	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
ANDILAN	O CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COIVII L	LILD
		HAL098030	B. WING		R- 03/2	C 2/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PARKWO	OD VILLAGE	1730 PARK WILSON, N	WOOD BLVD C 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 000	Initial Comments		D 000			
	follow-up survey and 03/19/24 - 03/22/24 w telephone on 03/22/2 investigation was initi	sure Section conducted a complaint investigation on with an exit conference via 4. The complaint ated by the Wilson County Services on 03/14/24.				
D 125	10A NCAC 13F .0403 Medication Staff	3(a) Qualifications Of	D 125			
	aides, and their direct training, clinical skills written examination a 131D-4.5B. Persons a occupational licensure	staff who administer or referred to as medication t supervisors shall complete validation, and pass the s set forth in G.S. authorized by state e laws to administer opt from this requirement.				
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
	interviews, the facility documentation for 3 c aides who administer completed the state a or 15-hour medication	of 6 sampled medication ed medications to residents approved 5-hour and 10-hour a aide training (Staff A, Staff tate approved medication				
		personnel record revealed: 06/19/23 as a medication				
	aide (MA).					

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL098030	B. WING		R-C 03/22/2024	
NAME OF F	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE		
PARKWO	OD VILLAGE		NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLET	
D 125	-There was no docun the state approved 5 medication aide traini -There was no docun the medication clinical Interview with Staff A revealed: -She remembered comedication training askills about a year agathe training was procontracted Registered Review of residents' 2024 medication admirevealed: -Staff A documented medications on 15 of 02/29/24 including 02 02/08/24, 02/10/24 - 02/19/24, 02/21/24, 00/2/28/24, and 02/29/2-Staff A documented medications on 4 of 203/21/24 including 03 and 03/10/24. Review of a resident' controlled substance made errors by doculurazepam (a control and agitation) on the 02/25/24, 02/26/24, adocument the admini February 2024 MAR rendering the MAR in	nentation Staff A completed and 10 or 15-hour ing. nentation Staff A completed al skills validation checklist. on 03/21/24 at 6:03pm mpleting the 15-hour ind the medication clinical o. vided by the facility's d Nurse (RN). February 2024 and March inistration records (MARs) administration of 29 days from 02/01/24 - 1/01/24, 02/05/24, 02/07/24, 02/12/24, 02/16/24, 12/24/24 - 02/26/24, 12/24/24 - 02/26/24, 12/24/24, 03/07/24, 03/09/24, 13/06/24, 03/07/24, 03/09/24, 15/06/24, 03/07/24, 03/09/24, 15/06/24, 03/07/24, 03/09/24, 15/06/24, 03/07/24, 03/09/24, 16/06/24, 03/07/24, 16/06	D 125			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			35.25.110		R-C
		HAL098030	B. WING		03/22/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
PARKWO	OD VILLAGE		KWOOD BLVD		
	OLUMBA DV OT	WILSON,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 125	Continued From page	e 2	D 125		
	-She provided clinical included medication of about a year agoShe remembered proclinical skills check for she did not keep door and provided the door she did not provide to 15-hour medication to that may have been of contracted RN. Refer to interview with Care (DRC) and the Armonic 10:56am. 2. Review of Staff B's shall shal	I services to the facility that clinical skills validations oviding the medication or Staff A. cumentation of the training ument to the facility. the 5-hour and 10-hour or raining services to the facility			
	the state approved 5- 15-hour medication a	hour and 10-hour, or			
	2024 medication adm revealed: -Staff B documented medications on 6 of 2 02/29/24 including 02 02/22/24, 02/24/24, a -Staff B documented medications on 7 of 2 03/21/24 including 03 03/13/24, 03/14/24, 0	29 days from 02/01/24 - 2/01/24, 02/08/24, 02/15/24, and 02/25/24. the administration of 21 days from 03/01/24 - 3/04/24, 03/07/24, 03/11/24, 3/15/24, and 03/18/24. interview with Staff B on			
		h the Director of Resident Administrator on 03/22/24 at			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
					F	R-C
		HAL098030	B. WING		03/	22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PARKWO	OD VILLAGE		KWOOD BLVD			
0.0.15	CLIMMADV CT	·	NC 27895	PROVIDER'S PLAN C	OF CORRECTION	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
D 125	125 Continued From page 3		D 125			
	10:56am.					
	-Staff D was hired on aide (MA). -There was no docum	personnel record revealed: 09/23/17 as a medication nentation Staff D completed hour and 10-hour or 15-hour ng.				
	2024 medication adm revealed: -Staff D documented medications on 2 of 2 02/29/24 including 02 -Staff D documented medications on 4 of 2	9 days from 02/01/24 - /18/24 and 02/19/24.				
	used to treat severe passociated with end co- -Staff D documented	by documenting not one (a controlled substance oain and breathing difficulties of life symptoms) as ordered. The holding Morphine on 4 due to the resident being was ordered to be				
	Attempted telephone 03/22/24 at 1:47pm w	interview with Staff D on as unsuccessful.				
		n the Director of Resident Administrator on 03/22/24 at				
	Interview with the DR	 C and the Administrator on				

Division of Health Service Regulation

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S COMPLI	
		HAL098030	B. WING		R- 03/2	C 2/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	•	
PARKWO	OD VILLAGE	1730 PAF	RKWOOD BLVD			
TARRE	JD VILLAGE	WILSON,	NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 125	Continued From page 4		D 125			
	03/22/24 at 10:56am -The Business Office Administrator were re records were up-to-da required information a -An audit of staff reco every 6 monthsShe did not know wh records was conducte -The facility had a cor the medication clinical for staffShe contacted the ph 5-hour, 10-hour and 1 training for staff. Refer to Tag 358 10A Medication Administra Refer to Tag 367 10A Medication Administra Refer to Tag 399 10A Controlled Substance The facility failed to p Staff A, B, and D were medications to reside not completing the re- 10 or 15-hour medical medication clinical sk resulting in medicatio MARs. This failure wa safety and welfare of Type B Violation.	revealed: Manager (BOM) or sponsible for ensuring staff ate and contained the and training. rds should be conducted then the last audit of staff ad. Intracted RN that provided all skills validation check off the shour medication aide INCAC 13F .1004(a) ation. INCAC 13F .1008(a) ation. INCAC 13F .1008(a) ation. INCAC 13F .1008(a) ation. INCAC 13F .1008(b) ation. INCAC 13F .1008(a) ation. INCAC 13F .1008(b) ation. INCAC 13F .1008(a) ation. INCAC 13F .1008(a) ation. INCAC 13F .1008(b) ation. INCAC 13F .1008(a) ation. INCAC 13F .1008(a) ation. INCAC 13F .1008(b) ation. INCAC 13F .1008(a) ation. INCAC 13F .1008(b) ation. INCAC 13F .1008(a) ation. INCAC 13F .1008(b) ation. INCAC 13F .1008(a) ation. INCAC 13F .1008(b) ation. INCAC 13F .1008(b				
	resulting in medicatio MARs. This failure was afety and welfare of Type B Violation. The facility provided a	n errors and inaccurate as detrimental to the health, residents and constitutes a				

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STATE FORM 6899 N1S211 If continuation sheet 5 of 104

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			_		R-C
		HAL098030	B. WING		03/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
PARKWO	OD VILLAGE		NC 27895		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 125	Continued From page CORRECTION DATE VIOLATION SHALL N		D 125		
D 344	10A NCAC 13F .1002 10A NCAC 13F .1002 (a) An adult care hon the resident's physicia for verification or clari medications and treat (1) if orders for admis resident are not dated of admission or readm (2) if orders are not cl (3) if multiple admission admission or readmis forms are not the same	P(a) Medication Orders P. Medication Orders The shall ensure contact with the contact of the contact with the contact of the	D 344		
	clarification is docume record. This Rule is not met a Based on interviews a facility failed to ensure	ented in the resident's as evidenced by: and record reviews, the e clarification of medication bled residents (#5) including			
	01/16/24 revealed: -Diagnoses included to neuralgia and anxiety -The resident was ord three times a day for may be used to treat. Review of Resident #	dered Gabapentin 600mg chronic pain. (Gabapentin			

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7. BOILDING.		D C
		HAL098030	B. WING		R-C 03/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
PARKWO	OD VILLAGE	1730 PARI WILSON, N	WOOD BLVD		
	OUR MARK OT	·		DD0/4DED00 D/ AM OF 00DD50710	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 344	Continued From page 6 D 344				
	01/18/24.				
	-There was an entry f times daily for chronic -Staff documented Ga administered to Resic from 01/19/24 to 01/3 -There were no additi dosages Gabapentin. Review of Resident # revealed: -There was an entry f times daily for chronic -Staff documented Ga administered three tim 02/10/24The entry for 600mg day was marked discordabapentin 600mg t documented as admin 02/29/24.	ation record (MAR) revealed: for Gabapentin 600mg three c pain. abapentin 600mg was dent #5 three times daily 1/24. onal entries for different for Gabapentin 600mg three c pain. abapentin 600mg was nes daily 02/01/24 through Gabapentin three times a ontinued on 02/11/24. hree times daily was not nistered from 02/11/24 to			
	03/01/24 - 03/19/24 re	5's March 2024 MAR from evealed: for Gabapentin 600mg three			
	times daily for chronic -The entry for 600mg day was marked disc -Gabapentin 600mg t documented as admir 03/19/24.	c pain. Gabapentin three times a ontinued on 02/11/24. hree times daily was not nistered 03/01/24 to			
	-There were no additi dosages of Gabapent	onal entries for different tin.			
	Interview with the Dire	ector of Resident Care			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R-C
		HAL098030	B. WING		03/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
PARKWO	OD VILLAGE	1730 PAR	WOOD BLVD		
TARRE	OD VILLAGE	WILSON, I	NC 27895		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 344	Continued From page	e 7	D 344		
	#5 had recently switc	t 11:38am revealed Resident hed pharmacies, but she ctual date for the change in			
	at the facility's contrar at 3:10pm revealed: -Resident #5 was adr 01/18/24 as a "profile -A profile only resider the resident used a d but the contracted ph	nt was usually in place when ifferent primary pharmacy, armacy could provide refills			
	pain dated 01/16/24.	current order for nree times a day for chronic			
	-The pharmacy did no discontinue Gabapen	ot have any orders to tin 600mg three times daily.			
	at Resident #5's prev at 3:36pm revealed: -The resident had cur for Gabapentin 300m	with a Pharmacy Technician ious pharmacy on 03/20/24 rrent orders, dated 01/17/24, g in the morning, 300mg at night for other diseases of			
	and start Gabapentin				
	medication bubble pa dosage of Gabapenti -The family member of	evealed: member brought a new ck to the facility with a new			

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to clarify the order on 02/11/24.

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION (X3) DATE SUF		
7440 1 2744	or contraction	BERTH 10, WOR HOMBER.	A. BUILDING:		55	
		HAL098030	B. WING		I	R-C 3/ 22/2024
NAME OF D	ROVIDER OR SUPPLIER		DDDESS CITY STATI	- ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE		
PARKWO	OD VILLAGE		RKWOOD BLVD , NC 27895			
	OUR MARK OF			DDOWDEDIO DI AM OF	000000000000000000000000000000000000000	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 344	Continued From page	e 8	D 344			
	-The pharmacy told the Gabapentin three time discontinuedThe pharmacy faxed the MA attached the obubble pack and place cartShe was not aware for start Gabapentin 300 at noon and 2 tablets not enter that order or she wrote the entry of Gabapentin on Residence of She was not able to attached to the bubble. She had not contacted care provider (PCP) of because she thought the order and sent the Interview with Reside 2:25pm revealed: -Facility staff told her Gabapentin 600mg the discontinued by the resident's chart, but some condition of the c	the order to the facility and order to the medication ed it back in the medication resident #5 had an order to mg in the morning, 300mg (600mg) at night, so she did not resident #5's MAR. To discontinue the ent #5's MAR. To discontinue provider the pharmacy had clarified to order to the facility. In #5's PCP on 03/21/24 at that the resident's pain clinic provider discontinue order in the ent as it was managed by the provider. To discontinue order that the bapentin 300mg in the boon and 600mg at night, the facility had not contacted ent to obtain clarification for for Gabapentin when the new medication packs.				
		ministrator on 03/21/24 at en the MA received the new				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
74101244	or contraction	ibertii io, tiioit iombert	A. BUILDING: _			
		HAL098030	B. WING		R- 03/2	C 2/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PARKWO	OD VILLAGE	1730 PARK WILSON, N	WOOD BLVD C 27895			
040.45	CHMMADY CT	·		DROVIDER'S DI ANI OF CORRECTION	NI .	0.450
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 344	Continued From page	9	D 344			
	medication pack from member, she should	Resident #5's family have contacted the ers and she should have tts PCP or pain clinic rification before she				
	Attempted telephone #5's medical provider 03/21/24 at 8:26am a unsuccessful.	•				
D 358	10A NCAC 13F .1004 Administration	(a) Medication	D 358			
	(a) An adult care hor preparation and admi prescription and non-by staff are in accorda(1) orders by a licens which are maintained	Medication Administration ne shall assure that the nistration of medications, prescription, and treatments ance with: sed prescribing practitioner in the resident's record; and on and the facility's policies				
	This Rule is not met TYPE A1 VIOLATION					
	reviews, the facility fa were administered as (#9, #10) observed do including errors with a and a topical antibioti medication for mild to for 5 of 7 sampled resincluding errors with a and shortness of brea	ns, interviews, and record iled to ensure medications ordered for 2 of 3 residents uring the medication pass a topical antifungal powder cointment (#9) and a moderate pain (#10); and sidents (#2, #4, #5, #7, #8) a narcotic used to treat pain ath at end of life (#7, #8), a anxiety (#7), a medication				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	or doring of the state of the s	IDENTIFICATION NOMBER.	A. BUILDING: _		
		HAL098030	B. WING		R-C 03/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
PARKWO	OD VILLAGE		KWOOD BLVD		
		WILSON, I	NC 2/895		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE
D 358	Continued From page	2 10	D 358		
		ain and chronic pain (#5), an d a diuretic for excess fluid			
	The findings are:				
	1. The medication err evidenced by 3 errors during the 8:00am an passes on 03/20/24.	out of 28 opportunities			
	dated 03/02/23 revea Alzheimer's disease,	t #9's most recent FL-2 led diagnoses included paroxysmal atrial fibrillation, n, and major depressive			
	(PCP) order dated 03 an order for Triple And bandage to left foot w	otic Ointment is a topical			
	03/20/24 revealed: -The medication aide administered oral medicated powerThe MA did not prepare	dications at 8:35am and a wder at 8:36am. are or attempt to apply Triple Resident #9 when the other medications			
	revealed she had con scheduled morning m	on 03/20/24 at 8:50am explored administering all ledications for Resident #9. 9's March 2024 medication			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		· ,	E SURVEY PLETED
						R-C
		HAL098030	B. WING		03	3/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
DA DIGINO	00.1/11.1.4.05	1730 PA	RKWOOD BLVD			
PARKWO	OD VILLAGE	WILSON	I, NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 11	D 358			
	Antibiotic Ointment an wound once daily unt 03/07/24. -Triple Antibiotic Ointradministration at 9:00 -Triple Antibiotic Ointradministered daily fro-Documentation for T 03/20/24 was blank wow Observation of Resid hand on 03/20/24 at 1-There was no Triple Resident #9 available 1-There was no house	ment was documented as om 03/07/24 - 03/19/24. riple Antibiotic Ointment for vith no reason noted. ent #9's medications on 11:05am revealed: Antibiotic Ointment for				
	11:05am revealed: -New medication order pharmacy via electron the provider or the MapharmacyShe did not recall if some second and the provider or the MapharmacyShe did not recall if some second and the provider of the pharmacyShe did not know if for a some second and initial administrating or all measures and the provided and the provided and the provided and the provided and the pharmacy in the provided and the pharmacy in the pharm	edications. er Resident #9's Triple eat morning, 03/20/24, ot find any in the medication cock tube of Triple Antibiotic				
	Ointment to apply to					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND I EAR OF GOTTLESTICK		A. BUILDING: _		COMPLETED	
		HAL098030	B. WING		R-C 03/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
PARKWO	OD VILLAGE	1730 PAR	KWOOD BLVD		
FARRWO	OD VILLAGE	WILSON,	NC 27895		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 358	Continued From page	e 12	D 358		
	not sure why it was n -She had also used s Antibiotic Ointment fr	npty yesterday, so she was ot in the cart today. ome small packets of Triple om the facility's first aid kit in not have any more of those			
	hospice nurse on 03/2 there was a 1cm rour surrounded by red tis	ent #9 with the MA and the 20/24 at 11:19am revealed and unopened yellow area sue about the size of a dime foot on a bony prominence			
	03/20/24 at 11:19am -This was the first time resident's foot wound -The resident's foot we the Triple Antibiotic O ordered by the PCPIt was important to u Ointment on the foot	e she had seen the			
	on 03/20/24 at 11:46a -The PCP usually ser -She told the MAs to pharmacy as wellShe was not aware If Antibiotic Ointment w pharmacy and none w resident.	nt e-scripts to the pharmacy. always fax orders to the Resident #9's order for Triple has not received by the has dispensed for the ave standing orders, so they tock medications. kit usually had some			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
HAL098030			B. WING			R-C 3/22/2024
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE		<i>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</i>
DA DKWO	OD VILLAGE	1730 PA	RKWOOD BLVD			
PARKWO	OD VILLAGE	WILSON	, NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 13	D 358			
	(DRC) on 03/20/24 at -The facility usually h Antibiotic Ointment in -The pharmacy usual individual resident aft -Resident #9 should I supply of Triple Antibi medication was order -The MCD was responders were transcrib the pharmacy, and im Interview with the Adr 1:17pm revealed: -The MAs usually ser pharmacy via faxOnce an order was f pharmacy would send facilityResident #9's order	ad small packets of Triple the first aid kits. ly sent medication for each er receiving an order. have received her own totic Ointment when the red by the PCP. hasible for ensuring new ed onto the MARs, faxed to haplemented. ministrator on 03/20/24 at ht medication orders to the axed to the pharmacy, the d the medication to the for Triple Antibiotic Ointment ht to the pharmacy to be				
	Telephone interview of at the facility's contral at 3:20pm revealed: -They had not dispen Ointment for Residen was dispensed in Octor-The pharmacy did not order for Triple Antibio 03/07/24If the pharmacy had	with a pharmacy technician cted pharmacy on 03/20/24 sed any Triple Antibiotic t #9 since one 28-gram tube tober 2022. Ot receive Resident #9's otic Ointment dated received the order, they d and sent the medication to				
	Interview with Reside 2:21pm revealed:	nt #9's PCP on 03/21/24 at				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R-C	
		HAL098030	B. WING		03/22/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PARKWO	OD VILLAGE		KWOOD BLVD			
		WILSON,	NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	e 14	D 358			
D 350	-She wrote the order to be applied due to the footShe did not want the require further wound. Interview with Reside 11:10am revealed: -The resident was unaquestions about her nesident denied. The resident denied. B. Review of Resider dated 03/02/23 reveated 100,000 units abdomen every day. topical powder used to the skin.) Review of Resident #08/30/23 and 12/21/2 Nystatin Powder 100, breasts and abdoministered Nystatin #9's abdominal foldsThe medication aide administered Nystatin #9's abdominal foldsThe areas under Reside apply any Nystatin Porton The area under Reside and The Area under	for Triple Antibiotic Ointment he redness on the resident's area to open which would care to prevent infection. Int #9 on 03/20/24 at able to answer specific medication. Int #9's most recent FL-2 led an order for Nystatin s/gram, apply to right lower (Nystatin Powder is a o treat fungal infections of 9's physician's orders dated 3 revealed orders for 000 units/gram, apply under al skin folds once daily. In the system of the red of the system o	D 336			
	Review of Resident # administration record	9's March 2024 medication (MAR) revealed:				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING B. WING O3/22/22 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PARKWOOD VILLAGE 1730 PARKWOOD BLVD WILSON, NC 27895 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 15 -There was a handwritten entry for Nystatin COMPLETED R-C 03/22/22 D 3780 D 3780 D 3780 D 3780 COMPLETED R-C 03/22/22 D 3780 D 3780		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1730 PARKWOOD BLVD WILSON, NC 27895 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 15 -There was a handwritten entry for Nystatin	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1730 PARKWOOD BLVD WILSON, NC 27895 (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 15 -There was a handwritten entry for Nystatin		
NAME OF PROVIDER OR SUPPLIER PARKWOOD VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 15 -There was a handwritten entry for Nystatin	124	
PARKWOOD VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 15 -There was a handwritten entry for Nystatin		
PARKWOOD VILLAGE WILSON, NC 27895 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 15 -There was a handwritten entry for Nystatin		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 15 -There was a handwritten entry for Nystatin		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 15 -There was a handwritten entry for Nystatin		
-There was a handwritten entry for Nystatin	(X5) OMPLETE DATE	
Powder 100,000 units/gram apply under breasts, abdomen daily scheduled for 9:00am. -Nystatin Powder was documented as administered daily from 03/01/24 - 03/20/24. Observation of Resident #9's medications on hand on 03/20/24 at 11:37am revealed: -There was a supply of Nystatin Powder dispensed on 09/19/23 with instructions to apply topically to lower abdomen 4 times a day as needed for skin irritation. -There was a supply of Nystatin Powder dispensed on 09/28/23 with instructions to apply to right groin twice daily for 10 days. Interview with the MA on 03/20/24 at 11:34am revealed: -She did not apply Nystatin Powder under Resident #9's breast because the skin was not red. -She did not notice the instructions on the MAR were to apply under the breasts as well. -She thought the order to apply Nystatin Powder under the resident's breast had been		
discontinued.		
Interview with the Director of Resident Care (DRC) on 03/20/24 at 1:00pm revealed: -The MAs should apply the Nystatin Powder to the areas indicated in the order. -If an area was healed, the MAs should notify the resident's provider to see if the order could be discontinued. -Until there was a discontinue order, the MAs should follow the order to administer the medication, including under the breasts.		

