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 02/27/2025

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 February 26, 2025 and February 27, 2025.	D 000	See attached	
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A 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 and interviews, the facility failed to ensure the facility was free of obstructions and hazards by free-standing, unsecured oxygen tanks being stored in a resident's room on Assisted Living (AL). The findings are: Observation of the resident suite, room108b on 02/26/25 at 9:51am revealed: -There were four oxygen tanks, standing upright and unsecured on the floor placed against the wall. -The four oxygen tanks were not placed in a cylinder rack. -There was one oxygen tank placed in a cylinder rack placed against the wall. -All five of the oxygen tanks were full. Interview with the resident on 02/26/25 at 9:52am revealed:	D 079		

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

Jan Watts — Executive Director 3-31-25

Reviewed and Acknowledged SC 4/14/25

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D 079	Continued From page 1 -He used oxygen because of his diagnosis of chronic obstructive pulmonary disease (COPD). -He used his concentrator and did not need to use the oxygen tanks. -He could not remember how long he had the oxygen tanks but knew the tanks had not been stored in a cylinder rack. Interview with the contracted company on 02/27/25 at 3:35pm revealed: -They provided oxygen supplies. -The resident had a regular concentrator and portable oxygen tanks. -There were 5 tanks delivered to the resident at the facility on 11/26/24. -The facility had not returned any unused or empty tanks. -Oxygen tanks were delivered and set up in a cylinder rack. -She was not sure why the resident did not have a cylinder rack for the oxygen tanks. Interview with a medication aide (MA) on 02/27/25 at 11:00am revealed: -She had not observed the resident using his concentrator or an oxygen tank. -She did not know if the resident had an order for oxygen. -Residents who used oxygen had an as needed (PRN) or scheduled order for oxygen. -Oxygen tanks were stored in a crate and kept in the residents' room. -Empty oxygen tanks were returned to the contracted company. Interview with the Maintenance Director on 02/27/25 at 4:09pm revealed: -He knew the resident used oxygen. -The contracted company delivered the oxygen tanks and set them up in a cylinder rack.	D 079		

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D 079	Continued From page 2 -He did not remember the resident being admitted to the facility with oxygen tanks. -He would learn of residents who used oxygen in a staff meeting when safety community would be addressed. -He was responsible for completing room checks for residents who used oxygen to ensure all oxygen tanks were stored in a crate. -If the oxygen tanks were not in a crate he would call the contracted company to request a crate to store the oxygen tanks. -Oxygen tanks that were not stored properly could fall over and cause an explosion. Interview with the Licensed Health Professional Support (LHPS) nurse on 02/27/25 at 11:49am revealed: -The resident required oxygen because of his diagnosis of COPD. -The resident had not used the oxygen tanks because he rarely left his room or the facility and preferred to use his concentrator. -The resident kept the oxygen tanks stored in his room. -She was unsure how the oxygen tanks were stored but should be stored in a crate. Interview with the Director of Health and Wellness (DHW) on 02/27/25 at 11:54am revealed: -The resident had an order for oxygen. -The resident was admitted to the facility from a rehabilitation facility with the oxygen tanks and a concentrator. -Residents were to have all oxygen tanks stored in a crate to prevent them from falling over. -The maintenance staff were to complete walk throughs of residents' rooms who had oxygen tanks to ensure the tanks were stored properly. -She completed walk throughs of residents' rooms quarterly.	D 079		

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D 079	Continued From page 3 -Her last walk through of the facility to check residents' rooms was last week (date not provided). -She was person responsible for ensuring all concentrators and oxygen tanks are stored and used properly. Interview with the Administrator on 02/26/25 at 4:30pm revealed: -She was unaware that there were free-standing and unsecured oxygen tanks in the resident's room. -All oxygen tanks were to be stored safely in a crate and all empty oxygen tanks were to be returned to the contracted company. -Oxygen tanks that were not stored properly could fall over and cause an explosion. -The maintenance staff and the DHW were responsible for checking all residents' rooms who used oxygen to ensure the tanks were stored securely in a crate. Observation of the resident suite, room 108 b on 02/25/27 at 4:16pm revealed the four oxygen tanks were placed in a 6 cylinder rack. Interview with the Health and Wellness Director on 02/27/25 at 4:15pm revealed: -She was not aware Resident #3 had ordered more oxygen canisters and they were stored unsecured in his room. -She was part of monthly safety meetings but the safety topic was sent from the corporate office. -The Maintenance Director was expected to conduct daily safety rounds to look for hazards. Interview with the Administrator on 02/27/25 at 3:55pm revealed: -Resident #3 had oxygen canisters delivered to the facility without staff knowledge and the company delivered the canisters and left them	D 079		

