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 07/12/2023

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 07/11/23 through 07/12/23.	D 000	A) 10A NCAC 13F. 1004(j) Medication Administration. The resident's medication administration record shall be accurate and include the following: a) Resident name b) Name of the medication or treatment order c) strength and dosage or quantity of medication administered; d) instructions for administering the medication or treatment; e) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; f) date and time of administration; g) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, h) 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 B) This rule was not met due to the facility failed to ensure the medication records were accurate for 2 of 5 residents sampled including a medication used for pain and shortness of breath,	
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .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, record reviews, and interviews, the facility failed to ensure the electronic medication administration records were accurate for 2 of 5 sampled residents (#2, #4) including a medication used for pain and shortness of breath, a medication used for anxiety (#2), and an injectable medication used to treat blood sugar (#4).	D 367		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jaime Watt — TITLE: EP — (X6) DATE: 8-15-23

Reviewed and Acknowledged SCM 08/15/23

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D 367	Continued From page 1 The findings are: 1. Review of Resident #4's current FL-2 dated 12/09/22 revealed diagnoses included dementia, acute kidney injury, insulin dependent type 2 diabetes mellitus, diabetic ketoacidosis, accidental falls, vitamin D deficiency, and frontal lobe syndrome. Review of a physician order dated 03/01/23 revealed there was an order for Trulicity 0.75 mg/0.5ml weekly on Friday. (Trulicity is an injectable medication used to control high blood sugar). Review of a physician order dated 06/08/23 revealed there was an order for Trulicity 1.5mg/0.5ml weekly on Friday. Review of Resident #4's May 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Trulicity 0.75mg/0.5ml, inject 0.5ml weekly on Friday at 9:00am -There was no documentation Trulicity 0.75mg/0.5ml was administered on 05/05/23 and 05/29/23 at 9:00am Review of Resident #4's June 2023 eMAR revealed: -There was an entry for Trulicity 0.75mg/0.5ml weekly on Friday at 9:00am -There was an entry for Trulicity 1.5mg/0.5ml weekly on Friday to be administered at 9:00am with a start date of 06/08/23. -There was no documentation Trulicity 15mg/.0.5ml was administered on 06/23/23 at 9:00am	D 367	A medication for anxiety and an injectable. C) The alleged deficient practice will be/has been corrected by the facility by taking the following action: All medication records were reviewed on 7-12-23 to ensure accuracy in documentation and orders. Medication carts were audited on 7-12-23 to ensure medications were in stock as ordered. Medication Records will be checked by DRC and/or designee daily for 3 weeks to ensure proper documentation. D) Other residents potentially affected by the same alleged deficient practice will be identified as follows: All residents could potentially be affected. E) The following systemic changes will be made to ensure compliance with this regulation: The DRC and/or designee will review all medication records and medication carts weekly to ensure compliance with documentation and storage of medication. F) The facility will monitor the following actions as follows: The DRC and/or designee will complete a medication cart audit monthly. The DRC and/or designee will ensure training is completed with all med techs annually	8-2-23

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D 367	Continued From page 2 Observation of Resident #4's medications on hand on 07/12/23 at 10:30am revealed there was a box containing 4 Trulicity pens with each pen containing 1.5mg/ 0.5ml. with instructions to inject 1.5mg/0.5ml weekly, dispensed date 07/07/23. Telephone interview with the facility's contracted pharmacist on 06/12/23 at 2:02pm revealed: -Trulicity was dispensed for Resident #4 on 04/30/23 for a box of 4 pens with each pen containing 0.75mg/0.5ml. -Trulicity was dispensed for Resident #4 on 05/30/23 for a box of 4 pens with each pen containing 0.75/mg/0/5ml. -There was a new order for Resident #4 for Trulicity dated 06/08/23 for 1.5mg/0.5ml. -Trulicity was dispensed for Resident #4 on 06/08/23 for a box of 4 pens with each pen containing 1.5mg/0.5ml. -Trulicity was dispensed for Resident #4 on 07/07/23 for a box of 4 pens with each pen containing 1.5mg/0.5ml. Telephone interview with the medication aide (MA) on 07/12/23 at 3:08pm revealed: -She was the medication aide on 06/23/23. -She recalled administering Resident #4's Trulicity 1.5mg/0.5ml on 06/23/23. -She must have forgotten to document on the eMAR the administration of the medication. -She was trained to document the administration of the medication when administered. Interview with the Administrator on 07/12/23 at 5:00pm revealed: -She spoke to the MA on today, 07/12/23, who was working on 05/05/23 and 05/29/23. -The MA indicated that she administered Resident #4's Trulicity on those two dates, but forgot to document it on the MAR.	D 367	regarding medication administration and documentation. Attached is the training that will be provided annually.	