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1:17pm revealed:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED		
		71. BOILBING.		R-C	
		HAL098030	B. WING		03/22/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
PARKWO	OD VILLAGE	1730 PARK	WOOD BLVD		
TARRE	JD VILLAGE	WILSON, N	IC 27895		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 358	Continued From page	e 16	D 358		
	-The MA should admi where it was ordered	nister Nystatin Powder			
	(PCP) on 03/21/24 at -Resident #9 had exprash under her breast itching, burning, and c-Nystatin Powder was prevent fungal rashes -She was concerned	rerienced a consistent fungal ts and abdominal folds with discomfort. s ordered to help treat and s. if Nystatin Powder was not ident's breasts, the rash			
	questions about her n -The resident denied burning, itching, or dis	able to answer specific			
	11/06/23 revealed dia Review of Resident # 12/14/23 revealed an 325mg 2 tablets twice used to treat mild to n Observation of the 9:03/20/24 revealed: -The medication aide administered 1 Aceta Resident #10 at 8:46a -The MA administered tablet instead of 2 tab	ignosis included dementia. 10's physician's order dated order for Acetaminophen a day. (Acetaminophen is noderate pain.) 00am medication pass on (MA) prepared and minophen 325mg tablet to am. dd 1 Acetaminophen 325mg			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		A. BUILDING: _				
HAL098030		B. WING		R-C 03/22/2	2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
DV DK/MU	OD VILLAGE	1730 PARI	KWOOD BLVD			
PARRIVO	OD VILLAGE	WILSON, I	NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	tablets 2 times a day 8:00pmAcetaminophen 325r administered from 03. Observation of Reside hand on 03/20/24 at 2-There was a supply tablets dispensed on take 2 tablets 2 times -There were 15 of 30 tablets remaining in the Interview with the MA revealed: -She usually administ 325mg tablets to Res -She thought she adn 325mg tablets to Res 03/20/24The resident receive she usually complaine pain.	(MAR) revealed: or Acetaminophen 325mg 2 scheduled for 9:00am and mg was documented as /01/24 - 03/20/24 (9:00am). ent #10's medications on 11:05am revealed: of Acetaminophen 325mg 03/06/24 with instructions to a day. Acetaminophen 325mg ne bubble card. on 03/20/24 at 11:05am ered 2 Acetaminophen ident #10. ninistered 2 Acetaminophen ident #10 that morning, d Acetaminophen because ed of left hip and left knee	D 358			
	-Resident #10 should Acetaminophen 325m 03/20/24; it was an ov	ng tablets that morning on				
	on 03/20/24 at 11:48a -The MA should have Acetaminophen 325m that morning on 03/20 -The MAs were suppo when administering n the medications acco	administered 2 ng tablets to Resident #10 0/24. osed to read the MARs nedications and administer rding to the orders. ector of Resident Care				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HAL098030	B. WING			R-C 8/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
DA DKWO	OD VII I ACE	1730 PAI	RKWOOD BLVD			
PARKWO	OD VILLAGE	WILSON	, NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	labels and administer -Resident #10 should Acetaminophen 325n on 03/20/24. Interview with the Add 1:17pm revealed the compare the medicat administer the medicat review with Reside provider (PCP) on 03 -Resident #10 was planthritis painReceiving only half t could increase the re Based on observation reviews, it was detern not interviewable. Observation of Resid 10:54am revealed: -There were 2 staff in incontinence care to MA who was adminis resident's left knee an -Resident #10 moans turned her from side care and application Interview with the MA revealed the resident	d the MARs and medication redication as ordered. If have been administered 2 and tablets instead of 1 tablet ministrator on 03/20/24 at MAs were supposed to the cition labels and MARs and ations as ordered. The sprimary care structured and the supposed to the cition labels and markets and ations as ordered. The sprimary care structured at 2:21 pm revealed: the strescribed Acetaminophen for the dose of Acetaminophen sident's arthritic pain. The sprimary care structured and record mined that Resident #10 was the structured at the sprimary care at the room providing the streing an arthritis gel to the streing an arthritis gel to the and left hip. The streing and	D 358	DEFICIENCY		
	dated 01/25/24 revea	nt #7's closed record FL-2 aled diagnoses included al fibrillation, heart failure,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND I LAN OF	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:		
		HAL098030	B. WING		R-C 03/22/2024
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
PARKWOO	D VILLAGE	1730 PARI WILSON, I	KWOOD BLVD NC 27895		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
	dated 01/25/24 revea Sulfate 100mg/5ml Sci give 0.5ml (10mg) every for pain/shortness of lacontrolled substance breathing difficulties a symptoms.) Review of Resident # dated 02/14/24 (7:00a-The resident returned arm from a fall during -Hospice was contact-The resident was in p-Facility staff would corresident. Review of Resident # (PCP) electronic president. There was an entry for the electronic president in resident's correquest. Review of Resident # (PCP) electronic president in resident's correquest. Review of Resident # (PCP) electronic president in resident's correquest. There was an entry for 100mg/5ml Solution promotes and electronic president in promotes and elec	t #7's closed record FL-2 led an order for Morphine colution prefilled syringes ery 4 hours as needed (prn) breath. (Morphine is a used to treat severe pain, and other end of life 7's facility nurses' notes am - 3:00pm) revealed: d to the facility with a broken the previous night. ied. coain. continue to monitor the 7's primary care provider cription (e-script) dated evealed an order for take 0.5ml every 4 hours, due to increased pain, condition, and per family's 7's February 2024 ation record (MAR) revealed:	D 358		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BOILBING.		R-C		
		HAL098030	B. WING		03/22/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
PARKWO	OD VILLAGE		KWOOD BLVD			
		WILSON, I	NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
D 358	Continued From page	e 20	D 358			
	5:00am. -The first dose of sch documented as admi 9:00am and again at 9:00pm. -There was no sched documented as admi was ordered to be ad 7:20pm. -The resident would h scheduled Morphine on 02/29/24 at 1:00al Review of Resident # 03/01/24 - 03/22/24 r. -There was an entry 1 prefilled syringes give hours for pain/shortness.	7's March 2024 MAR dated				
		hine was documented as casions at 1:00am, 5:00am, /24.				
	at the facility's contra at 5:00pm revealed: -The pharmacy only of Resident #7 one time	nsed 30 prefilled syringes of				
	records from the facil for Morphine dated 0' -There were 30 prefill 100mg/5ml dispensed	supplies of Morphine				

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NAME OF PROVIDER OR SUPPLIER PARKWOOD VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES NAME OF PROVIDER'S PLAN OF CORRECTION R-C 03/22/2024 R-C 03/22/2024 PROVIDER'S PLAN OF CORRECTION (X5)	STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1730 PARKWOOD BLVD WILSON, NC 27895 (X41)0 PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 21 D 358 Review of Resident #7's controlled substance (CS) logs for Morphine 100mg/5ml revealed: -There was a supply of 30 prefilled syringes with Morphine Sulfate at 11:35am and 8:00pm on 02/28/24. -The next documented dose of Morphine was administered at 10:15am on 10/29/23. -There were 19 doses of Morphine documented as administered on 02/29/24 at 1:15pmThere was a second handwritten CS log dated 02/29/24 with 11 prefilled syringes with Morphine Sulfate 100mg/5ml received on 02/29/24, leaving a balance of 11There was a second handwritten CS log dated 02/29/24 with 11 prefilled syringes with Morphine Sulfate 11:15pmThere was a second handwritten CS log were				A. DUILDING: _			
NAME OF PROVIDER OR SUPPLIER 1730 PARKWOOD BLVD WILSON, NC 27895 (X4) ID PREFIX TAG (SUMMARY STATEMENT OF DEFICIENCES WINST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 21 D 358 Review of Resident #7's controlled substance (CS) logs for Morphine 100mg/5ml revealed: -There was a supply of 30 prefilled syringes with Morphine Sulfate 100mg/5ml received on 07/12/23 with instructions to give 0.5ml (10mg) every 4 hours pm for pain/shortness of breathThe first pm dose of Morphine was administered at 10:15am on 10/29/23There were prodoses of Morphine documented as administered on 02/29/24 at 9:00am, a 13-hour gap from the dosage administered at 8:00pm on 02/28/24, when the resident should have received a scheduled dose every 4 hoursThere was a balance of 11There was a signal salance of 11There was a second handwritten CS log dated 02/29/24, with 11 prefilled syringes with Morphine Sulfate 100mg/5ml goses of Morphine documented as administered at 11:15pmThere was a second handwritten CS log dated 02/29/24 with 11 prefilled syringes with Morphine Sulfate 100mg/5ml goses with Morphine Sulfate 100mg/5ml documented as received (carried over from the supply received on 07/12/23)The instructions on the handwritten CS log were	HAI 009030			B. WING		1	
PARKWOOD VILLAGE SUMMARY STATEMENT OF DEFICIENCY WILSON, NC 27895						1 03/22/2024	
SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG PROVIDER'S PLAN OF CORRECTION COMMENT TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE	NAME OF PI	ROVIDER OR SUPPLIER			TE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION (CAC) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (CAC) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (CAC) PREFIX TAG PROVIDER'S PLAN OF CORRECTION PREFIX TAG PROVIDER'S PLAN OF CORRECTION CACO PART	PARKWO	OD VILLAGE					
PREFEX TAG		OUR MARK OT	·				
Review of Resident #7's controlled substance (CS) logs for Morphine 100mg/5ml revealed: -There was a supply of 30 prefilled syringes with Morphine Sulfate 100mg/5ml received on 07/12/23 with instructions to give 0.5ml (10mg) every 4 hours prn for pain/shortness of breathThe first prn dose of Morphine was documented as administered at 10:15am on 10/29/23There were prn doses of Morphine documented as administered at 11:35am and 8:00pm on 02/28/24The next documented dose of Morphine was administered on 02/29/24 at 9:00am, a 13-hour gap from the dosage administered at 8:00pm on 02/28/24 when the resident should have received a scheduled dose every 4 hoursThere were 19 doses of Morphine documented as administered from 10/29/23 through 1:00pm on 02/29/24, leaving a balance of 11There was handwritten documentation that the prn dose was discontinued on 02/29/24 at 1:15pmThere was a second handwritten CS log dated 02/29/24 with 11 prefilled syringes with Morphine Sulfate 100mg/5ml documented as received (carried over from the supply received on 07/12/23)The instructions on the handwritten CS log were	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE COMPLETE	
(CS) logs for Morphine 100mg/5ml revealed: -There was a supply of 30 prefilled syringes with Morphine Sulfate 100mg/5ml received on 07/12/23 with instructions to give 0.5ml (10mg) every 4 hours prn for pain/shortness of breathThe first prn dose of Morphine was documented as administered at 10:15am on 10/29/23There were prn doses of Morphine documented as administered at 11:35am and 8:00pm on 02/28/24The next documented dose of Morphine was administered on 02/29/24 at 9:00am, a 13-hour gap from the dosage administered at 8:00pm on 02/28/24 when the resident should have received a scheduled dose every 4 hoursThere were 19 doses of Morphine documented as administered from 10/29/23 through 1:00pm on 02/29/24, leaving a balance of 11There was handwritten documentation that the prn dose was discontinued on 02/29/24 at 1:15pmThere was a second handwritten CS log dated 02/29/24 with 11 prefilled syringes with Morphine Sulfate 100mg/5ml documented as received (carried over from the supply received on 07/12/23)The instructions on the handwritten CS log were	D 358	Continued From page	e 21	D 358			
shortness of breath. -The first dose was documented as administered at 2:20pm on 02/29/24. -There were 2 other doses documented as administered at 6:00pm and 10:00pm on 02/29/24. -There were 3 doses documented as administered on 03/01/24 at 2:00am, 6:00am, and 9:00am, leaving a balance of 5 syringes.		(CS) logs for Morphin -There was a supply of Morphine Sulfate 100 07/12/23 with instruct every 4 hours prn for -The first prn dose of as administered at 10 -There were prn dose as administered at 11 02/28/24. -The next documente administered on 02/29 gap from the dosage 02/28/24 when the re a scheduled dose every -There were 19 doses as administered from on 02/29/24, leaving a -There was handwritte prn dose was discont 1:15pm. -There was a second 02/29/24 with 11 prefix Sulfate 100mg/5ml do (carried over from the 07/12/23). -The instructions on the 07/12/23). -The first dose was deat 2:20pm on 02/29/24. -There were 2 other of administered at 6:00p 02/29/24. -There were 3 doses administered on 03/0	see 100mg/5ml revealed: of 30 prefilled syringes with lmg/5ml received on cions to give 0.5ml (10mg) pain/shortness of breath. Morphine was documented 0:15am on 10/29/23. es of Morphine documented :35am and 8:00pm on ed dose of Morphine was 9/24 at 9:00am, a 13-hour administered at 8:00pm on sident should have received ery 4 hours. es of Morphine documented 10/29/23 through 1:00pm a balance of 11. en documentation that the inued on 02/29/24 at handwritten CS log dated illed syringes with Morphine ocumented as received es supply received on the handwritten CS log were ml) every 4 hours for pain or ocumented as administered 4. doses documented as om and 10:00pm on documented as 1/24 at 2:00am, 6:00am,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				R-C	
		HAL098030	B. WING		03/22/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
PARKWO	OD VILLAGE	1730 PAR	RKWOOD BLVD		
- ARRIVO	OD VILLAGE	WILSON	, NC 27895		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 358	Continued From page	: 22	D 358		
	9:00am, then handwri indicated, "resident de	itten documentation			
		7's hospice note dated resident's time of death /24.			
	Interview with a MA or revealed: -Resident #7 was in p	•			
	broken her armThe resident was sho	ort of breath and always on			
	oxygenMorphine helped with shortness of breath.	n the resident's pain and			
	shortness of breath. -She did not always administer the Morphine because if the resident was "knocked out cold", she did not want to put more in the resident's				
	order changes when t	nsible for implementing the order was received. by Resident #7's scheduled			
	Morphine order was nafter it was received.	of Morphine on hand that			
	could be used for the because it was the sa	scheduled Morphine			
	Telephone interview w	evealed:			
	 She did know why the transcribing Resident order. 	ere was a delay in #7's scheduled Morphine			
	-She did not know wh the MAR because the documented.	o transcribed the order on re were no initials			
	-She administered prr before the order was	n Morphine to Resident #7 changed to schedule was in distress, yelling			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED
		HAL098030	B. WING		R-C 03/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
DADKWO		1730 PARK	WOOD BLVD		
PARKWO	OD VILLAGE	WILSON, N	IC 27895		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Continued From page	23	D 358		
	-She passed on to first resident was in distretion -When she administed resident would yell less wore off.	st shift staff and hospice that			
	(DRC) on 03/21/24 at -Any MA on duty at the received was responsion the MARsThere were new order be used to track the responsion to the usually got the responsion to the tracking form to trespect was not sure with MAs transcribing Responsion to the same transcribing responsible to the tracking order onto the same transcribing at the front of the same transcribing at the front of the same transcribing at the front of the same transcribe at the front of the same transcribe at	te time an order was sible for transcribing orders er tracking forms that could nedication orders. nedication orders and used ack the orders. by there was a delay in the ident #7's scheduled			
	nurse on 03/21/24 at -Resident #7's Morph scheduled due to incr decline in her conditio -Resident #7 had pair had facial grimacing, "help me, help me"Resident #7 also had broken arm from a fal Telephone interview v 03/19/24 at 2:56pm re -On 02/28/24, the hos	ine was changed to reased pain all over and on. In to touch all over as she moaning, and calling out d increased pain due to a l. with Resident #7's PCP on			