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D 079	Continued From page 4 unsecured. -She was not aware oxygen canisters were stored unsecured in the Resident #3's room. -Oxygen canisters were supposed to be secured in a crate when stored for safety. -Facility staff were trained upon hire during orientation and during online resident safety trainings that were done annually. -Staff were expected to identify and report hazards during general rounds. -The Maintenance Director and the Health and Wellness Director lead monthly safety meetings but she was not sure if oxygen canister storage had specifically been addressed.	D 079		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to maintain a current list with physician ordered therapeutic or modified diets for guidance of food service for 3 of 6 sampled residents (#1, #3 and #4). The findings are:	D 309		

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D 309	Continued From page 5 1. Observation of the dinner meal on 02/26/25 at 4:10pm to 4:45pm revealed: -Resident #1 was served lima beans, chicken pastry, water and coffee. -Resident #1 ate 100% of the lunch meal. -Resident #1 was served a regular diet meal. Review of Resident #1's current FL-2 dated 08/26/24 revealed: -Diagnoses included type II diabetes with diabetic polyneuropathy, vasomotor rhinitis, and hyperlipidemia. -The diet order was a diet order for controlled carbohydrate regular diet (CCHO). Review of the regular diet menu for the lunch meal on 02/26/25 at 10:21am revealed: -There was an entry for chicken pastry or broccoli and cheese soup. -There was an entry for lima beans and dinner roll. Observation of the kitchen on 02/26/25 at 10:21am revealed there was not a diet list of residents placed on the bullentin board. Interview with Resident #1 on 02/26/25 at 9:51am revealed she was on a regular diet with no added sugar. Refer to the interview with the cook on 02/26/25 at 2:12pm. Refer to the interview with dietary manager on 02/26/25 at 2:16pm. Refer to the interview with the Directory of Health and Wellness (DHW) on 02/27/25 at 11:54am.	D 309		

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D 309	Continued From page 6 Refer to the interview with the Administrator on 02/27/25 at 4:30pm. 2. Observation of the dinner meal on 02/26/25 at 4:20pm to 4:45pm revealed: -Resident #3 was served lima beans, chicken pastry, water, tea and coffee. -Resident #3 at his meal in his room -He ate 100% of the lunch meal. -Resident #3 was served a regular diet. -There was no additional salt in Resident #3's room. Review of Resident #3's current FL-2 dated 10/24/24 revealed diagnoses included acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, pleural effusion not elsewhere classified, ventricular tachycardia - unspecified, and acute on chronic diastolic (congestive heart failure). Review of Resident #3's diet order dated 11/06/24 revealed a regular no added salt (NAS) diet. Review of the regular diet menu for the lunch meal on 02/26/25 at 10:21am revealed: -There was an entry for chicken pastry or broccoli and cheese soup. -There was an entry for lima beans and dinner roll. Interview with Resident #3 on 02/26/25 at 9:48am revealed: -Resident #3 did not like a lot of sodium or salty food. -The kitchen staff would not put a lot of salt in his food. -Resident #3 usually ate all of his meal unless he was not feeling well.	D 309		

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D 309	Continued From page 7 Refer to the interview with the cook on 02/26/25 at 2:12pm. Refer to the interview with dietary manager on 02/26/25 at 2:16pm. Refer to the interview with the Directory of Health and Wellness (DHW) on 02/27/25 at 11:54am. Refer to the interview with the Administrator on 02/27/25 at 4:30pm. 3. Observation of the dinner meal on 02/26/25 at 4:14pm to 4:45pm revealed: -Resident #4 was served broccoli and cheese soup, lima beans, tea and water. -Resident #4 ate all of the broccoli and cheese soup and ¾ of the lima beans. -Resident #4 was served a regular diet. Review of Resident #4's FL2 dated 01/10/25 revealed diagnoses included cerebral autosomal dominant arteriopathy, radiculopathy, cervical regional, other cervical disc degeneration, spiral stenosis and type II diabetes. Review of Resident #4's diet order dated 01/10/25 revealed a controlled carbohydrate (CCHO) regular diet. Review of the regular diet menu for the lunch meal on 02/26/25 at 10:21am revealed: -There was an entry for chicken pastry or broccoli and cheese soup. -There was an entry for lima beans and dinner roll. Refer to the interview with the cook on 02/26/25 at 2:12pm.	D 309		

