dated 06/21/24 to discontinue the Seroquel 100mg twice daily and begin Seroquel 100mg tablet in the morning and Seroquel 100mg take two tablets every night. Review of Resident #1's July 2024 medication administration records (MARs) revealed: -There was an entry for Mirtazapine F/C 15mg tablet at bedtime daily scheduled for 8:00pm. -There was documentation for administration of the Mirtazapine 15mg tablet at 8:00pm daily from 07/01/24 through 07/23/24. -There was an entry for Seroquel 100mg two tablets at bedtime daily scheduled for 8:00pm. -There was documentation for administration of the Seroquel 100mg two tablets at 8:00pm daily from 07/01/24 through 07/23/24. Observation during the initial facility tour on 07/24/24 at 9:50am revealed: -There was a clear medication cup visible on the sink countertop and visible from the doorway of Resident #1's room. -There were two round yellow tablets and one yellow small oblong tablet inside the medication cup. -Resident #1 was alone in her room and in bed with her eyes closed, and there was no medication aide (MA) in the resident's room or within view of the medications. Interview with the Wellness Coordinator (WC) on 07/24/24 at 9:50am, who approached upon request of the surveyor, revealed:	D 366		

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D 366	Continued From page 2 -Resident #1 did not self-administer medications. -She did not know what the pills were in the medication cup on the countertop in Resident #1's room. -She had not been in Resident #1's room the morning of 07/24/24. -She would contact the MA to find out about the three medications in the cup in Resident #1's room. Interview with Resident #1 on 07/24/24 at 9:52am revealed: -She could not tell the surveyor her name and stated she had forgotten her name. -At 9:53am, the resident stated her name. -She had not been administered any medication on 07/24/24. -She did not know the names of her medications. Interview with the MA on 07/24/24 9:54am revealed: -She was not sure what the three tablets were in the medication cup in Resident #1's room. -She administered medication to Resident #1 in the hall on the morning of 07/24/24. -Resident #1's medications were crushed and mixed with chocolate pudding. Interview with the Director of Resident Care (DRC) on 07/24/24 at 9:58am revealed: -The medications in the cup in Resident #1's room were Remeron and two Seroquel tablets. -Resident #1 was supposed to be administered the medications at 8:00pm. -It was a "good question" when asked why the medications were still in Resident #1's room, and Resident #1 was "good" about taking her medications. Observation of Resident #1's medications on	D 366		

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D 366	Continued From page 3	D 366		

hand on 07/24/24 at 10:00am revealed:
-There was a pharmacy labeled bubble pack of Mirtazapine F/C (generic for Remeron) 15mg tablets take one tablet at bedtime.
-The printed pharmacy label documented 30 tablets were dispensed on 06/25/24 and there were 7 tablets remaining.
-There was a pharmacy labeled bubble pack of Quetiapine Fumarte (generic for Seroquel) 100mg tablets take one tablet every morning and two tablets every night.
-The printed pharmacy label documented 90 tablets were dispensed on 07/02/24 and there were 56 tablets remaining.

Interview with a MA on 07/24/24 at 2:49pm revealed:
-Resident #1 got confused sometimes.
-There were no residents living on the same hall as Resident #1 that were wanderers.

Telephone interview with a second MA on 07/24/24 at 4:25pm revealed:
-She worked as the MA on 07/23/24 on the 3:00pm - 11:00pm shift.
-When she administered medications to Resident #1, she usually had to find the resident first.
-Resident #1 was administered medications, including two Seroquels and one Mirtazapine.
-Resident #1 usually stood by the sink in her room to take her medications.
-She allowed the resident to get her pills in her mouth before she took the medication cup.
-The resident handed her (MA) the pill cup once she (resident) "dumped" the pills in her mouth.
-She gave Resident #1 medications in the resident's room on night of 07/23/24 while the resident was at the sink running water. The resident took her pills.
-The pills found in the medication cup in Resident

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D 366	Continued From page 4 #1's room on 07/24/24 could have come from pills prior to 07/23/24. -She always made sure Resident #1 took her pills. -Resident #1 had dementia. -She could not answer how the pills got on the sink countertop in Resident #1's room. Interview with the DRC on 07/24/24 at 5:00pm revealed: -She instructed everyone to watch the residents take their medications. -When she administered medications, some of the residents would tell her she could go ahead and leave the medications. Review of current FL-2's for residents residing on the hall with Resident #1 revealed there were 2 of 3 additional residents who were intermittently disoriented and 1 of the 3 additional residents with wandering behavior. Interview with the Mental Health Provider for Resident #1 on 07/25/24 at 2:24pm revealed: -Resident #1 was prescribed Remeron 15mg at bedtime and Seroquel 100mg tablet every morning and two tablets at night. -There were Seroquel 100mg tablets that were yellow and round. -Seroquel 200mg would be a high dose for someone not used to taking it and would make someone overly sedated, sleepy, somnolent, tired, groggy, and a fall risk. -Remeron would make someone drowsy or might be hungry because Remeron was an appetite stimulant. -Resident #1 had a significant bipolar disorder in the past. -The Seroquel and Remeron were more of comfort medications for the resident now.	D 366		

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D 366	Continued From page 5 Attempted telephone interview with the Administrator on 07/25/24 at 1:19pm was unsuccessful. Interview with the DRC on 07/25/24 at 1:19pm revealed: -The Regional Director was in the facility and available for interview if needed. -The Administrator's supervisor was available by phone in the absence of the Administrator. -Resident #1's medications could not be left at the bedside. -The MAs were expected to see the residents take their medications. -She expected the MAs to take a little extra time and make sure the residents took medications and swallowed them.	D 366		

Preparation and/or execution of this plan of corrections 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-098-029

1) 10A NCAC 13F. 1004(i) Medication Administration
Based on observations, interviews, and record reviews, the facility failed to ensure the medication aide observed one resident take her medications before documenting the medication was administered as evidenced by 3 tablets of the resident's medication found in the resident's room unsupervised and unsecure from other residents with dementia and wandering.

   a) *Training to be completed on medication technicians for the Basics of Medication Management to include emphasis on ensuring no medications are left in resident's room without the Medication Technician supervision.*
   b) *DRC and/or designee to observe a medication pass weekly for 4 weeks then monthly.*
   c) *ED and/or designee to review the medication pass observations completed by the DRC and/or designee weekly for 4 weeks then monthly.*

The date of correction for this will be no later than 8-16-24