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	
	HAL098030	
PARKWOOD BLVD		
PARKWOOD VILLAGE WILSON, NC 27895	PARKWOOD VILLAGE	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CORRECTIVE ACTION SHOUL	PREFIX (EACH	
rapid breathing) so she changed the order for Morphine to be scheduled every 4 hours around 7:30pm that night. -She faxed the order to the facility on 02/28/24 around 7:30pm. -When she arrived to the facility the next morning, 02/29/24, the resident had increased work of breathing, shortness of breath, and agitation. -She checked the MAR and the Morphine order had not been changed to scheduled. -The facility staff indicated they did not receive the order but she received fax confirmation that the order was received when faxed on 02/28/24. A second interview with Resident #7's PCP on 03/21/24 at 1:50pm revealed: -Resident #7's scheduled Morphine order went directly to the facility via fax and email at the date and time stamped on the prescription. -She did not send a copy of the Morphine order increasing to a scheduled dose to the pharmacy because the resident already had Morphine available for administration at the facility and did not need any sent from the pharmacy. -At least 2 or 3 doses of the scheduled Morphine should have been administrated from the time the order was received on 02/28/24 until the MAs started administrating it the next day, 02/29/24. -The resident was really agitated, visibly uncomfortable, fidgely, and moaning a little on the morning of 02/29/24. -After the resident received the scheduled Morphine dose at 9.00am on 02/29/24, the resident's symptoms improved. -The resident was no longer moaning and she was resting and asleep. Attempted telephone interview with Resident #7's family member on 03/21/24 at 12:40pm was unsuccessful.	rapid breath Morphine to 7:30pm that -She faxed the around 7:30 -When she at 02/29/24, the breathing, single-she checked had not bee -The facility the order but the order was a second into 03/21/24 at -Resident #7 directly to the and time state -She did not increasing to because the available for not need an -At least 2 of should have order was restarted adming -After the resider uncomfortable the morning -After the resider was resident's syntheresident's syntheresident the morning -After the resider was resting the Attempted to family members.	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
HAL098030		B. WING		R-C 03/22/2024		
	ROVIDER OR SUPPLIER		DRESS, CITY, STA KWOOD BLVD NC 27895	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	2 5	D 358			
	o1/25/24 revealed: -There was an order of tablet every day for some controlled substance agitation, and restlessThere was an order of tablet every 4 hours are or agitation or restles. Review of Resident # (PCP) verbal orders of the controlled or the controlled or the controlled of the controlled	for Lorazepam 0.5mg take 1 as needed (prn) for anxiety sness. 7's primary care provider dated 02/29/24 revealed: to discontinue Lorazepam to discontinue Lorazepam prn. to start Lorazepam 0.5mg nours for agitation, may s of cheeks. onic prescription (e-script) 26am for Lorazepam 0.5mg quantity of 120 tablets to be				
	had circled initials fro	ne scheduled Lorazepam m 01/27/24 - 01/31/24 with dicate why Lorazepam was				
	revealed: -There was an entry f	7's February 2024 MAR or Lorazepam 0.5mg 1 leep scheduled for 8:00pm. ne 8:00pm dose of				

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Lorazepam 0.5mg was blank 02/01/24 and

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AND BLAN OF CORRECTION IDENTIFICATION NUMBER		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		7 20.23		R-C
	HAL098030	B. WING		03/22/2024
NAME OF PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STAT	TE, ZIP CODE	
PARKWOOD VILLAGE	1730 PAR	KWOOD BLVD		
PARRWOOD VILLAGE	WILSON,	NC 27895		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 358 Continued From page	je 26	D 358		
Lorazepam was not -Lorazepam 0.5mg wadministered from 0 02/18/24 due to "aw -Lorazepam 0.5mg wadministered at 8:00 and on 02/19/24, the -There was a second 1 tablet every 4 hour or restlessnessThe prn Lorazepam administered on one 4:00am for anxietyThere was a third had Lorazepam 0.5mg wagitation scheduled 1:00pm, 5:00pm, 9:0-Lorazepam 0.5mg wadministered at 5:00-The Lorazepam 0.5mg wadministered at	was documented as not 2/02/24 - 02/11/24 and aiting pharmacy". was documented as opm from 02/12/24 - 02/14/24 en noted to be discontinued. It dentry for Lorazepam 0.5mg rs prn for anxiety or agitation as was documented as a occasion on 02/19/24 at andwritten entry for for administration at 9:00am, 1:00am, and 5:00am. Was documented as opm and 9:00pm on 02/29/24. In gloses for 1:00am and were blank with no reason			
revealed: -There was an entry tablet at bedtime for	·			
documented as adm -There was a second 1 tablet every 4 houd 1:00pm, 5:00pm, 9:00 -Lorazepam 0.5mg was administered on 3 on	tablet at bedtime for sleep schedule for 8:00pm. -There was no Lorazepam 0.5mg at bedtime documented as administered in March 2024. -There was a second entry for Lorazepam 0.5mg 1 tablet every 4 hours scheduled for 9:00am, 1:00pm, 5:00pm, 9:00pm, 1:00am, and 5:00am. -Lorazepam 0.5mg was documented as administered on 3 occasions at 1:00am, 5:00am, and 9:00am on 03/01/24.			

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was 9:50am.

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AND DIAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		A. BOILDING.			_	
HAL098030			B. WING		R- 03/2	2/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DA DKWO	OD VILLAGE	1730 PARK	WOOD BLVD			
PARKWO	OD VILLAGE	WILSON, N	IC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 27	D 358			
	(CS) logs for Lorazep -There was a CS log tablets received on 0° -There were 15 Loraz documented as admit 8:00pm through 01/26 balance of 0There was no CS log Lorazepam 0.5mg we at 8:00pm from 01/26 -There was a CS log tablets received on 0° of Lorazepam started 8:00pm. Review of Resident #	with 15 Lorazepam 0.5mg 1/09/24. repam 0.5mg tablets nistered from 01/11/24 at 5/24 at 8:00pm, leaving a g indicating any doses of ere administered as ordered 1/24 - 02/11/24. with 30 Lorazepam 0.5mg 1/2/24 and administration 1/2/24 again on 02/12/24 at 1/3/s pharmacy dispensing				
	for Lorazepam dated revealed: -There were 15 Loraz dispensed on 07/08/2 10/05/23, 11/09/23, 1 01/06/24. -There were 30 Loraz	zepam 0.5mg tablets 23, 08/08/23, 09/13/23, 2/10/23, 12/23/23, and				
	at the facility's contrar at 5:00pm revealed: -The pharmacy dispe tablets on 01/06/24. -The facility requested on 02/08/24 but there -The pharmacy faxed let them know they no the Lorazepam.	with a pharmacy technician cted pharmacy on 03/21/24 should be a refill on the Lorazepam were no refills. The facility on 02/08/24 and deeded a new prescription for the state of the state				

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on 02/11/24 with 30 Lorazepam 0.5mg tablets.

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE Co			E SURVEY PLETED
JUB 1 EAR OF CONTROL OF THE PROPERTY OF THE PR		A. BUILDING:		COIVI	ILLILD	
HAL098030		B. WING		I	R-C 3/22/2024	
		•			0	3/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
PARKWO	OD VILLAGE		RKWOOD BLVD			
		WILSON	I, NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 28	D 358			
	call the pharmacy and She was not sure about Lorazepam being unated She did not recall issuborazepam. Interview with the Dir (DRC) on 03/21/24 are The MAs were responsed to notify he supposed to notify he She was not aware It.	evealed: unavailable, the MAs should d the provider. bout Resident #7's available or discontinued. sues with the resident's ector of Resident Care t 3:07pm revealed: bnsible for ordering unavailable, the MAs were				
	1:50pm revealed: -Resident #7's bedtin not discontinued until increased the scheduland discontinued the -The resident should the scheduled bedtime that timeShe was not aware to doses during that time been documented as order on 02/29/24 chelling the the companion of the resident was "rewhich was the reason scheduled doseNot receiving the Lorente and the companion of the c	prn Lorazepam. have continued to receive he dose of Lorazepam until the resident missed any e and it should not have discontinued until the verbal anging it to every 4 hours. eal agitated and anxious" in she increased the razepam during that time to the resident's anxiety and				

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STATE FORM 6899 N1S211 If continuation sheet 29 of 104

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1730 PARKWOOD BLVD WILSON, NC 27895 CACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE D 358 Continued From page 29		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		, ,	E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER PARKWOOD VILLAGE (X4) ID PREFIX TAGS (X5) ID PREFIX TAGS (X6) ID PREFIX TAGS (X7) ID PREFIX TAGS (X7) ID PREFIX TAGS (X6) ID PREFIX TAGS (X7) ID PREFIX TAGS (X7) ID PREFIX TAGS (X6) ID PREFIX TAGS (X7) ID PREFIX TAGS (X8) ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE (X8) ID PREFIX TAGS (X9) ID PREFIX TAGS		HAI 008030					-
PARKWOOD VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DIVIDED IN TAKE OF THE APPROPRIATE DIVIDED IN T	NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	1 00	112212024
NULSON, NC 27895 PROVIDER'S PLAN OF CORRECTION PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION CACHO SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE					,		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 29 unavailable during that time. -If the facility needed a new hard prescription, they could contact her because their office had service available 24 hours a day if needed. -She was also at the facility every Monday and Thursday and they could request a prescription if needed. -The facility staff should let her know a new prescription was needed when they got down to a 5-day supply. 3. Review of Resident #8's closed record FL-2 dated 08/23/23 revealed diagnoses included dementia and hypertension. Review of Resident #8's primary care provider (PCP) note dated 02/28/24 revealed: -The resident was started on an antibiotic on 02/27/24 for treatment of a presumed respiratory infection. -Today, 02/28/24, the resident's condition had deteriorated substantially. -The resident had a respiratory rate of 60 breaths per minute and did not appear to be comfortable. -After discussion with the resident's family, the resident was started on as needed (pm)	PARKWO	OD VILLAGE	WILSON,	NC 27895			
unavailable during that time. -If the facility needed a new hard prescription, they could contact her because their office had service available 24 hours a day if needed. -She was also at the facility every Monday and Thursday and they could request a prescription if needed. -The facility staff should let her know a new prescription was needed when they got down to a 5-day supply. 3. Review of Resident #8's closed record FL-2 dated 08/23/23 revealed diagnoses included dementia and hypertension. Review of Resident #8's primary care provider (PCP) note dated 02/28/24 revealed: -The resident was started on an antibiotic on 02/27/24 for treatment of a presumed respiratory infection. -Today, 02/28/24, the resident's condition had deteriorated substantially. -The resident had a respiratory rate of 60 breaths per minute and did not appear to be comfortable. -After discussion with the resident's family, the resident was started on as needed (pm)	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	COMPLETE
Morphine for management of shortness of breath. (Morphine is a controlled substance used to treat severe pain, breathing difficulties and other end of life symptoms.) -The resident was on oxygen via nasal cannula today as well. Review of Resident #8's PCP order dated 02/28/24 revealed: -There was an electronic prescription (e-script) for Morphine 10mg/0.5ml Oral Solution, take 0.5ml every 4 hours as needed for pain or shortness of breath. -It was electronically signed on 02/28/24 at	D 358	unavailable during that lift the facility needed they could contact he service available 24 hrows also at the facility staff should prescription was needed. Review of Resident #(PCP) note dated 02/-The resident was staff of the deteriorated substant. The resident had a reper minute and did not a reper minute and did not a factor of the deteriorated substant. The resident had a reper minute and did not a factor of the deterior manage (Morphine for manage (Morphine for manage (Morphine is a control severe pain, breathing of life symptoms.) The resident was on today as well. Review of Resident #02/28/24 revealed: There was an electrof for Morphine 10mg/0. 0.5ml every 4 hours a shortness of breath.	at time. a new hard prescription, r because their office had fours a day if needed. facility every Monday and build request a prescription if all let her know a new ded when they got down to a t #8's closed record FL-2 led diagnoses included ension. 8's primary care provider 28/24 revealed: arted on an antibiotic on at of a presumed respiratory resident's condition had ially. espiratory rate of 60 breaths of appear to be comfortable. the resident's family, the on as needed (prn) ment of shortness of breath. Illed substance used to treat g difficulties and other end oxygen via nasal cannula 8's PCP order dated onic prescription (e-script) 5ml Oral Solution, take as needed for pain or	D 358			

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	AND DLAN OF COPPECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R-C	
		HAL098030	B. WING		03/22/2	024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PARKWO	OD VILLAGE		WOOD BLVD			
		WILSON, N	IC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE C	(X5) COMPLETE DATE
D 358	Continued From page	e 30	D 358			
	7:17pmThere was documen fax and email to the fat 7:19pm.	tation the order was sent via acility on 02/28/24 at				
	Review of Resident #8's hospice visit note by the hospice social worker (SW) dated 03/01/24 revealed: -Upon SW arrival, the resident was laying supine					
	in bedThe resident appeared to be decliningThe resident complained of pain all overThe hospice nurse was aware.					
	Review of Resident #8's hospice visit note by the hospice nurse dated 03/01/24 revealed: -The resident was tachycardic (fast heart rate) with tachypnea (abnormally rapid breaths)The resident complained of pain, had facial grimacing, and was sore to touchThe hospice nurse noted the resident had an order for Morphine scheduled every 4 hours.					
	dated 03/01/24 revea	8's hospice verbal order led an order for Morphine ve 0.5ml every 4 hours				
	nurse on 03/02/24 rev -The facility's concerr scheduled Morphine -The hospice nurses'					
	Review of Resident # 03/03/24 revealed: -The resident was act	8's hospice order dated				

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comfort medications.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING: _			
		HAL098030	B. WING		R-C 03/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
PARKWO	OD VILLAGE	1730 PARI WILSON, N	(WOOD BLVD		
	OLIMANA DV. OT	·		DDOWDEDIO DI ANI OF CODDECTIO	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 358	Continued From page	e 31	D 358		
	awake or asleep.	ohine if the resident was indicated "administer t) awake or asleep".			
	Resident #8 revealed -The resident was act respiratory distressThe resident was con with respiratory chang moved/repositionedThere was an order of Morphine from every severe pain or respira administer if the resid Review of Resident # medication administra -There was a handwr	mfortable but uncomfortable ges when to increase scheduled 4 hours to every 2 hours for atory distress, do not hold, lent awake or asleep.			
	-There was no Morphine documented as administered in February 2024There were no other orders for Morphine transcribed onto the February 2024 MAR.				
	Sulfate 100mg/5ml ta needed for pain or sh -There was no prn Mo administered for this of -There was a second Morphine 100mg/5ml with a written date of 8:00am, 12:00pm, 4:0 and 4:00am.	itten entry for Morphine ke 0.5ml every 4 hours as ortness of breath. orphine documented as entry.			

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AND DUAN OF CODDECTION		(X2) MULTIPLE	(X3) DATE SURVE			
		A. BUILDING: _		OOW!! EETED		
		B. WING		R-C	10.4	
		HAL098030			03/22/20	124
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
DARKWO	OD VILLAGE	1730 PARI	KWOOD BLVD			
PARKWO	OD VILLAGE	WILSON, I	NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE CO	(X5) DMPLETE DATE
	-Morphine was docun on 03/02/24 at 12:00a	with an asterisk and ster if awake or asleep. nented as not administered am and 4:00am, on 03/03/24 am due to the resident				
	-Staff initials were circ and 8:00pm with no re the medication. -There was a third ha 100mg/5ml give 0.5m	cled on 03/01/24 at 8:00am eason for not administering ndwritten entry for Morphine I every 2 hours scheduled				
	for 8:00am, 10:00am, 12:00pm, 2:00pm, 4:00pm, 6:00pm, 8:00pm, 10:00pm, 12:00am, 2:00am, 4:00am, and 6:00am. -The first documented dose was administered at 10:00pm on 03/03/24. -A second dose was documented as administered at 12:00am on 03/04/24. -There were no other doses documented as administered in March 2024.					
	-There was a handwr expired on 03/04/24 a	tten note that the resident at 12:37am.				
	(CS) log for Morphine	8's controlled substance revealed: CS log for Morphine with 30				
	there was a direction	eived on 02/29/24. e date of 02/29/24 and change sticker placed over prescription label at the top				
	of the CS logThere were no doses as administered in Fe	of Morphine documented bruary 2024.				
	03/01/24 at 12:00pm. -There was a second	dose documented as				
	administered on 03/0 -There were no other documented as admin ordered.	•				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BUILDING		D 0	
HAL098030		B. WING		R-C 03/22/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
PARKWO	OD VILLAGE	1730 PARK WILSON, N	WOOD BLVD C 27895		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 358	administered on 03/02 4:00pm, and 8:00pmThe next dose was madministered until 03/hours after the last do -The last dose was do on 03/04/24 at 12:00a Review of Resident # records from 07/01/25 -The pharmacy dispe Morphine Sulfate 100 -The date the order w -The instructions were 4 hours as needed for breath. Review of Resident # 03/04/24 at 12:20am assess the resident at Interview with a media 03/21/24 at 2:55pm re -Resident #8 was in attrouble breathingThe resident was gas -She could tell the resident was frow to 3 days of her lifeThere were two MAs resident's Morphine be the resident was trans not think the resident -Those MAs document	alled doses documented as 2/24 at 8:00am, 12:00pm, not documented as 103/24 at 8:45am, over 12 ose. ocumented as administered am. 8's pharmacy dispensing 3 - 03/20/24 revealed: nsed 30 prefilled syringes of 10mg/5ml on 02/29/24. The totake 0.5ml (10mg) every repain or shortness of 17's incident report dated revealed hospice came to not the resident had expired. The cation aide (MA) on 10mg every repain or shortness of 10mg/5ml and having 10mg/5ml and moaning the last 2 of 10mg/5ml and 1	D 358		
		clining and hospice ordered			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND I LAW OF CONNECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED	
		HAL098030	B. WING		R-C 03/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
DA PKWO	OD VILLAGE	1730 PARI	KWOOD BLVD		
PARRWO	OD VILLAGE	WILSON, I	NC 27895		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 358	Continued From page	e 34	D 358		
D 358	scheduled Morphine a-When she assessed said she was not in pif the resident could go bathroom, she held the Morphine because she needed it. -She did not notify the held the resident's Mobeen told to notify the Attempted telephone 03/21/24 at 5:41pm was at the facility's contrar at 5:00pm revealed: -They received an ord Morphine on 02/28/24 -The order was proceived at the each of the order was proceived at 4:00pm to process or Resident #8's Morph 02/29/24 and delivered at 4:08pm. -The back up pharmal dispense Morphine was a pharmal facility needed to confidence with the Direct of the MAs were having medication from the pher and the provider if	the resident, if the resident ain or not short of breath or get up and walk to the ne resident's scheduled ne did not think the resident e hospice nurse that she orphine because she had not e hospice nurse. Interview with a third MA on was unsuccessful. With a pharmacy technician cted pharmacy on 03/21/24 der for Resident #8's 4 after 7:00pm. essed the next day, 02/29/24, or one at the pharmacy after ders. In the was dispensed on ed to the facility on 02/29/24 acy would not be able to without the hard copy decist on call after hours if the tact them. ector of Resident Care to 3:07pm revealed: Ing trouble getting a pharmacy, they should let	D 358		
	-There had been som	order for Resident #8. ne issues with the ident #8's Morphine brought			