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D 367	Continued From page 3 Attempted telephone interview with the MA on 07/12/23 at 5:15pm who was working on 05/05/23 and 05/29/23 was unsuccessful. Refer to telephone interview with the facility's contracted primary care provider (PCP) on 07/12/23 at 1:57pm. Refer to interview with the Memory Care Manager (MCC) on 07/12/23 at 4:40pm. Refer to interview with the Administrator on 07/12/23 at 5:40pm. Based on observations, record reviews, and interviews, it was determined Resident #4 was not interviewable. 2. Review of Resident #2's current FL-2 dated 09/22/23 revealed: -Diagnoses included history of femur fracture, hypertension, chronic obstructive pulmonary disease, emphysema, congestive heart failure and type II diabetes. -She was constantly disoriented. a. Review of Resident #2's physician's order dated 09/26/22 revealed morphine sulfate 100mg/5ml 0.25ml was to be administered every 4 hours as needed for pain or shortness of breath. Review of Resident #2's medication administration record (MAR) for June 2023 revealed: -There was an entry for morphine sulfate 100mg/5ml 0.25ml to be administered every 4 hours as needed for pain or shortness of breath. -There was no documentation morphine sulfate	D 367		

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D 367	Continued From page 4 0.25ml was administered. Observation of medications on hand for Resident #2 on 07/12/23 at 3:40pm revealed there were 31 pre-filled syringes (0.25ml) labeled morphine sulfate with instructions to administer 0.25ml every 4 hours as needed for pain or shortness of breath with a dispense date of 04/23/23. Review of Resident #2's control log for morphine sulfate on 07/12/23 at 3:40pm revealed: -There was documentation a quantity of 32 prefilled syringes were received on 04/24/23. -There was documentation 1 syringe was administered on 06/02/23 at 8:30pm with 31 doses remaining. Telephone interview with Resident #2's pharmacist on 07/12/23 at 4:50pm revealed a quantity of 32 prefilled syringes of 0.25ml each was last dispensed on 04/23/23. Telephone interview on 07/12/23 at 4:16pm with the medication aide (MA) who signed the controlled substance log on 06/02/23 revealed: -She worked part time at the facility as a MA. -She had not administered morphine to Resident #2 at any time because there was never a need to and she did not signed any of the medication out on the control log. Based on observation, record review and interviews, it was determined that Resident #2 was not interviewable. b. Review of Resident #2's physician's order dated 09/26/22 revealed lorazepam 0.5mg was to be administered every 4 hours as needed for anxiety.	D 367		

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D 367	Continued From page 5 Review of Resident #2's medication administration record (MAR) for June 2023 revealed: -There was an entry for lorazepam 0.5mg was to be administered every 4 hours as needed for anxiety. -There was no documentation lorazepam 0.5mg was administered. Observation of medications on hand for Resident #2 on 07/12/23 at 3:40pm revealed there were -There were 3 dispensing cards (total of 90 doses) labeled lorazepam 0.5mg to be administered every 4 hours as needed for anxiety with a dispense date of 09/26/23. -There was a total of 82 doses remaining. Review of Resident #2's control log for lorazepam 0.5mg on 07/12/23 at 3:40pm revealed: -There were 3 sheets labeled for lorazepam 0.5mg with documentation on each that a quantity of 30 was received on 09/27/22 for a total of 90 doses. -There was documentation 1 dose was administered at 10:00am on 09/30/22, 6 doses were wasted on 12/28/22 and 1 dose was administered at 8:30pm on 06/02/23 with 22 doses remaining for the dispensing card. Telephone interview with Resident #2's pharmacist on 07/12/23 at 4:50pm revealed a quantity of lorazepam 0.5mg was last dispensed on 09/26/22 with no refills. Telephone interview 07/12/23 at 4:16pm with the medication aide (MA) who signed the controlled substance log on 06/02/23 revealed: -She worked part time at the facility as a MA. -She had not administered lorazepam 0.5mg to Resident #2 at any time because there was never	D 367		

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D 367	Continued From page 6 a need to and she did not signed any of the medication out on the control log. Based on observation, record review and interviews, it was determined that Resident #2 was not interviewable. Refer to telephone interview with the facility's contracted primary care provider (PCP) on 07/12/23 at 1:57pm. Refer to interview with the Memory Care Manager (MCC) on 07/12/23 at 4:40pm. Refer to interview with the Administrator on 07/12/23 at 5:40pm. Interview with the Memory Care Manager (MCC) on 07/12/23 at 4:40pm revealed MAs were expected to document administration of all medications on the MAR at the time of administration. Telephone interview with facility's contracted primary care provider (PCP) on 07/12/23 at 1:57pm revealed it was important for MARs to accurately reflect medications that were administered in order to assess effectiveness of prescribed medications and guide treatment. Interview with the Administrator on 07/12/23 at 5:40pm revealed: -She expected all medications to be documented on the MAR at the time of administration. -Medications that were scheduled as needed should have documentation on the back of the MAR regarding time of administration and a follow-up with in 1 hour that documented the effectiveness of the medication. -MAs were trained on these expectations during	D 367		

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D 367	Continued From page 7 MA training and again when the facility nurse completed the Medication Administration Skills Checklist upon hire.	D 367		