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D 309	Continued From page 8 Refer to the interview with dietary manager on 02/26/25 at 2:16pm. Refer to the interview with the Directory of Health and Wellness (DHW) on 02/27/25 at 11:54am. Refer to the interview with the Administrator on 02/27/25 at 4:30pm. Interview with the cook on 02/26/25 at 2:12pm revealed: -All resident orders were posted and kept on the bulletin board. -The diet order list was removed but the individual diet orders were posted. -He followed the diet list to prepare the residents' meals. -He did not know why the diet orders for Residents #1, #3 and #4 were removed. Interview with the dietary manager on 02/26/25 at 2:16pm revealed: -There was not a composed diet order list. -The individual diet orders were submitted by the Director of Health and Wellness (DHW) and posted in the kitchen. -The individual resident profile sheets were posted on the bullentin board for reference. -He did not know why the diet orders for Residents #1, #3 and #4 were removed. Interview with the DHW on 02/27/25 at 11:54 revealed: -She submitted a new resident advisory to the dietary staff when residents are admitted to the facility. -The new resident advisory listed the resident's diet order. -She created and submitted a combined diet order list to the dietary staff of 02/26/25.	D 309		

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D 309	Continued From page 9 -She was the person responsible for submitting all new and updated dietary orders to the dietary manager. Interview with the Administrator on 02/27/25 at 4:30pm revealed: -There were to be an updated diet order list posted for the kitchen staff to use as a guide to prepare meals. -The DHW was responsible for providing the dietary staff with a list of all new and revised diet orders. Interview with the Health and Wellness Director on 02/27/25 at 4:15pm revealed: -Diet lists were printed monthly and when new orders were written. -The diet list was given to the Kitchen Manager but she did not know what happened with the diet list after it was given to the Kitchen Manager. -There was a contracted company that was responsible for overseeing the kitchen processes. Interview with the Administrator on 02/27/25 at 3:55pm revealed: -The Health and Wellness Director was responsible for ensuring the Kitchen Manager had an updated resident diet list and the Kitchen Manager was responsible for ensuring a complete and accurate list of all resident diets was available in the kitchen. -Kitchen staff needed to have a compete and accurate diet list for resident so they knew how to prepare each residents' diet according the physician's order. -She conducted monthly sanitation audits but diet list availability was included in the audit. -She should have been conducting random checks to ensure diet lists were available in the kitchen.	D 309		

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. 0306(a)(5) Housekeeping and Furnishings
Based on observation, interview and record review the facility failed to ensure the facility was free of obstructions and hazards by free standing unsecured oxygen tanks being stored in a resident's room.

a) *All rooms were assessed immediately to ensure Oxygen tanks were in a secured crate.*
b) *The community will verify that outside agencies (home health, hospice, etc.) are aware of the oxygen storage policy and will provide the appropriate storage for the oxygen they are providing.*
c) *Staff will be trained to report oxygen tanks left in rooms without being crated/stored appropriately.*
d) *The DHW/designee will round weekly on rooms and verify the oxygen tanks are stored appropriately as per the policy.*
e) *The Maintenance Tech will verify extra oxygen tanks are stored appropriately. The ED will monitor monthly for storage.*

The date of correction for this will be no later than 2-28-25.

2) 10A NCAC 13F. 0904(e)(3) Nutrition and Food Service
Based on observations, record reviews and interviews, the facility failed to maintain a current list with physicin ordered therapeutic or modified diets for guidance of food service for 3 of 6 sampled residents.

a) The DHW will submit an updated diet list to dietary after each move in or diet change.
b) The dietary manager will post the updated diet list in the kitchen for accurate plating of food.
c) The ED will check the kitchen weekly to verify the diet list is posted.

The date of correction for this will be no later than 2-28-25.