Division of Health Service Regulation

STATE FORM 6899 N1S211 If continuation sheet 35 of 104

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1730 PARKWOOD BLVD WILSON, NC 27895 (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 35 to her attention by a hospice nurseSome of the MAs did not administer the Morphine when the resident was asleep because the resident was not in distress while she was sleeping and did not look like she was in pain to the MAsThey had to get a clarification order to administer the Morphine when the resident was asleep or awakeThe MAs did not realize the Morphine was also for shortness of breath.	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER 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) D 358 Continued From page 35 to her attention by a hospice nurseSome of the MAs did not administer the Morphine when the resident was asleep because the resident was not in distress while she was sleeping and did not look like she was in pain to the MAsThey had to get a clarification order to administer the Morphine when the resident was asleep or awakeThe MAs did not realize the Morphine was also	R-C	
PARKWOOD VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 35 to her attention by a hospice nurseSome of the MAs did not administer the Morphine when the resident was asleep because the resident was not in distress while she was sleeping and did not look like she was in pain to the MAsThey had to get a clarification order to administer the Morphine when the resident was asleep or awakeThe MAs did not realize the Morphine was also	03/22/2024	
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 35 to her attention by a hospice nurseSome of the MAs did not administer the Morphine when the resident was asleep because the resident was not in distress while she was sleeping and did not look like she was in pain to the MAsThey had to get a clarification order to administer the Morphine when the resident was asleep or awakeThe MAs did not realize the Morphine was also		
WILSON, NC 27895 (X4) ID PREFIX TAG OR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 35 to her attention by a hospice nurseSome of the MAs did not administer the Morphine when the resident was asleep because the resident was not in distress while she was sleeping and did not look like she was in pain to the MAsThey had to get a clarification order to administer the Morphine when the resident was asleep or awakeThe MAs did not realize the Morphine was also		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 35 to her attention by a hospice nurseSome of the MAs did not administer the Morphine when the resident was asleep because the resident was not in distress while she was sleeping and did not look like she was in pain to the MAsThey had to get a clarification order to administer the Morphine when the resident was asleep or awakeThe MAs did not realize the Morphine was also		
to her attention by a hospice nurseSome of the MAs did not administer the Morphine when the resident was asleep because the resident was not in distress while she was sleeping and did not look like she was in pain to the MAsThey had to get a clarification order to administer the Morphine when the resident was asleep or awakeThe MAs did not realize the Morphine was also	BE COMPLETE	
-Some of the MAs did not administer the Morphine when the resident was asleep because the resident was not in distress while she was sleeping and did not look like she was in pain to the MAsThey had to get a clarification order to administer the Morphine when the resident was asleep or awakeThe MAs did not realize the Morphine was also		
-Some of the MAs did not think the resident needed Morphine if the resident was able to get up independently and go to the bathroomShe asked the hospice nurse to provide more education to the MAs. Telephone interview with Resident #8's family member on 03/21/24 at 12:27pm revealed: -Resident #8's Morphine was ordered every 4 hours and then every 2 hours near the end of her lifeShe only saw Resident #8 draw her eyebrows together once or twice on the day she died so she thought the facility was administering enough MorphineAt one time the resident's breathing was irregular and she had "a death rattle" when she breathed but she thought that was part of the dying process. Telephone interview with Resident #8's hospice nurse on 03/21/24 at 4:30pm revealed:		
-Resident #8 was in pain, having pain to touch and she was rapidly breathing at 60 breaths per minute. -The last several days of Resident #8's life, the resident would withdraw from touch, furrow her forehead, and had facial grimacing, indicating she		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		L COM			SURVEY PLETED	
7.1.2.2.1.1		152.111.16/11.16.11.16.11.1	A. BUILDING: _			
		HAL098030	B. WING			R-C / 22/2024
NAME OF B	ROVIDER OR SUPPLIER	CTDEET AF	INDESS CITY STAT	TE ZIR CODE		
NAIVIE OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STAT	TE, ZIP CODE		
PARKWO	OD VILLAGE		KWOOD BLVD			
			NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 358	Continued From page	e 36	D 358			
D 358	-The MAs at the facilir resident's Morphine at be in painShe had educated st make sure they admit orderedResident #8 was not ordered on 2 nights be during the weekendThe weekend hospic were not administering when the resident warenot administering when the resident warenot receiving Morphithe resident to be in prapid breathing. Attempted telephone 4:30pm and 03/22/24 #8's hospice nurse which was unsuccessful. Interview with Reside 2:06pm revealed: -Resident #8 complaint few weeks and needed 02/28/24The resident had right breathing as wellThe hospice nurse respiratory rate was 60 02/28/24 and when side checked it was 40 breathing enurses in the c	ty needed to administer the is ordered so she would not aff when at the facility to histered the Morphine as administered Morphine as efore she passed away are nurse reported the MAs g Resident #8's Morphine is sleeping. The as ordered would cause that and could contribute to an interviews on 03/21/24 at at 4:01pm with Resident the worked on the weekend and the prn Morphine dated and this pain and difficulty exported the resident's so breaths per minute on the got to the facility and	D 358			
	the resident was asle -The weekend hospic Monday, 03/04/24, ar	•				

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STATE FORM 6899 N1S211 If continuation sheet 37 of 104

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY PLETED	
			A. BUILDING:			
		HAL098030	B. WING		I	R-C 3 /22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
DARKWO	OD VII I ACE	1730 PAF	RKWOOD BLVD			
PARKWO	OD VILLAGE	WILSON,	NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 358			D 358			
	staff had not administ ordered because som the resident needed if	ne of the MAs did not think t.				
	-The order was changed to administer whether the resident was awake or asleep because the resident was actively dying and having continuous air hunger (feeling of severe breathlessness)Not receiving the Morphine while actively dying could cause the resident to be more uncomfortable and have terminal restlessness with a feeling of air hunger. 4. Review of Resident #5's current FL-2 dated					
	01/16/24 revealed:	t #3's current FL-2 dated				
		fibromyalgia, trigeminal				
	neuralgia and anxiety					
		dered Gabapentin 600mg chronic pain. (Gabapentin nerve pain.)				
		5's Resident Register admitted to the facility				
	dated 02/21/24 revea					
		en at the pain clinic related to n (pain in the head and				
	-A refill of Gabapentir	n 300mg in the morning, 600mg at night was initiated /21/24.				
	-The provider docume Gabapentin would no					
		e the Gabapentin dosage				
	Review of Resident #	5's pain clinic visit notes				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING		
		HAL098030	B. WING		R-C 03/22/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
PARKWO	OD VILLAGE	1730 PARK WILSON, N	WOOD BLVD C 27895		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	planned treatment (Trigeminal Nerve Pair Trigeminal Nerve Pair Tri	led: en at the pain clinic for a rigeminal Nerve Block) for n. t able to tolerate the it was not completed. vas reviewed and verified by on list included orders for capsule twice daily and 2 5's January 2024 ation record (MAR) revealed: for Gabapentin 600mg three e pain. vas documented as dent #5 three times daily in/24. onal entries for different for Gabapentin 600mg three e pain. abapentin 600mg three e pain. abapentin 600mg had been nes daily 02/01/24 through Gabapentin three times a ontinued on 02/11/24. hree times daily was not nistered from 02/11/24 to onal entries for different tin. 5's March 2024 MAR dated	D 358		
	03/01/24 - 03/19/24 re -There was an entry f	evealed: or Gabapentin 600mg three			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			\ , ,	(X3) DATE SURVEY COMPLETED		
		HAL098030	B. WING			R-C 3/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
PARKWO	OD VILLAGE		RKWOOD BLVD I, NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 358	times daily for chronic-The entry for 600mg day was marked disco-Gabapentin 600mg the documented as admin 03/19/24. There were no additious dosages of Gabapentin 600mg the hand for Resident #5. Interview with the Dire (DRC) on 03/20/24 at #5 had recently switch was not sure of the acceptance. Telephone interview wat the facility's contract at 3:10pm revealed: Resident #5 was admonthal entry in the resident used a dibut the contracted phof medications upon to the pharmacy had and Gabapentin 600mg the pain dated 01/16/24. The pharmacy had no 600mg because the famedication to be filled. The pharmacy did no discontinue Gabapen.	c pain. Gabapentin three times a continued on 02/11/24. hree times daily was not nistered 03/01/24 to conal entries for different tin. dent #5's medications on 10:32am revealed aree times daily was not on ector of Resident Care 11:38am revealed Resident hed pharmacies, but she ctual date for the change in extending the change in the change in the change in the change in extending the change in the change	D 358			

Division of Health Service Regulation

STATE FORM 6899 N1S211 If continuation sheet 40 of 104

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION (X3) DAT		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
		HAL098030	B. WING		R-C 03/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
PARKWO	OD VILLAGE		KWOOD BLVD NC 27895		
	OUR MARK OF	·			NTION
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETE
D 358	Continued From page	e 40	D 358		
	at 3:36pm revealed:	and the state of OA/A7/OA			
		rrent orders, dated 01/17/24,			
		g in the morning, 300mg at night for other diseases of			
	the neurological syste				
	-There was an order				
	discontinue Gabapen	tin 600mg three times daily			
	and start Gabapentin 300mg in the morning,				
300mg at noon, and 2 tablets (600mg) at night with a 21-day supply dispensed and picked up from the pharmacy on 01/18/24 and a 28-day supply dispensed on 02/28/24 and picked up from					
	the pharmacy on 03/09/24.				
	Telephone interview v	· · · · · · · · · · · · · · · · · · ·			
	Resident #5's previou 3:43pm revealed:	us pharmacy on 03/20/24 at			
		not aware Resident #5 had			
	been admitted to an a				
		viously been using the			
		ervices and the resident's			
	family usually picked	up medications from the			
	pharmacy.				
	-	otly stopping Gabapentin			
	could include an incre	ease in anxiety.			
	Telephone interview v	with a second pharmacist at			
		us preferred pharmacy on			
	03/21/24 at 2:40pm re				
	-The pharmacy had n	-			
		the facility to request a refill			
		for any Gabapentin orders.			
	an increase in pain.	abapentin could contribute to			
	·				
	Interview with a medi				
	03/20/24 at 10:35am				
	1	eived new or changed			
		e MA's faxed the order to ribed the new order on the			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A RUN PLAN OF		, ,	E SURVEY PLETED		
,		152.1111.13/1116.1116.1116	A. BUILDING: _		""	
		HAL098030	B. WING			R-C 3/ 22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE		
		1730 PAR	KWOOD BLVD			
PARKWO	OD VILLAGE		NC 27895			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
D 358	Continued From page	e 41	D 358			
	residents' MAR with the order, and placed chartShe thought Resider discontinued because 2024 MARs, noted R been discontinued or -She was not the MA discontinue Gabapen who had entered the discontinue Gabapen -She had not adminis Resident #5 after it w #5's MAR on 02/11/2 -The resident frequer headaches, but she in the resident headaches	the MA's initials and date of the order in the resident' at #5's Gabapentin had been the February and March the resident #5's Gabapentin had to 02/11/24. Who received the order to the internal she was not the MA documentation to the mark on 02/11/24. Attered Gabapentin to the mass discontinued on Resident 4. Attly complained of the internal she increase ches, complaints of in the resident's behavior				
	4:45pm revealed: -Resident #5's family medication bubble padosage of Gabapenti: -The family member of medication order so to clarify the order on -The pharmacy told the Gabapentin three time discontinuedThe pharmacy faxed the MA attached the obubble pack and place cartShe wrote the discontinued:	did not have the signed he MA called the pharmacy 02/11/24. he MA the 600mg es daily had been I the order to the facility and order to the medication ed it back in the medication httinue order on Resident				

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attached to the bubble pack.

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		, ,	(X3) DATE SURVEY COMPLETED	
		HAL098030	B. WING			R-C 8/22/2024	
			I		00	0/22/2024	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	E, ZIP CODE			
PARKWO	OD VILLAGE		RKWOOD BLVD				
		WILSON	I, NC 27895				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
D 358	Continued From page	: 42	D 358				
	Gabapentin 300mg in	here was an order to start the morning, 300mg at 600mg) at night, so she did n Resident #5's MAR.					
	-She had been taking year to help with pain shinglesShe thought one of h dose of Gabapentin rusure whenShe always had som but she had not notice	ered all of her medications. Gabapentin for over one after she had an episode of the doctors had lowered the ecently, but she was not the pain in her legs and head, and a difference in her pain dosage had been reduced.					
	member/power of atto 12:25pm revealed: -The facility had been medication since she -She had recently, in switched Resident #5 contracted pharmacyBefore the pharmacyBefore the pharmacy Resident #5's medica pharmacy and took the -Since the resident's a had picked up severa pharmacy and deliver she could not recall the each medicationThe facility had not to the medication orders the pharmacy had the the prescriptionsThe resident had been medicated.	administering Resident #5's was admitted. the last couple of weeks, 's pharmacy to the facility's changed, she picked up tion bubble packs from the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED		
			A. BUILDING:				
		HAL098030	B. WING		l	R-C 3 /22/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE			
DADKWO		1730 PAF	RKWOOD BLVD				
PARKWO	OD VILLAGE	WILSON,	NC 27895				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
	reduced Resident #5' recent appointmentThe facility had not to visit notes to the facility Resident #5's most recentlier that day on 03She thought Resident month she was living -After the first month noticed Resident #5 co well and was showing called the family mem	ecent visit notes to the facility /21/24. nt #5 did great for the first					
	-She was not aware t administering Reside was concerned becautaking that medication was concerned this maresident's recent char	he facility had not been nt #5's Gabapentin and she use the resident had been n for a long time and she hay have contributed to the nges in mood and anxiety.					
	revealed: -On 03/10/24 at 3:00president was sent to telft sided weakness aron 03/11/24 at 11:00	opm, staff documented the nthe the emergency room (ER)					
	03/10/24 revealed: -The resident was set weakness with uncert-There were no new corders or treatments.	5's hospital records dated en in the ER related to tain cause on 03/10/24. or changed medication DRC and Regional Director					
		ss (RDHW) on 03/21/24 at					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:			E SURVEY PLETED	
			A. Boilebino.			R-C
		HAL098030	B. WING		I	R-C 3/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATI	E, ZIP CODE		
		1730 PAF	RKWOOD BLVD			
PARKWO	OD VILLAGE	WILSON,	NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 44	D 358			
	11:57am revealed: -The facility's process administration was the and sent the orders to then entered the med and use on the MARThe staff entering the was supposed to date MARThe MAs completed times per week and refor further direction of the facility had impleated the mass of the medication range. The MAs were supported the medication range was not aware of the medication range. The was not aware of the medication of the medication range was not aware of the medication range. The was not aware of the medication range was not aware of the medication range. The was not aware of the medication range was not aware of the medication range. The was not aware of the medication range was not aware of the medication range. The was not aware of the medication range was not aware of the medication range. The was not aware of the medication range was not aware of the medication range. The mass of the medication range was not aware of the medication range without physician ord. The mass of the medication range was not aware of the medication range without physician ord. The mass of the medication range was not aware of the medication range was not aware of the medication range without physician ord. The mass of the medication range was not aware of the m	s for medication e MAs received the orders of the pharmacy, the MAs dication, dosage, instructions e information on the MAR e and initial the entry on the medication cart audits two eported their findings to her r clarification. emented a new process r where she would follow audit one time per week to ges and errors. had decided to change the facility's contracted psed to use the residents' dications and requests the elity's contracted pharmacy in out. of a facility process for atus of the transitions when harmacies. Resident #5's Gabapentin day was discontinued ers. he Resident #5's orders to mg in the morning, 300mg at night were not entered on of administered to the nt #5's primary care provider				
	(PCP) on 03/21/24 at -Facility staff told her Gabapentin 600mg th discontinued by the re	that the resident's				

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STATE FORM 6899 N1S211 If continuation sheet 45 of 104

AND DUAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C		(X3) DATE COMP	SURVEY PLETED		
			A. BUILDING:	A. BUILDING:			
		HAL098030	B. WING			R-C / 22/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	E, ZIP CODE			
		1730 PAR	KWOOD BLVD				
PARKWO	OD VILLAGE	WILSON,	NC 27895				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
D 358	on 02/11/24She did not see the oresident's chart, but see resident's Gabapentin pain clinic's medical paramacy had for Gamorning, 300mg at not she was not aware of 02/21/24 which noted provider had provided Gabapentin 300mg in noon, and 600mg at reshe was concerned Resident #5's orders prescribed by the pain she was concerned abruptly stopped with clinic's medical provided. When discontinuing Gabapentin, the mediwith a gradual taper to slide effects of abrupcould include nausea anxietyShe was aware the real of the control of the contr	discontinue order in the he did not manage the n as it was managed by the provider. If the orders that the bapentin 300mg in the poon, and 600mg at night. If the pain clinic visit note on the pain clinic medical direfills for Resident #5's in the morning, 300mg at night. If the facility had not followed for Gabapentin as in clinic. If that Resident #5 was out orders from the pain der. If the pain clinic with the facility had not followed for Gabapentin as in clinic. If the facility had not followed for Gabapentin as in clinic. If the pain clinic with the pain der. If the pain clinic with gas out orders from the pain der. If the pain clinic with gas out orders from the pain der. If the pain clinic with gas out orders from the pain der. If the pain clinic with gas out orders from the pain der. If the pain clinic with gas out orders from the pain der. If the pain clinic with gas out orders from the pain der. If the pain clinic visit note on the pain derection with gas out orders from the pain derection with	D 358	DEFICIENCY)			
	was not previously av -When the MA receive from Resident #5's fa	papentin on 03/21/24 but she ware of the errors. The new medication pack mily member she should harmacy for the orders and					

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STATE FORM 6899 N1S211 If continuation sheet 46 of 104

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:		, ,	SURVEY PLETED	
		HAL098030	B. WING		1	R-C 8/ 22/2024
NAME OF P	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
PARKWO	OD VILLAGE		RKWOOD BLVD , NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	she should have cont pain clinic to obtain or discontinued the Gab - The DRC typically coresidents who were trepharmacy, this was no previously followed unhave been reported to the Attempted telephone provider at the pain or and 12:41pm were unsured to the pain of an and 12:41pm were unsured to the pain of an analysis o	acted the resident's PCP or larification before she apentin on the MAR. Ompleted the process for ransitioning to a new ot something that she had p on or something that would of her. interviews with the medical linic on 03/21/24 at 8:26am insuccessful. Int #2's current FL-2 dated dementia, hypertension, major depressive disorder. ated from a local hospital. ented hospital admission e from the hospital was 8/24. an's order for Olanzapine and used to treat behaviors ag tablet two times a day. I information printed on the documenting medications lated once it was known for s the resident would be onal FL-2s dated after at #2. It physician prescription anzapine 5mg rapid dissolve es a day. order" dated 03/07/24 for	D 358			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
ANDILAN	OI CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMI ELTED
					R-C
		HAL098030	B. WING		03/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E, ZIP CODE	
		1730 PAF	RKWOOD BLVD		
PARKWO	OD VILLAGE		NC 27895		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 358	Continued From page	e 47	D 358		
	physician visit form da Zyprexa to 10mg two	an's order documented on a ated 03/16/24 increasing the times a day for facility agitation" and "up all night".			
	tablet take one tablet	ation records (MARs) itten entry for Zyprexa 5mg two times a day and			
	scheduled for 9:00am				
	-There were circled medication aide (MA) initials in the section for documentation of administration				
		e 9:00am and 8:00pm			
	dosages from 02/23/2				
	_	mentation on the back of the			
		ough 02/29/24 the Zyprexa			
		dministered because the			
		der from the pharmacy.			
		nentation of administration			
	for the Zyprexa for Fe	ebruary 2024 following			
	Resident #2's dischar				
	Review of Resident #	2's March 2024 MARs			
	-There was a printed tablet take one tablet	entry for Zyprexa 20mg every night.			
		tal line drawn through the			
		and 5mg was handwritten			
	in the instructions for	•			
	-There was a horizon	tal line drawn through the			
		every night and a frequency			
	of two times a day wa				
	instructions for admin				
	-The Zyprexa was sc	heduled for administration			
	twice daily at 9:00am				
	_	A initials in the section for			
	documentation of adr	ninistration for the Zyprexa			
	for the 9:00am and 8: 03/01/24 through 03/0				

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STATE FORM 6899 N1S211 If continuation sheet 48 of 104

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
					R-C	
		HAL098030	B. WING		03/22/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	= ZIP CODE		
TO UNIC OT T	NOVIDEN ON OUT FIEN		RKWOOD BLVD	-, -II		
PARKWO	OD VILLAGE		NC 27895			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		
D 358	Continued From page	2 48	D 358			
D 358	-There was MA docur MAR for 03/01/24 throsomy tablet was not as medication was on or There was document the first dose of the Zydischarge from the hoadministered on 03/07. Observation of Reside hand on 03/20/24 at 1-Zyprexa 10mg tablet tablet twice daily was There was a quantity. Review of staff notes 02/23/24 through 03/17-On 02/23/24 at 2:43pthe facility from the horesident #2 refused -Resident #2 refused 02/24/24. On 02/29/24 during the documented Resident asking if anyone had 2-On 02/29/24 during the staff documented Resident Resi	mentation on the back of the bugh 03/07/24 the Zyprexa diministered because the der from the pharmacy. Itation of administration for yprexa 5mg tablet following ospitalization being 7/24 at 9:00am. The state of the state of the staff desk seen his family member. The state of the staff desk sident #2 got agitated, and	D 358			
		he 11:00pm - 7:00am shift, sident #2 was agitated (no				
		cumented) after second shift				
	I = -	ice nurse was contacted.				
		ministered Haldol per the				
	hospice nurse instruc	tions and the resident				
	became calm.	ha 2:00nm 11:00nm shift				
		he 3:00pm - 11:00pm shift, at dinner, became agitated				
		at dinner, became agitated t take his medications,				
		ons out of the MA hand, and				
		IA to stay in the room to look				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
			A. BUILDING.			
		1141 00000	B. WING			R-C
		HAL098030			03	3/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
DADKWO	OD VILLAGE	1730 PA	RKWOOD BLVD			
PARKWO	OD VILLAGE	WILSON	I, NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 49	D 358			
	for all the medications return in the room after remainder of the medications return in the room after remainder of the medications. -On 03/15/24 at 3:00a Resident #2 was through the memory care unit could not redirect the required an as needed. Interview with the Medication on 03/20/24 at 3:29pi. She remembered fat 02/23/24 Zyprexa prewhen Resident #2 reto and hot the instruction prescription from the and not the instruction prescription from the she noticed Resider administered Zyprexa was not available in the circling their initials on the was not administered to mission. -Circled initials on the was not administered to provided) that the phase the Zyprexa and wou because of an expensiontacted the hospice	es. The MA was able to er an hour to look for the lications once Resident #2 am, staff documented wing himself on the door of trying to get out. The staff resident. Resident #2 ad (prn) medication. mory Care Director (MCD) medication. mory Care Director (MCD) mevealed: wing the 02/23/24 FL-2 and escription to the pharmacy turned from the hospital. Doed the instructions to per administration of the every order on the 02/23/24 FL-2 and hospital physician. In the MAR was not being a because the medication the facility, and the MAs were in the MAR but did not date she noticed the earmacy was contacted about and not dispense the Zyprexalse issue so the MA enurse who assisted in				
	#2.	or administration to Resident CD on 03/21/24 at 3:38pm				
	revealed:	e for reviewing the physician				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOWIDER.	A. BUILDING: _		COM	LLILD
		HAL098030	B. WING		l l	R-C /22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PARKWO	OD VILLAGE		KWOOD BLVD			
		WILSON,	NC 27895			_
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 50	D 358			
D 358	-The MAs transcribed MARsIf she was not in the responsible to review received for the residunitOn 03/05/24, she satheir initials for the Zyabout it and sent a mprovider (PCP). Telephone interview vat the facility's contra at 12:03pm revealed: -The pharmacy received at the facility's contra at 12:03pm revealed: -The pharmacy received the dated 02/23/24 for Zyablets take two tableThe pharmacy never 5mg rapid dissolve the insurance coverage is -The facility was faxed the Zyprexa 5mg rapid 02/24/24The facility was respect PCP regarding the notion of alternativesOn 03/07/24, the phase 5mg tablets, quantity	facility, the MA on duty was any physician orders ents in the memory care with the MAs were circling prexa so she asked the MA essage to the primary care with the pharmacy technician cted pharmacy on 03/21/24 and order for Resident #2 prexa 5mg rapid dissolve ts twice daily. In dispensed the Zyprexa shelts because of an anon-coverage form for	D 358			
		onal Zyprexa dispensed to				
	the facility for Reside Zyprexa 10mg tablets	nt #2 until 03/16/24 when s were dispensed.				
	health provider (MHP revealed: -The facility had not r regarding Resident #.	with Resident #2's mental ') on 03/21/24 at 2:45pm notified her of any issues 2's Zyprexa medication, nor				
	was she aware Resid	lent #2 was not administered				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			7. BOILDING			R-C	
		HAL098030	B. WING			3/22/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	. ZIP CODE			
			RKWOOD BLVD	,			
PARKWO	OD VILLAGE	WILSON	, NC 27895				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
D 358	any Zyprexa from 02. Resident #2 would be and more likely to ha someone or injure his administration of the The resident could esymptoms of Zyprexa restlessness, poor slewhen she visited the reports that Resident with his mood, had gonails into the skin, was the morning, and boun and down under the associated with Zypre-She increased Resident to treat behaviors) or because she assume administered the Zypthe dosage he was phospitalization. If Resident #2 had be Zyprexa 5mg tablet to the resident would have 20mg daily but in a desident designed because to ensure stay longer to ensure	ive behaviors and harm imself without the Zyprexa. Experience withdrawal at that included irritability, eep, and agitation. It is a sanxious and restless in uncing his feet and legs up breakfast table which were exa withdrawal. Ident #2's Clonazepam (used no3/12/24 when she visited ed Resident #2 was being breax 20mg daily, which was rescribed prior to leen administered the ake two tablets twice a day, ave still been getting Zyprexa ivided dosage. Ospital prior to Resident #2 cause the resident needed to this behavior medications	D 358				
	Interview with the Ad 4:41pm revealed:	rmal dosages". ministrator on 03/21/24 at					
	-She was not aware of Resident #2's Zyrexa -She expected the M issues for residents in -She expected the fall made aware if there	CD to handle medication In the memory care unit. It is a memory care unit					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
VIAD LEWIN	DI GOMMEDITON	IDENTIFICATION NUMBER.	A. BUILDING: _		
		HAL098030	B. WING		R-C 03/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
PARKWO	OD VILLAGE		WOOD BLVD		
		WILSON, N	NC 27895		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 52	D 358		
		ns, interviews, and record ined Resident #2 was not			
	03/07/24 revealed:	t #4's current FL-2 dated			
	- Diagnoses included hypertension crisis, dementia, chronic kidney disease, translucent ischemic attack, and generalized weakness.				
	-There was no order tablet daily.	for Furosemide 20mg, 1			
	Review of Resident # revealed an admission	•			
	physician's order date order for Furosemide	4's electronically signed ed 03/01/24 revealed an 20mg, 1 tablet daily. dication used to treat fluid			
	administration record	4's March 2024 medication (MAR) revealed there was de 20mg, 1 tablet daily.			
	revealed there was no pharmacy received an Resident #4 for Furos	st on 03/21/24 at 3:30pm			
		nt #4 on 03/22/24 at 3:00pm reported that her hands and			
	Observation of Residence 3:00pm revealed the	ent #4 on 03/22/24 at resident's left hand was			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					E SURVEY PLETED	
ANDILAN	or connection	BENTI TOATTON NOMBER.	A. BUILDING:			
		HAL098030	B. WING		l l	R-C 3/22/2024
NAME OF D		CTDEET A	DDDESS CITY STATE	ZID CODE	,	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
PARKWO	OD VILLAGE		RKWOOD BLVD			
	T		, NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 53	D 358			
	slightly swollen.					
	03/21/24 at 5:09pm re-Medication orders we fax (facsimile) from the The MAs were responsively and transcription of the Mas were responsively and transcription of the Mas not aware of Resident #4 or how the resident's record with	ere received in the facility via the prescribing practioner. In the order to pushing the order to ribing the order on the MAR of the Furosemide order for the order got into the out being sent to pharmacy. By the Furosemide order for the order for the order for the out being sent to pharmacy.				
	(DRC) on 03/21/24 at -Medication orders we and the facility by the -She or the Wellness order to the MA's stat -The MAs were responsible pharmacy to ensure the order from the pretranscribe the order of already been preparementh.	prescribing practitioner. Secretary would take the cion. Insible for faxing the order to be the pharmacy received escribing practioner and to be the MAR if the MAR had be be pharmacy for the the Furosemide was not sent				
	1:55pm revealed: -The MAs usually ser pharmacy and transc if needed when the of facility by the prescribused or why the facility recently services.	y the process was not				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			_		R-C	
		HAL098030	B. WING		03/22/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
			RKWOOD BLVD	,		
PARKWO	OD VILLAGE		NC 27895			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)		
D 358	Continued From page	: 54	D 358			
	accuracy.					
	care provider (PCP) of revealed: -She periodically presses Resident #4 due to a be swollen as a result. Her expectation was tablet daily to be adm 7 daysShe was not aware to the pharmacy and the medicationShe usually sent a material pharmacy and the fact of the pharmacy and the pharmacy an	for the Furosemide 20mg 1 inistered to Resident #4 for the Furosemide was not sent the resident did not receive redication order to the fillity at the same time. #4 today and observed her and the resident reported feet. Id have relieved some of the				
	ordered to 2 of 3 resident medication passes or resident with a redder	ned foot wound with a yellow				
	ointment putting the v	eated with an antibiotic yound at risk of opening and				
	becoming infected. T	ne facility failed to a controlled substance used				
	-	ymptoms such as severe				
	pain, shortness of bre					
		red to Resident #7 and				
		e receiving terminal hospice				
	_	ne residents experiencing				
	-	shortness of breath while				
		ent #2 did not receive an				
	antipsychotic medicat the resident exhibiting	ion as ordered resulting in agitated behaviors.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL098030	B. WING		R- 03/2	C 2/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PARKWO	OD VILLAGE	1730 PARK WILSON, N	WOOD BLVD C 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	nerve pain as ordered without an order putti headaches and dizzir seen at the emergend the time of the missed not receive a diuretic as ordered resulting i and having pain in he the facility to administ resulted in serious ph constitutes a Type A1 The facility provided a accordance with G.S. this violation.	d that was abruptly stopped ing the resident at risk for ness and the resident was by room for dizziness during didoses. Resident #4 did for swelling and excess fluid in her left hand being swollen it left hand. The failure of the medications as ordered by sical harm and neglect and Violation.	D 358			
D 367	(j) The resident's me record (MAR) shall be following: (1) resident's name; (2) name of the medic (3) strength and dosa administered; (4) instructions for ad or treatment; (5) reason or justifica medications or treatm	Medication Administration dication administration e accurate and include the cation or treatment order; age or quantity of medication ministering the medication tion for the administration of nents as needed (PRN) and alting effect on the resident; dministration;	D 367			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY PLETED	
		HAL098030	B. WING			R-C 3/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
PARKWO	OD VILLAGE		RKWOOD BLVD			
			, NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 367	omission, including r (8) name or initials of the medication or tresignature equivalent documented and material administration record. This Rule is not met Based on observation reviews, the facility for the fac	ments and the reason for the efusals; and, f the person administering ratment. If initials are used, a to those initials is to be intained with the medication of (MAR). The as evidenced by: The as	D 367			
		Solution prefilled syringes				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED	
		HAL098030	B. WING			R-C 8 /22/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
PARKWO	OD VILLAGE		RKWOOD BLVD , NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 367	give 0.5ml (10mg) e for pain/shortness or controlled substance breathing difficulties symptoms.) Review of Resident (PCP) electronic pre 02/28/24 at 7:20pm Morphine 100mg/5m scheduling Morphine decline in resident's request. Review of Resident (CS) logs for Morphine There was a supply Morphine Sulfate 10 07/12/23 with instructive every 4 hours prn for There was a second (carried over from the 07/12/23). There were 20 prefidocumented as admitted over the documented as a second over the documented over the documente	very 4 hours as needed (prn) f breath. (Morphine is a ge used to treat severe pain, and other end of life #7's primary care provider escription (e-script) dated revealed an order for all take 0.5ml every 4 hours, de due to increased pain, condition, and per family's #7's controlled substance ine 100mg/5ml revealed: of 30 prefilled syringes with comg/5ml received on ctions to give 0.5ml (10mg) r pain/shortness of breath. d handwritten CS log dated diffilled syringes with Morphine documented as received the supply received on filled syringes of Morphine dinistered from 02/16/24 -	D 367			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HAL098030	B. WING			R-C 8/22/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
PARKWO	OOD VILLAGE	1730 PA	RKWOOD BLVD			
FARRIVO	OD VILLAGE	WILSON	I, NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From page	e 58	D 367			
	documented as admi 02/29/24. -Morphine Sulfate was administered on the I 02/25/24 at 8:00pm, at these doses were do on the CS logDocumentation for the Morphine Sulfate on and did not match do Interview with a medi 03/19/24 at 9:19am results. The MAs were suppadministration of a compart of the MAR and the CS logSometimes the MAs the administration of the MAR but would do Interview with a secon 2:49pm revealed: -Morphine helped with shortness of breathShe did not always a because if the reside she did not want to perform the match that is the submouthIf a medication was were supposed to do MARShe thought she usuon the MAR. Interview with the Dir (DRC) on 03/21/24 are The MAs were supposed.	the MAR was not accurate ocumentation on the CS logs. Ication aide (MA) on evealed: osed to document the ontrolled substance on the would forget to document a controlled substance on ocument it on the CS log. Ind MA on 03/21/24 at the Resident #7's pain and administer the Morphine of twas "knocked out cold", but more in the resident's mot administered, the MAs cument the reason on the ually documented a reason ector of Resident Care to 3:07pm revealed: osed to document the trolled substances on the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		R-C
		HAL098030	B. WING		03/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
PARKWO	OD VILLAGE	1730 PARK WILSON, N	WOOD BLVD		
(X4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 367	Continued From page	e 59	D 367		
	-The MAR should be documentation on the	accurate and match the cS log.			
	Refer to interview with 03/21/24 at 11:00am.	n a medication aide (MA) on			
	Refer to interview with (MCD) on 03/21/24 at	n the Memory Care Director t 11:20am.			
	Refer to interview witl Care (DRC) on 03/21	n the Director of Resident /24 at 11:40am.			
	Refer to telephone int Administrator on 03/2				
		t #8's closed record FL-2 led diagnoses included ension.			
	(PCP) order dated 02 electronic prescription 10mg/0.5ml Oral Solu hours as needed for p (Morphine is a contro	8's primary care provider /28/24 revealed an (e-script) for Morphine ution, take 0.5ml every 4 pain or shortness of breath. Illed substance used to treat g difficulties and other end			
	dated 03/01/24 PCP or revealed an order for				
	03/03/24 revealed: -The resident was act comfort medicationsGive scheduled Morpawake or asleep.	8's hospice order dated tively dying, continue ohine if the resident was indicated "administer			

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STATE FORM 6899 N1S211 If continuation sheet 60 of 104

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
						R-C
		HAL098030	B. WING			/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
		1730 PAF	RKWOOD BLVD			
PARKWO	PARKWOOD VILLAGE WILSON					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From page	e 60	D 367			
	Morphine if pt (patien	t) awake or asleep".				
	Resident #8 revealed -The resident was according respiratory distressThe resident was considered with respiratory changemoved/repositionedThere was an order of Morphine form every	tively dying, having mfortable but uncomfortable ges when to increase scheduled 4 hours to every 2 hours for atory distress, do not hold,				
	administration record -There was a handwr Sulfate 100mg/5ml ta needed for pain or sh -There was no prn Mo administered for this of -There was a second Morphine 100mg/5ml with a written date of 8:00am, 12:00pm, 4:0 and 4:00amThere was a handwr entry dated 03/03/24 instructions to admini -Staff initials were circ and 8:00pm with no re the medicationDocumentation for the	itten entry for Morphine ke 0.5ml every 4 hours as ortness of breath. orphine documented as entry. handwritten entry for give 0.5ml every 4 hours 03/01/24 scheduled at 00pm, 8:00pm, 12:00am, itten note underneath the with an asterisk and ster if awake or asleep. cled on 03/01/24 at 8:00am eason for not administering the administration of on 03/01/24 at 12:00am and				
	100mg/5ml give 0.5m for 8:00am, 10:00am,	ndwritten entry for Morphine Il every 2 hours scheduled 12:00pm, 2:00pm, 4:00pm, 00pm, 12:00am, 2:00am,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
						R-C
		HAL098030	B. WING		I	8/22/2024
NAME OF F	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
		1730 PA	RKWOOD BLVD			
PARKWO	OD VILLAGE	WILSON	I, NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 367	expired on 03/04/24 Review of Resident # (CS) log for Morphine -There was only one prefilled syringes rec -There was a dispen there was a direction the instructions on the of the CS logThe first dose docur 03/01/24 at 12:00pm -There was a second administered on 03/0 -There were no other documented as adm orderedThere were 4 sched administered on 03/0 4:00pm, and 8:00pm -The next dose was administered until 03 hours after the last d -The last dose was d on 03/04/24 at 12:00 Interview with a med 03/21/24 at 2:55pm r -Resident #8 was in trouble breathingThe resident was ga- She could tell the re the resident was frow to 3 days of her lifeThere were two MA resident's Morphine of	ritten note that the resident at 12:37am. #8's controlled substance e revealed: CS log for Morphine with 30 reived on 02/29/24. see date of 02/29/24 and or change sticker placed over represcription label at the top mented as administered was administered was rescheduled doses inistered on 03/01/24 as rescheduled doses inistered on 03/01/24 as rescheduled doses documented as 02/24 at 8:00am, 12:00pm, rescheduled doses documented as 02/24 at 8:45am, over 12 rescheduled doses documented as 10/03/24 at 8:45am, over 12 rescheduled doses documented as 10/03/24 at 8:45am, over 12 rescheduled doses documented as 10/03/24 at 8:45am, over 12 rescheduled doses documented as 10/03/24 at 8:45am, over 12 rescheduled doses documented as 10/03/24 at 8:45am, over 12 rescheduled doses documented as 10/03/24 at 8:45am, over 12 rescheduled doses documented as 12/03/24 at 8:45am, over 12 rescheduled doses documented as 12/03/24 at 8:45am, over 12 rescheduled doses documented as 12/03/24 at 8:45am, over 12 rescheduled doses documented as 12/03/24 at 8:45am, over 12 rescheduled doses documented as 12/03/24 at 8:45am, over 12 rescheduled doses documented as 12/03/24 at 8:45am, over 12 rescheduled doses documented as 12/03/24 at 8:45am, over 12 rescheduled doses documented as 12/03/24 at 8:45am, over 12 rescheduled doses documented as 12/03/24 at 8:45am, over 12 rescheduled doses documented as 12/03/24 at 8:45am, over 12 rescheduled doses documented as 12/03/24 at 8:45am, over 12 rescheduled doses documented as 12/03/24 at 8:45am, over 12 rescheduled doses documented as 12/03/24 at 8:45am, over 12 rescheduled doses documented as 12/03/24 at 8:45am, over 12 rescheduled doses documented as 12/03/24 at 8:45am, over 12 rescheduled doses documented as 12/03/24 at 8:45am, over 12 rescheduled doses documented as 12/03/24 at 8:45am, over 12 rescheduled doses documented as 12/03/24 at 8:45am, over 12 rescheduled doses documented as 12/03/24 at 8:45am, over 12/03/24 at 8:45am, over 12/03/24 at 8:45am, over 12/03/24 at 8:45am, over 12/03/24 at 8	D 367			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL098030	B. WING		R-0	C 2/2024
	ROVIDER OR SUPPLIER		RESS, CITY, STA WOOD BLVD IC 27895	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	was asleep when the MorphineShe was not sure when MAR. Interview with the Dire (DRC) on 03/21/24 at -There had been some administration of Reseto her attention by a handle -Some of the MAS did Morphine when the resident was not it sleeping and did not here it the MASThey had to get a class the Morphine when the awakeThe MAS were supported the MAR when a madministered. Refer to interview with 03/21/24 at 11:00am. Refer to interview with (MCD) on 03/21/24 at 11:00am. Refer to interview with Care (DRC) on 03/21 Refer to telephone into Administrator on 03/2 3. Review of Resident diagnoses included ministrator.	As documented the resident y did not administer the by there were blanks on the ector of Resident Care 3:07pm revealed: e issues with the ident #8's Morphine brought hospice nurse. I not administer the esident was asleep because in distress while she was look like she was in pain to arification order to administer the resident was asleep or losed to document a reason medication was not in a medication aide (MA) on the Memory Care Director is 11:20am. In the Director of Resident 124 at 11:40am.	D 367			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or dorace mon	IDENTIFICATION NOMBER.	A. BUILDING:		
		HAL098030	B. WING		R-C 03/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
PARKWO	OD VILLAGE		WOOD BLVD		
- Antitorio	ob vietage	WILSON, N	IC 27895		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 367	Continued From page	e 63	D 367		
	a. Review of Resident #3's physician orders dated 01/01/24 revealed an order for Amlodipine 5mg, tablet daily at 9:00am. (Amlodipine is a medication used to treat high blood pressure).				
	administration record -There was an entry f daily at 9:00amThere was no docum tablet was administer	nentation Amlodipine 5mg, 1 ed at 9:00am on 03/17/23, o reason given as to why the			
	b. Review of Resident #3's physician orders dated 01/01/24 revealed an order for Aspirin 81mg, 1 chewable tablet daily at 9:00am. (Aspirin is a medication that may be used to reduce the risk of heart attack and stroke).				
	tablet daily at 9:00am -There was no docum chewable tablet was a 03/17/24, that was bla	or Aspirin 81mg, 1 chewable			
	01/01/24 revealed an tablet daily at 9:00am used to treat folate de Review of Resident # revealed:	3's March 2024 MAR			
	daily at 9:00am. -There was no docum	or Elfolate 15mg, 1 tablet nentation Elfolate 15mg, 1 ed at 9:00am on 03/17/24,			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SUR COMPLETE		
			A. BOILDING	A. BUILDING.		
		HAL098030	B. WING		R-C 03/22/2	2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PARKWO	OD VILLAGE		WOOD BLVD			
		WILSON, N	C 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page	e 64	D 367			
	that was blank and no medication was not a	reason given as to why the dministered.				
	dated 01/01/24 revea Propionate 50mcg, 1					
	-There was an entry f 50mcg, 1 spray in eac -There was no docum Propionate 50mcg, 1	spray in each nostril was m on 03/17/24, that was given as to why the				
	dated 01/01/24 reveal 200mg, 2 tablets daily	t #3's physician orders led an order for Lamotrigine v at 9:00am. (Lamotrigine is treat seizures and bipolar				
	tablets daily at 9:00ar -There was no docum 200mg, 2 tablets were 03/17/24, that was bla to why the medication	or Lamotrigine 200mg, 2 n.				
	01/01/24 revealed an 150mg, 1 capsule dai	order for Lithium Carbonate				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			B WING		R-	
		HAL098030	B. WING		03/2	2/2024
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
PARKWOOD VILLAGE		WOOD BLVD				
<u> </u>		WILSON, N				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page	e 65	D 367			
D 367	Review of Resident # -There was an entry f 150mg, 1 capsule dai -There was documen 150 mg, 1 capsule wa 03/14/24 denoted by as to why the medica and no documentation 150mg,1 capsule was 03/17/24, that was bla to why the medication g. Review of Resident dated 01/01/24 revea B-12 1000mcg, 1 tabl B-12 used to treat Vit Review of Resident # revealed: -There was an entry f tablet daily at 9:00am -There was no docum 1000mcg, 1 tablet wa at 9:00am, that was be to why the medication Review of Resident # revealed: -There was an entry f tablet daily at 9:00am -There was no docum 1000mcg, 1 tablet wa at 9:00am, that was be to why the medication Review of Resident # revealed: -There was an entry f tablet daily at 9:00am -There was no docum 1000mcg, 1 tablet wa on 03/17/24, that was as to why the medica	3's March 2024 revealed: or Lithium Carbonate ly at 9:00am. tation Lithium Carbonate as not administered on circled initials with no reason tion was not administered, in that Lithium Carbonate as administered at 9:00am on ank and no reason given as in was not administered. It #3's physician orders led an order for Vitamin et daily at 9:00am. (Vitamin amin B-12 deficiency). It s'a's January 2024 MAR It or Vitamin B-12 1000mcg, 1 Intentation Vitamin B-12 Is administered on 01/19/24 Islank and no reason given as in was not administered. 3's March 2024 MAR It or Vitamin B-12 1000mcg, 1 It is administered on 01/19/24 Islank and no reason given as in was not administered. 3's March 2024 MAR	D 367			
	dated 01/01/24 revea	led an order for Mirtazapine time at 8:00pm. (Mirtazapine				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R-C
		HAL098030	B. WING		03/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
PARKWO	OD VILLAGE	1730 PARK	WOOD BLVD		
- ARRIVO	ob vietage	WILSON, N	C 27895		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 367	Continued From page	e 66	D 367		
	Review of Resident # revealed: -There was an entry f tablet at bedtime at 8 -There was no docum 1 tablet was administed 02/23/24, and 02/27/2 reason given as to whadministered.	3's February 2024 MAR or Mirtazapine 15mg, 1 :00pm. nentation Mirtazapine 15mg, ered at 8:00pm on 02/20/24, 24, that was blank and no ny the medication was not			
	Review of Resident #3's March 2024 MAR revealed: -There was an entry for Mirtazapine 15mg, 1 tablet at betime at 8:00pm. -There was no documentation Mirtazapine 15mg, 1 tablet was administered at 8:00pm on 03/12/24, that was blank and no reason given as to why the medication was not administered.				
	i. Review of Resident #3's physician orders dated 01/01/24 revealed an order for Zyprexa 2.5mg, 1 tablet at bedtime at 8:00pm. (Zyprexa is a medication used to treat schizophrenia and bipolar disorder).				
	revealed: -There was an entry f at bedtime at 8:00pm -There was documen tablet was not admini by circled initials and the medication was n	tation Zyprexa 2.5mg, 1 stered on 01/14/24 denoted no reason given as to why ot administered.			
Review of Resident #3's February 2024 MAR revealed: -There was an entry for Zyprexa 2.5mg, 1 tablet at bedtime at 8:00pmThere was no documentation Zyprexa 2.5mg, 1 tablet was administered at 8:00pm on 02/20/24,					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING:		COMPLETED
		HAL098030	B. WING		R-C 03/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
PARKWO	OD VILLAGE	1730 PAR	WOOD BLVD		
WILSON,			NC 27895		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 367	Continued From page	e 67	D 367		
	01/23/24, and 02/27/2	24 that was blank and no ny the medication was not			
	01/01/24 revealed an	#3's physician orders dated order for Trazodone 100mg, g at 8:00pm. (Trazodone is a eat depression).			
	revealed: -There was an entry f tablet at 8:00pmThere was documen tablet was not admini	3's January 2024 MAR for Trazodone 100mg, 1 tation Trazodone 100mg, 1 stered on 01/29/24 and circled initials and no reason nedication was not			
	revealed: -There was an entry f tablet at 8:00pmThere was no docum 1 tablet was administ 02/23/24, and 02/27/2	3's February 2024 MAR for Trazodone 100mg, 1 mentation Trazodone 100mg, ered at 8:00pm on 02/20/24, 24, that was blank and no my the medication was not			
	tablet at 8:00pmThere was no docum 1 tablet at 8:00pm wa at 8:00pm.	for Trazodone 100mg, 1 nentation Trazodone 100mg, as administered on 03/12/24			
	0 1/01/24 revealed ar	t #3's physician orders dated n order for Ammonium apply to bilateral feet every			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY IPLETED	
		HAL098030	B. WING			R-C 3/22/2024
	ROVIDER OR SUPPLIER OD VILLAGE	STREET A 1730 PAI WILSON	E, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 367	Review of Resident # revealed: -There was an entry f Lotion, apply to bilate -There was no docum Lactate 12% Lotion won 9:00am on 02/05/2 that was blank and no medication was not a Review of Resident # revealed: -There was an entry f Lotion, apply to bilate -There was no docum Lactate 12% Lotion we 9:00am on 03/17/24, reason given as to whadministered. I. Review of Resident 01/01/24 revealed an Lotion, apply topically 9:00am. (Thera-Derm dry skin). Review of Resident # revealed: -There was an entry f apply topically to face: -There was no docum Lotion was applied to 02/14/24, 02/16/24, a	conium Lactate is a eat dry and scaly skin). 3's February 2024 MAR for Ammonium Lactate 12% ral feet every day at 9:00am. Inentation Ammonium ras applied to bilateral feet 24, 02/14/24, and 02/24/24, or reason given as to why the dministered. 3's March 2024 MAR for Ammonium Lactate 12% ral feet every day at 9:00am. Inentation Ammonium ras applied to bilateral feet at that was blank and no my the medication was not #3's physician orders dated order for Thera-Derma rate face every day at a is a lotion used to treat 3's February 2024 MAR for Thera-Derma Lotion, a every day at 9:00am. Inentation Thera-Derma the face at 9:00am on not 02/24/24, that was blank as to why the medication	D 367			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL098030	B. WING		R-C 03/22/2024	
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 03/22/2024	
PARKWO	OD VILLAGE	1730 PAR	WOOD BLVD			
TARRE	JD VILLAGE	WILSON, N	IC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 367	apply topically to face -There was no docum Lotion was applied to 03/17/24, that was bla to why the medication m. Review of Resider dated 01/01/24 revea 0.5mg, 1 tablet every anxiety. (Ativan is a c treat anxiety). Review of Resident # revealed: -There was an entry f every 4 hours as need -There was documen was administered on 02/28/24 but no reaso was administered and medication. Refer to interview with 03/21/24 at 11:00am. Refer to interview with (MCD) on 03/21/24 at Refer to interview with Care (DRC) on 03/21 Refer to telephone int Administrator on 03/2	for Thera-Derma Lotion, e every day at 9:00am nentation Thera-Derma the face at 9:00am on ank and no reason given as a was not administered. In #3's physician orders led an order for Ativan 4 hours as needed (prn) for ontrolled substance used to a sis February MAR 2024 For Ativan 0.5mg, 1 tablet ded for anxiety. Itation Ativan 0.5mg, 1 tablet 02/21/24, 02/25/24 and on was given as to why it dieffectiveness as a prn in a medication aide (MA) on the Memory Care Director to 11:20am. In the Director of Resident 12/24 at 11:40am. In the Director of Resident 12/24 at 10:56am.	D 367			
		ementia, chronic kidney				

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disease, transient ischemic attack, and

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING:		
		HAL098030	B. WING		R-C 03/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
PARKWO	OD VILLAGE	1730 PARI WILSON, N	(WOOD BLVD NC 27895		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 367	Continued From page	e 70	D 367		
	generalized weaknes	S.			
	dated 01/01/24 reveal Skin Conditioner Lotic area due to skin irritar (Aloe Vesta Skin Conmedication used to truskin and minor skin ir Review of Resident # medication administration administration was an entry for Conditioner Lotion, applied to skin irritation every to skin irritation every to skin irritation every to skin irritation every conditioner Lotion was 9:00am on 01/04/24 of	eat dry, rough, scaly, itchy ritations). 4's January 2024 ation record (MAR) revealed: for Aloe Vesta Skin pply to sacral/rectal area due of day at 9:00am. Itation Aloe Vesta Skin as not administered at denoted by circled initials as to why the medication			
	revealed: -There was an entry f Conditioner Lotion, ap to skin irritation every -There was no docum Conditioner Lotion wa area at 9:00am on 02	pply to sacral/rectal area due			
	dated 01/01/24 revea 81mg, chewable 1 tal is a medication that n risk of heart attack an	at #4's physician orders aled an order for Aspirin blet daily at 9:00am. (Aspirin may be used to reduce the and stroke). 44's January 2024 MAR			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL098030	B. WING		R-C 03/22/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PARKWOOD VILLAGE			WOOD BLVD			
		IC 27895	PROVIDER'S PLAN OF CORRECTION	N (X5)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 367	Continued From page	? 71	D 367			
	tablet daily at 9:00am -There was documen chewable 1 tablet was 9:00am on 01/04/24 of	tation Aspiring 81mg, s not administered at denoted by circled initials as to why the medication				
	c. Review of Resident #4's physician orders dated 01/01/24 revealed an order for Diltiazem ER 360mg, 1 capsule daily at 9:00am. (Diltiazem is a medication uses to treat high blood pressure).					
	Review of Resident #4's January 2024 MAR revealed: -There was an entry for Diltiazem ER 360mg, 1 capsule daily at 9:00amThere was documentation Diltiazem ER 360mg, 1 capsule was not administered at 9:00am on 01/04/24 denoted by circle initials and no reason given as to why the medication was not administered.					
	d. Review of Resident #4's physician orders dated 01/01/24 revealed an order for Losartan-HCTZ 100mg-25mg, 1 tablet daily at 9:00am. (Losartan-HCTZ is a medication used to treat high blood pressure, reducing he risk of stroke and heart attack).					
	revealed: -There was an entry f 100mg-25mg, 1 table -There was documen 100mg-25mg, 1 table 9:00am on 01/04/24 of	t daily at 9:00am. tation Losartan-HCTZ t was not administered at denoted by circled initials as to why the medication				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COMPLETED
		HAL098030	B. WING		R-C 03/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
DADKWO	PARKWOOD VILLAGE 1730 PAR				
PARKWO	OD VILLAGE	WILSON,	NC 27895		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
D 367	Continued From page	e 72	D 367		
	Review of Resident # revealed: -There was an entry f 100mg-25mg, 1 table -There was no docum 100mg-25mg, 1 table 9:00am on 02/26/24, reason given as to whadministered. e. Review of Residen dated 01/01/24 revealed:	4's February 2024 MAR or Losartan-HCTZ			
	a medication used to Review of Resident # revealed: -There was an entry f capsule daily at 9:00a -There was documen capsule was not adm 01/04/24 and 01/23/2 and no reason given	treat vitamin D deficiency). 4's January 2024 MAR for Vitamin D3 50mg, 1 am. tation Vitamin D3 50mg, 1 inistered at 9:00am on 4 denoted by circled initials as to why the medication			
	01/01/24 revealed an Lidocaine 4%, apply to top two times daily fo (Aspercreme Lidocair Review of Resident # revealed: -There was an entry f 4%, apply to right neodaily for pain at 9:00a-There was documen 4% was not administe 01/17/24, 01/20/24, 0	#4's physician orders dated order for Aspercreme to right neck/right shoulder r pain at 9:00am. The is a topical pain reliever.) 4's January 2024 MAR For Aspercreme Lidocaine ck/right should top times			

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1730 PARKWOOD PILLAGE 1730 PARKWOOD PILLAGE 1730 PARKWOOD PILLAGE SUMMARY STATEMENT OF DEFICIENCIES (PEACH DEFICIENCY MUST BE PRECEDED BY PILL) PREFIX TAO D 367 Continued From page 73 to why the medication was not administered. -There was documentation Aspercreme Lidocaine 4% was not administered at 8:00pm from 01/01/24 through 01/0724, from 01/0724, and 01/24/24 denoted by circled initials and no reason given as to why the mediation was not administered. Review of Resident #4's February 2024 MAR revealed: -There was a nentry for Aspercreme Lidocaine 4% was not applied to the right neckright shoulder top at 8:00pm denoted by circled initials on 02/06/24, 02/07/24, 02/07/24, 02/08/24 and 02/10/24 with no reason as to why the mediation was not administered. Review of Resident #4's February 2024 MAR revealed: -There was documentation Aspercreme Lidocaine 4% was not applied to the right neckright shoulder top at 8:00pm on 02/00/24, 02/07/24, 02/07/24, 02/08/24 and 02/10/24 with no reason as to why the mediation was not administered. Review of Resident #4's Barch 02/10/24 with no reason as to why the mediation was not administered. Review of Resident #4's March 2024 MAR revealed: -There was a necture of the right neckright shoulder at 8:00pm on 02/20/24, 02/23/24, and 02/27/24, that was blank and no reason was given as to why the medication was not administered. Review of Resident #4's March 2024 MAR revealed: -There was an entry for Aspercreme Lidocaine 4% apply to right neck-right should to two times daily at 9:00am and 8:00pmThere was an entry for Aspercreme Lidocaine 4% apply to right neck-right should to two times daily at 9:00am and 8:00pmThere was an ontowentation Aspercreme -There was an ontowentation Aspercreme -There was no documentation Aspercreme -There was an ontowentation Aspercreme -There was no documentation Aspercreme -There was no documentation Aspercreme -There was no documentation Aspercreme -There was no doc	` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER PARKWOOD VILLAGE (X4) ID PREFIX ID SUMMARY STATEMENT OF DEFICIENCIES IDEA (CROSS-ARE PLAN OF CORRECTION (CROSS-ARE PLAN OF CORRECTION AND IDEA (CROSS-ARE PLAN OF CROSS-ARE PLAN OF CORRECTION AND IDEA (CROSS-ARE PLAN OF CROSS-ARE PLAN OF CROSS-ARE PLAN OF CORRECTION AND IDEA (CROSS-ARE PLAN OF CROSS-ARE PLAN OF CORRECTION AND IDEA (CROSS-ARE PLAN OF CROSS-ARE PLAN OF CROSS			HA1 098030	B. WING			
PARKWOOD VILLAGE (X4) ID PREFIX TAG (RACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (RACH DEFICIENCY) D 367 Continued From page 73 to why the medication was not administered. -There was documentation Aspercreme Lidocaine 4% was not administered at 8:00pm from 01/01/24 through 01/19/24, 01/22/24, and 01/24/24 denoted by circled initials and no reason given as to why the medication was not administered and no documentation Aspercreme Lidocaine 4% was administered at 8:00pm on 01/08/24 and 01/11/24, that was blank and no reason as to why the medication was not administered. Review of Resident #4's February 2024 MAR revealed: -There was an entry for Aspercreme Lidocaine 4% apply to right neck/right shoulder top tow times daily for pain at 9:00am. -There was documentation Aspercreme Lidocaine 4% was not applied to the right neck/right shoulder top at 80 work medication was not administered. Review of Resident #4's Mass applied to the right neck/right shoulder at 8:00pm on 02/20/24, 02/27/24, 1ad vas blank and no reason was given as to why the medication was not administered. Review of Resident #4's March 2024 MAR revealed: -There was an entry for Aspercreme Lidocaine 4%, apply to right neck-right should to two times daily at 9:00am and 8:00pm.	NAME OF D				TE ZID CODE	1 03/22/2024	
DATE	NAIVIE OF FI				TE, ZIF CODE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) D 367 Continued From page 73 to why the medication was not administeredThere was documentation Aspercreme Lidocaine 4% was not administered at 8:00pm from 01/01/24 through 01/07/24, from 01/17/24 through 01/19/24, 01/12/24, and 01/24/24 denoted by circled initials and no reason given as to why the medication was not administered and no documentation Aspercreme Lidocaine 4% was administered as 8:00pm on 01/08/24 and 01/11/24, that was blank and no reason as to why the medication was not administered. Review of Resident #4's February 2024 MAR revealed: -There was an entry for Aspercreme Lidocaine 4% was not apile to the right neck/right shoulder top tow times daily for pain at 9:00amThere was documentation Aspercreme Lidocaine 4% was not apile to the right neck/right shoulder to was not administered, and there was no documentation Aspercreme Lidocaine 4% was not apile to the right neck/right shoulder to the right neck/right shoulder at 8:00pm on 02/20/24, 02/23/24, and 02/27/24, that was blank and no reason was given as to why the medication was not administered. Review of Resident #4's March 2024 MAR revealed: -There was an entry for Aspercreme Lidocaine 4% was not apile to the right neck/right shoulder at 8:00pm on 02/20/24, 02/23/24, and 02/27/24, that was blank and no reason was given as to why the medication was not administered. Review of Resident #4's March 2024 MAR revealed: -There was an entry for Aspercreme Lidocaine 4%, apply to right neck-right should to two times daily at 9:00am and 8:00pm.	PARKWO	OD VILLAGE					
to why the medication was not administered. -There was documentation Aspercreme Lidocaine 4% was not administered at 8:00pm from 01/01/24 through 01/07/24, for mo 01/7/24 through 01/19/24, 01/22/24, and 01/24/24 denoted by circled initials and no reason given as to why the medication was not administered and no documentation Aspercreme Lidocaine 4% was administered at 8:00pm on 01/08/24 and 01/11/24, that was blank and no reason as to why the medication was not administered. Review of Resident #4's February 2024 MAR revealed: -There was an entry for Aspercreme Lidocaine 4% apply to right neck/right shoulder top tow times daily for pain at 9:00am. -There was documentation Aspercreme Lidocaine 4% was not applied to the right neck/right shoulder top at 8:00pm denoted by circled initials on 02/06/24, 02/07/24, 02/09/24 and 02/10/24 with no reason as to why the medication was not administered, and there was no documentation Aspercreme Lidocaine 4% was applied to the right neck/right shoulder at 8:00pm on 02/20/24, 02/23/24, and 02/27/24, that was blank and no reason was given as to why the medication was not administered. Review of Resident #4's March 2024 MAR revealed: -There was an entry for Aspercreme Lidocaine 4%, apply to right neck-right should to two times daily at 9:00am and 8:00pm.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE COMPLETE	
-There was documentation Aspercreme Lidocaine 4% was not administered at 8:00pm from 01/10/124 through 01/07/24, from 01/17/24 through 01/19/24, 01/122/24, and 01/24/24 denoted by circled initials and no reason given as to why the medication was not administered and no documentation Aspercreme Lidocaine 4% was administered at 8:00pm on 01/08/24 and 01/11/24, that was blank and no reason as to why the mediation was not administered. Review of Resident #4's February 2024 MAR revealed: -There was an entry for Aspercreme Lidocaine 4% apply to right neck/right shoulder top tow times daily for pain at 9:00amThere was documentation Aspercreme Lidocaine 4% was not applied to the right neck/right shoulder top at 8:00pm denoted by circled initials on 02/06/24, 02/07/24, 02/09/24 and 02/10/24 with no reason as to why the medication was not administered, and there was no documentation Aspercreme Lidocaine 4% was applied to the right neck/right shoulder at 8:00pm on 02/20/24, 02/23/24, and 02/27/24, that was blank and no reason was given as to why the medication was not administered. Review of Resident #4's March 2024 MAR revealed: -There was an entry for Aspercreme Lidocaine 4%, apply to right neck-right should to two times daily at 9:00am and 8:00pm.	D 367	Continued From page	÷ 73	D 367			
Lidocaine 4% was applied to the right neck/right shoulder at 8:00pm on 03/12/24 and 03/15/24 that was blank and no reason as to why the	D 367	to why the medication—There was document 4% was not administed 01/01/24 through 01/02 through 01/19/24, 01/02 denoted by circled init to why the medication no documentation Asiadministered at 8:00p 01/11/24, that was blatthe mediation was not Review of Resident # revealed: There was an entry fa 4% apply to right neclatimes daily for pain at There was document 4% was not applied to shoulder top at 8:00p on 02/06/24, 02/07/24 with no reason as to vadministered, and the Aspercreme Lidocain right neck/right should 02/23/24, and 02/27/2 reason was given as an ot administered. Review of Resident # revealed: There was an entry fa 4%, apply to right neck daily at 9:00am and 8 There was no document docained 4% was ap shoulder at 8:00pm of the daily at 8:	a was not administered. Itation Aspercreme Lidocaine Bered at 8:00pm from 107/24, from 01/17/24 122/24, and 01/24/24 15 tials and no reason given as a was not administered and percreme Lidocaine 4% was am on 01/08/24 and ank and no reason as to why at administered. 14's February 2024 MAR 15 February 2024 MAR 16 February 2024 MAR 17 February 2024 MAR 18 February 2024 MAR 18 February 2024 MAR 19 February 2024 MAR 19 February 2024 MAR 19 February 2024 MAR 10 February 2024 MAR 10 February 2024 MAR 10 February 2024 MAR 11 February 2024 MAR 12 February 2024 MAR 13 February 2024 MAR 14 February 2024 MAR 15 February 2024 MAR 16 February 2024 MAR 17 February 2024 MAR 18 February 2024 MAR 19 February 2	D 367			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL098030	B. WING			R-C 8/ 22/2024
	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
PARKWO	OD VILLAGE		, NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 367	dated 01/01/24 revea 0.1mg, 1 tablet two til 8:00pm. (Clonidine is high blood pressure). Review of Resident # revealed: -There was an entry two times daily at 9:0 -There was documen tablet was not admini 01/04/24 denoted by given as to why the madministeredThere was documen tablet was not admini 01/01/24 through 01/01/22/24 and 01/24/2 with no reason given was not administered Clonidine 0.1mg, 1 ta 8:00pm at 01/14/24, treason given as to what administered. Review of Resident # revealed: -There was an entry the two times daily at 9:0	t #4's physician orders led an order for Clonidine mes daily at 9:00am and a medication used to treat 4's January 2024 MAR for Clonidine 0.1mg, 1 tablet 0am and 8:00pm. tation Clonidine 0.1mg, 1 stered at 9:00am on circled initials with no reason nedication was not tation Clonidine 0.1mg, 1 stered at 8:00pm from 07/24, and 01/19/24, 4 denoted by circled initials as to why the medication , and no documentation blet was administered at hat was blank and no ny the medication was not 4's February 2024 MAR for Clonidine 0.1mg, 1 tablet	D 367			
	02/19/24 denoted by given as to why the madministered, and no 0.1mg, 1 tablet was a 02/20/24, 02/23/24, 0	02/07/24, 02/09/24, and circled initials with no reason nedication was not documentation Clonidine administered at 8:00pm on 2/27/24, and 02/29/24, that ason given as to why the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			71. BOILDING			D 0
		HAL098030	B. WING			R-C 3 /22/2024
				TID CODE	1	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
PARKWO	OD VILLAGE		RKWOOD BLVD			
			I, NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From page	e 75	D 367			
	revealed: -There was an entry two times daily at 9:0 -There was no docur tablet was not admin 03/11/24 and 03/12/2 reason as to why the administered. h. Review of Resider dated 01/01/24 reveated the dated 01/01/24 reveated the dated 01/01/24 reveated the dated of	nentation Clonidine 0.1mg, 1 istered at 8:00pm on 24, that was blank and no medication was not at #4's physician orders aled an order for Metoprolol blet two times daily at (Metoprolol Tartrate is a leat high blood pressure.) 44 January 2024 revealed: for Metoprolol Tartrate 25mg, daily at 9:00am and 8:00pm. Intation Metoprolol Tartrate lot administered at 9:00am by circled initials with no hy the medication was not attation Metoprolol Tartrate not administered at 8:00pm h 01/07/24, and 01/19/24, 24 denoted by circled initials as to why the medication 4, and no documentation 5mg, 0.5 tablet was given as to why the				
		for Metoprolol Tartrate 25mg, laily at 9:00am and 8:00pm.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL098030	B. WING			R-C 8/22/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
PARKWO	OD VILLAGE	1730 PAF	RKWOOD BLVD			
TARRE		WILSON	, NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 367	25mg, 0.5 tablet was on 02/04/24, 02/06/2 02/19/24 denoted by given as to why the administered, and not attract 25mg, 0.5 to 8:00pm on 02/20/24 02/29/24, that was be to why the medication. Review of Resident revealed: -There was an entry 0.5 tablet two times and the two times and the two times. There was no docured 25mg, 0.5 tablet was 03/12/24, that was be to why the medication in the two the stable two the stable two times are the two times. There was no docured and the two times of the stable two the stable two times of the stable two times of the stable two times of the stable two the stable two times of the sta	ntation Metoprolol Tartrate is not administered at 8:00pm 24, 02/07/24, 02/09/24, and or circled initials with no reason medication was not obsolute the documentation Metoprolol ablet was administered at 0.02/23/24, 02/27/24, and lank with no reason given as on was not administered. #4's March 2024 MAR for Metoprolol Tartrate 25mg, daily at 9:00am and 8:00pm. mentation Metoprolol Tartrate is administered at 8:00pm at lank with no reason given as on was not administered. #4's physician orders dated in order for Nystatin 100,000 obly topically to groin two times 8:00pm. (Nystatin is a reat fungal or yeast infections #4's January 2024 MAR for Nystatin 100,000 unit/gm ally to groin two times daily at	D 367			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		HAL098030	B. WING			R-C 3/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
PARKWO	OD VILLAGE		RKWOOD BLVD I, NC 27895			
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
D 367	Continued From pag	e 77	D 367			
	was not administered Nystatin 100,000 uni administered at 8:00 blank and no reason medication was not a Review of Resident a revealed: -There was an entry Powder, apply topica 9:00am and 8:00pmThere was documer unit/gm Powder was on 02/04/24, 02/06/2 02/19/24 denoted by	pm at 01/14/24 that was given as to why the administered. #4's February 2024 MAR for Nystatin 100,000 unit/gm ally to groin two times daily at a station Nystatin 100,000 not administered at 8:00pm 4 , 02/07/24, 02/09/24, and circled initials with no reason				
	100,000 unit/gm Pow 8:00pm on 02/20/24, 02/29/24 that was bla	medication was not of documentation Nystatin ver was administered at 02/23/24, 02/27/24, and ank with no reason given as n was not administered.				
	revealed: -There was an entry Power, apply topicall 9:00am and 8:00pmThere was no docur unit/gm Power was a on 03/12/24 that was	for Nystatin 100,000 unit/gm y to groin two times a day at mentation Nystatin 100,000 applied to the groin at 8:00pm s blank with no reason given ation was not administered.				
	01/01/24 revealed ar 1 tablet three times of 8:00pm. (Hydralazine treat high blood pres	t #4's physician orders dated n order for Hydralazine 25mg, laily at 9:00am, 2:00pm, and e is a medication used to sure).				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		HAL098030	B. WING			R-C 3/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E ZIP CODE	·	
NAME OF T	NOVIDEN ON GOIT EIEN		RKWOOD BLVD	L, ZII 00DL		
PARKWO	OD VILLAGE		, NC 27895			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	DRRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETE DATE
D 367	Continued From page	e 78	D 367			
	revealed:					
	-There was an entry t	for Hydralazine 25mg 1				
	tablet three times dai	ly at 9:00am, 2:00pm, and				
	8:00pm,					
		tation Hydralazine was not				
		am on 01/04/24 denoted by				
		reason given as to why the				
	medication was not a					
	-There was documentation Hydralazine was not administered at 2:00pm from 01/01/24 through 01/07/24 denoted by circled initials and no reason given as to why the medication was not					
	administered.					
	-There was documen	tation Hydralazine was not				
	-	om from 01/01/24 through				
		24, 01/22/24, and 01/24/24				
	_	tials with no reason given as				
		n was not administered, and				
		dralazine was administered 4, that was blank and no				
	· ·	ny the mediation was not				
	administered.	ny the modifican was not				
	Review of Resident #	4's February 2024 MAR				
	revealed:					
		for Hydralazine 25mg, 1				
		ay at 9:00am, 2:00pm, and				
	8:00pm.	tation Undralazina 25mg 1				
	tablet was not admini	tation Hydralazine 25mg, 1				
		ank and no reason given as				
		n was not administered.				
		tation Hydralazine 25mg, 1				
		ot administered at 8:00pm				
		4 , 02/07/24, 02/09/24, and				
		circled initials with no reason				
	given as to why the n					
		documentation Hydralazine				
		dministered at 8:00pm on 02/27/24, and 02/29/24, that				

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STATE FORM 6899 N1S211 If continuation sheet 79 of 104

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
			A. BOILBING.			B.C
		HAL098030	B. WING			R-C 8 /22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
D. D. G. (10)	05.1/11.1.05	1730 PAF	RKWOOD BLVD			
PARKWO	OD VILLAGE	WILSON,	NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From page	e 79	D 367			
	was blank with no reason given as to why the medication was not administered.					
	Review of Resident # revealed:	4 March 2024 MAR				
	-There was an entry I three times a day at § 8:00pm. -There was no docum 1 tablet was administ	nentation Hydralazine 25mg, ered at 8:00pm on 03/12/24 as blank and no reason was				
	k. Review of Resident #4's physician orders dated 01/01/24 revealed an order for Atorvastatin 80mg, 1 tablet every evening at 8:00pm. (Atorvastatin is used to treat high cholesterol).					
	Review of Resident # revealed: -There was an entry / every evening at 8:00 -There was documen tablet was not admini 01/01/24 through 01/0	4's January 2024 MAR Atorvastatin 80mg, 1 tablet opm. tation Atorvastatin 80mg, 1 stered at 8:00pm on from 07/24, 01/19/24, and circled initials with no reason				
	revealed: -There was an entry to tablet every evening and tablet was document tablet was not adminited 02/04/24, 02/06/24, 02/19/24 denoted by given as to why the mass of table to tab	tation Atorvastatin 80mg, 1 stered at 8:00pm on 2/07/24, 02/09/24, and circled initials with no reason				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND LEAN	S. COMMEDITION	DENTILIOATION NOWDER.	A. BUILDING: _		
		HAL098030	B. WING		R-C 03/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
PARKWO	OD VILLAGE	1730 PARI	KWOOD BLVD		
TARRE	OD VILLAGE	WILSON, I	NC 27895		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 367	Continued From page	e 80	D 367		
	80mg, 1 tablet was administered at 8:00pm on 02/20/24, 02/23/24, and 02/27/24, that was blank and no reason given as to why the medication was not administered.				
	tablet every evening a -There was no docum 1 tablet was administe and 03/12/24, that wa given as to why the m	for Atorvastatin 80mg, 1			
	01/01/24 revealed an tablet every evening a	order for Donepezil 5mg, 1 at 8:00pm. (Donepezil is a eat Alzheimer's disease).			
	revealed: -There was an entry f every evening at 8:00 -There was documentablet was not adminis 01/01/24 through 01/0	tation Donepezil 5mg, 1 stered at 8:00pm from 07/24, 01/19/24, and circled initials with no reason			
	revealed: -There was an entry f every evening at 8:00 -There was document tablet every evening v on 02/04/24, 02/06/24 02/19/24 denoted by given as to why the m	tation Donepezil 5mg, 1 was administered at 8:00pm 1, 02/07/24, 02/09/24, and circled initials with no reason			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R-C	
		HAL098030	B. WING		03/22/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PARKWO	OD VILLAGE		WOOD BLVD			
		WILSON, N	C 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 367	Continued From page	e 81	D 367			
	5mg, 1 tablet every evening was administered at 8:00pm on 02/20/24, 02/23/24, and 02/27/24, that was blank and no reason given as to why the medication was not administered.					
	every evening at 8:00 -There was no docum tablet was not admini 03/12/24, that was bla to why the medication m. Review of Resider dated 01/01//24 revea 8mg, 1 tablet every even	for Donepezil 5mg, 1 tablet opm. nentation Donepezil 5mg, 1 stered at 8:00pm on ank and no reason given as a was not administered. In #4's physician orders aled an order for Doxazosin vening at 8:00pm. In treat high blood pressure				
	revealed: -There was an entry f every evening at 8:00 -There was documen tablet was not admini 01/01/24 through 01/0 01/22/24 denoted by given as to why the m administered Review of Resident #	tation Doxazosin 8mg, 1 stered at 8:00pm on from 07/24, 01/19/24, and circled initials with no reason				
	every evening at 8:00 -There was documentablet was not admini 02/04/24, 02/06/24, 0	tation Doxazosin 8mg, 1 stered at 8:00pm on 2/07/24, 02/09/24, and circled initials with no reason				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		HAL098030	B. WING			R-C / 22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATI	E, ZIP CODE		
PARKWO	OD VILLAGE	1730 PAR	KWOOD BLVD			
FARRIVO	OD VILLAGE	WILSON,	NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 367	Doxazosin 8mg, 1 tab 8:00pm on 02/20/24, was blank and no rea medication was not ac Review of Resident # -There was an entry fevery evening at 8:00 -There was no docum tablet was administer that was blank and no medication was not ac n. Review of Resident dated 01/01/24 revea 100mg, 1 capsule at be (Gabapentin may be of Review of Resident # revealed: -There was an entry for capsule at bedtime at -There was document capsule was not admi 01/01/24 through 01/0 01/22/24 denoted by given as to why the medication was not active.	are was no documentation olet was administered at 02/23/24, and 02/27/2, that son given as to why the dministered. 4's March 2024 revealed: or Doxazosin 8mg, 1 tablet pm. lentation Doxazosin 8mg, 1 ed at 8:00pm on 03/12/24, or reason given as to why the dministered. It #4's physician orders led an order for Gabapentin pedtime at 8:00pm. lesed to treat nerve pain). 4's January 2024 MAR or Gabapentin 100mg, 1 8:00pm. lation Gabapentin 100mg, 1 inistered at 8:00pm on from 17/24, 01/19/24, and circled initials with no reason	D 367			
	revealed: -There was an entry for capsule at bedtime at -There was document capsule was not admit 02/04/24, 02/06/24, 0.02/19/24 denoted by the capsule was not admit 02/04/24, 02/06/24, 0.002/19/24 denoted by the capsule was not admit to the capsule was not admit the capsule wa	tation Gabapentin 100mg, 1 inistered at 8:00pm on 2/07/24, 02/09/24, and circled initials with no reason				
	given as to why the m	ledication was not documentation Gabapentin				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		1 ' '	(X3) DATE SURVEY COMPLETED	
						R-C
		HAL098030	B. WING		03	/22/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
PARKWO	OD VILLAGE		KWOOD BLVD			
	OLUMBA DV OT		NC 27895	DD0//DEDI0 D/ 44/ 05 06	ADDECTION .	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From page 83		D 367			
	100mg, 1 capsule was administered at 8:00pm on 02/20/24, 02/23/24, and 02/27/24, that was blank and no reason given as to why the medication was not administered.					
	Review of Resident # revealed:	4's March 2024 MAR				
	-There was an entry for Gabapentin 100mg, 1 capsule at bedtime at 8:00pmThere was no documentation Gabapentin 100mg, 1 capsule was administered at 8:00pm on 03/12/24, that was blank and no reason given as to why the medication was not administered.					
	o. Review of Resident #4's physician orders dated 01/01/24 revealed an order for Baza Protect 1%-12% cream, apply to left hip and sacrum daily at 9:00am. (Baza Protect is a skin protectant used to treat and prevent skin irritation).					
	revealed: -There was an entry f cream, apply to left hi 9:00amThere was documen cream was not admin	tation Baza Protect 1%-12% istered at 9:00am on circled initials and no reason				
	dated 01/01/24 revea Unscented cream, ap 9:00am. (Eucerin is a or prevent dry, rough, skin irritations).	t #4's physician orders led an order for Eucerin ply topically to back daily at topical cream used to treat scaly, itchy skin and minor 4's January 2024 MAR				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED		(X3) DATE SURVEY COMPLETED	
AND I LAN OI	CONTROL	IDENTIFICATION NOWBER.	A. BUILDING: _		
		HAL098030	B. WING		R-C 03/22/2024
NAME OF PRO	OVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
PARKWOOI	D VILLAGE	1730 PAR WILSON,	KWOOD BLVD NC 27895		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
F () F	cream, apply topically. There was document cream was not admin 01/04/24 denoted by given as to why the madministered. Refer to interview with 03/21/24 at 11:00am. Refer to interview with (MCD) on 03/21/24 at 18. Refer to interview with Care (DRC) on 03/21/24 at 19. Refer to telephone into Administrator on 03/22. Interview with a MA or revealed: The process was for medication was not administrator on officials and on the back reason the medication including the name of time. There should never to MARs. Interview with the MC revealed: The MAs should circle on the back of the MA was not administered. The MARs should not contain the	or Eucerin Unscented to back daily at 9:00am. Itation Eucerin Unscented istered at 9:00am on circled initials and no reason nedication was not a medication aide (MA) on the Memory Care Director of 11:20am. In the Director of Resident 124 at 11:40am. Iterview with the 2/24 at 10:56am. In 03/21/24 at 11:00am Ithe MAs to document the dministered by circling their circle of the MARs and give an was not administered if the medication, date, and the blanks or holes on the ID on 03/21/24 at 11:20am Iter initials and document the Rs the reason a medication is the reason a medication in the reason and	D 367		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL098030	B. WING		03/22/2024
			1		1 00/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
PARKWOOD VILLAGE 1730 PAR			WOOD BLVD		
WILSON,			IC 27895		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 367	Continued From page	e 85	D 367		
	revealed: -The procedure was ficircle their initials and the MARs the reason administered such as refused, awaiting medication was a documentation should medication was given -The facility would be MARs which should he MARs. Telephone interview would be madication on the with the initials of the medicationIf the medication was should circle her initials.	for the MAs was to initial and document on the back of the medication was not resident out of the facility, dication from pharmacy, administered as needed, dinclude the reason the nand the effectiveness. In changing to electronic melp with the accuracy of the with the Administrator on revealed: The MARs should be accurate the MA who administered the said and document on the reason the medication was			
D 392	10A NCAC 13F .1008	3 (a) Controlled Substances 3 Controlled Substances ne shall assure a record of	D 392		
	controlled substances receipt, administration	s by documenting the			
	•	s. These records shall be			
	maintained with the re	esident's record in the facility			
	and in such an order	that there can be accurate			
	reconciliation of contr	olled substances.			
	This Rule is not met	as evidenced by:			
		and record reviews, the			
	facility failed to ensur	e accurate reconciliation of a			
		for 1 of 7 residents (#8)			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	or connection	IDENTIFICATION NOWIDER.	A. BUILDING: _		COMI LETED
		HAL098030	B. WING		R-C 03/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
PARKWO	OD VILLAGE	1730 PAR WILSON,	KWOOD BLVD		
0.0.1-	CLIMMADY CT	<u> </u>			ON
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 392	Continued From page	e 86	D 392		
	used to treat severe pat end of life, resulting	for a controlled substance pain and breathing difficulties g in missing and ages of the medication.			
	The findings are:				
	Review of Resident #8's closed record FL-2 dated 08/23/23 revealed diagnoses included dementia and hypertension.				
	(PCP) note dated 02/ -Today, 02/28/24, the deteriorated substant -The resident had a reper minute and did not a few dates of the control of t	resident's condition had ially. espiratory rate of 60 breaths ot appear to be comfortable. the resident's family, the			
	for Morphine 10mg/0. 0.5ml every 4 hours a shortness of breath. -It was electronically 97:17pm. -There was documen fax and email to the fa 7:19pm.	onic prescription (e-script) .5ml Oral Solution, take as needed for pain or signed on 02/28/24 at tation the order was sent via acility on 02/28/24 at			
	Review of Resident # dated 03/01/24 PCP	8's hospice verbal order order dated 03/01/24			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '			(X3) DATE SURVEY COMPLETED	
,	o. 002011011	.52	A. BUILDING: _	СОМРІ R 03/		
		HAL098030	B. WING			R-C 8 /22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STAT	E, ZIP CODE		
		1730 PAF	RKWOOD BLVD			
PARKWO	OD VILLAGE	WILSON,	NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 392	Continued From page	e 87	D 392			
	rovooled on order for	Marphine Culfate				
	revealed an order for 100mg/5ml give 0.5m	ni every 4 hours scheduled.				
	Review of Resident # 03/03/24 revealed:	8's hospice order dated				
	-The resident was accomfort medications.	tively dying, continue				
	-Give scheduled Morp	phine if the resident was				
	awake or asleep. -A second note again indicated "administer Morphine if pt (patient) awake or asleep". Review of a second hospice order on 03/03/24 for					
	Resident #8 revealed -The resident was ac					
	respiratory distress.	uvery dynig, naving				
		mfortable but uncomfortable				
	with respiratory chang moved/repositioned.	ges when				
	· •	to increase scheduled				
	Morphine form every	4 hours to every 2 hours for				
	severe pain or respiral administer if the resid	atory distress, do not hold, lent awake or asleep.				
	Review of Resident #	8's February 2024				
		ation record (MAR) revealed:				
		itten entry for Morphine				
	Sulfate 0.5ml every 4 shortness of breath.	hours for severe pain or				
	-There was no Morph	ine documented as				
	administered in Febru					
	-There were no other	•				
	transcribed onto the F	February 2024 MAR.				
	Review of Resident # revealed:	8's March 2024 MAR				
	-There was a handwr	itten entry for Morphine				
		ke 0.5ml every 4 hours as				
	needed for pain or sh					
	-There was no prn Mo	orphine documented as				

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE 1730 PARKWOOD BLVD WILSON, NC 27895 CAUGH DEPOILENCY MUST SEE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING MFORMATION) D 392 Continued From page 88 administered for this entry, -There was a second handwritten entry for Morphine 100mg/5ml give 0.5ml every 4 hours with a written date of 3031/24 sheedlaed at 8:00am, 12:00pm, 4:00pm, 8:00pm, 12:00am, and 4:00am. -There was documented as not administered on 03/02/24 at 12:00am and 4:00am and 4:00am and 8:00pm with no reason for not administering the medication. -There was a bird handwritten entry for Morphine 100mg/5ml give 0.5ml every 2 hours scheduled for 8:00am, and 4:00am and 4:00am and 6:00pm with no reason for not administering the medication. -There was a bird handwritten entry for Morphine 100mg/5ml give 0.5ml every 2 hours scheduled for 8:00am, 10:00am, 12:00am, 0:00pm, 10:00am, 0:00pm, 10:00pm, 10:00pm		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE S COMPLE	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1730 PARKWOOD BLVD WILSON, NC 27895 PROVIDER'S PLAN OF CORRECTION WILSON, NC 27895 D PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) D 392 Continued From page 88 administered for this entry There was a second handwritten entry for Morphine 100mg/Sml give 0.5ml every 4 hours with a written date of 03/01/24 scheduled at 8.00am, 12:00pm, 4:00pm, 8:00pm, 12:00am, and 4:00am - There was a handwritten note underneath the entry dated 03/03/24 with an asterisk and instructions to administered on 03/02/24 at 12:00am and 4:00am due to the resident askeep/no distress Staff initials were circled on 03/01/24 at 8:00am and 8:00pm with no reason for not administering the medication There was a third handwritten entry for Morphine 100mg/Sml give 0.5ml every 2 hours scheduled for 8:00am, 10:00am, 12:00pm, 2:00pm, 4:00pm, 6:00pm, 8:00pm, 10:00pm, 12:00am, 2:00pm, 4:00am, and 6:00am The first documented dose was administered at 10:00pm on 03/03/24 A second dose was documented as administered at 12:00am on 03/04/24 There were no other doses documented as administered in March 2024 There was a handwritten note that the resident expired on 03/04/24 at 12:37am.				_		 R-	c l
PARKWOOD VILLAGE (X4) ID PRETIX TAG (SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 392 Continued From page 88 administered for this entryThere was a second handwritten entry for Morphine 100mg/5ml give 0.5ml every 4 hours with a written date of 03/01/24 scheduled at 8:00am, 12:00pm, 4:00pm, 8:00pm, 12:00am, and 4:00amThere was a so not administered on 03/02/24 at 12:00am and 4:00am, on 03/03/24 at 12:00am and 4:00am to reason for not administering the medicationThere was a third handwritten entry for Morphine 100mg/5ml give 0.5ml every 2 hours scheduled for 8:00am, 10:00pm, 12:00pm, 2:00pm, 4:00pm, 6:00pm, 8:00pm, 10:00pm, 12:00pm, 2:00pm, 6:00pm, 8:00pm, 10:00pm, 12:00pm, 6:00pm 8:00pm, 10:00pm, 12:00pm, 6:00pm, 8:00pm, 10:00pm, 12:00pm, 6:00pm, 8:00pm, 10:00pm, 12:00pm, 6:00pm 8:00pm, 10:00pm, 12:00pm, 6:00pm 8:00pm, 10:00pm, 12:00pm, 6:00pm 8:00pm, 10:00pm, 12:00pm, 6:00pm, 8:00pm, 10:00pm, 12:00pm, 6:0			HAL098030	B. WING		I	
MILSON, NC 27895 MILSON, NC 27895	NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 392 Continued From page 88 administered for this entry. -There was a second handwritten entry for Morphine 100mg/5ml give 0.5ml every 4 hours with a written date of 03/01/24 scheduled at 8:00am, 12:00pm, 4:00pm, 8:00pm, 12:00am, and 4:00am. -There was a handwritten note underneath the entry date 03/03/24 with an asterisk and instructions to administer if awake or asleep. -Morphine was documented as not administered on 03/02/24 at 12:00am and 4:00am, on 03/03/24 at 12:00am and 4:00am, on 03/03/24 at 12:00am and 6:00am, 12:00pm give 100am, and 3:00pm with no reason for not administering the medication. -There was a third handwritten entry for Morphine 100mg/5ml give 0.5ml every 2 hours scheduled for 8:00am, 10:00pm, 2:00pm, 4:00pm, 6:00pm, 10:00pm, 12:00am, 2:00am, 4:00am, and 6:00am. -The first documented dose was administered at 10:00pm on 03/03/24. -A second dose was documented as administered at 12:00am on 03/04/24. -There were no other doses documented as administered at 12:00am on 03/04/24. -There was a handwritten note that the resident expired on 03/04/24 at 12:37am.	DA DICINO	DD VIII I ACE	1730 PARK	WOOD BLVD			
EREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 392 Continued From page 88 administered for this entry. -There was a second handwritten entry for Morphine 100mg/5mi give 0.5ml every 4 hours with a written date of 03/01/24 scheduled at 8:00am, 12:00pm, 4:00pm, 8:00pm, 12:00am, and 4:00am. -There was a handwritten note underneath the entry date 03/03/24 with an asterisk and instructions to administer if awake or asleep. -Morphine was documented as not administered on 03/02/24 at 12:00am and 4:00am, on 03/03/24 at 12:00am and 4:00am, on 03/03/24 at 12:00am and 6:00am, on 03/03/24 at 12:00am, and 6:00am, 10:00pm, 2:00pm, 4:00am, and 6:00am, 10:00pm, 1	PARKWO	JD VILLAGE	WILSON, N	C 27895			
administered for this entry. -There was a second handwritten entry for Morphine 100mg/5ml give 0.5ml every 4 hours with a written date of 03/01/24 scheduled at 8:00am, 12:00pm, 4:00pm, 8:00pm, 12:00am, and 4:00am. -There was a handwritten note underneath the entry dated 03/03/24 with an asterisk and instructions to administer if awake or asleep. -Morphine was documented as not administered on 03/02/24 at 12:00am and 4:00am, on 03/03/24 at 12:00am and 4:00am, on 03/03/24 at 12:00am and 4:00am due to the resident asleep/no distress. -Staff initials were circled on 03/01/24 at 8:00am and 8:00pm with no reason for not administering the medication. -There was a third handwritten entry for Morphine 100mg/5ml give 0.5ml every 2 hours scheduled for 8:00am, 10:00am, 12:00pm, 2:00pm, 4:00pm, 6:00pm, 8:00pm, 10:00pm, 12:00am, 2:00am, 4:00am, 4:00am, and 6:00am. -The first documented dose was administered at 10:00pm on 03/03/24. -A second dose was documented as administered at 12:00am on 03/04/24. -There were no other doses documented as administered in March 2024. -There was a handwritten note that the resident expired on 03/04/24 at 12:37am.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE
-There was a second handwritten entry for Morphine 100mg/5ml give 0.5ml every 4 hours with a written date of 03/01/24 scheduled at 8:00am, 12:00pm, 4:00pm, 8:00pm, 12:00am, and 4:00am. -There was a handwritten note underneath the entry dated 03/03/24 with an asterisk and instructions to administer if awake or asleep. -Morphine was documented as not administered on 03/02/24 at 12:00am and 4:00am, on 03/03/24 at 12:00am and 4:00am, on 03/03/24 at 12:00am and 4:00am, on 03/03/24 at 12:00am and 4:00am due to the resident asleep/no distress. -Staff initials were circled on 03/01/24 at 8:00am and 8:00pm with no reason for not administering the medication. -There was a third handwritten entry for Morphine 100mg/5ml give 0.5ml every 2 hours scheduled for 8:00am, 10:00am, 12:00pm, 2:00pm, 4:00pm, 6:00pm, 8:00pm, 10:00pm, 12:00pm, 2:00pm, 4:00pm, 6:00pm, 8:00pm, 10:00pm, 12:00am, 2:00am, 4:00am, and 6:00am. -The first documented dose was administered at 10:00pm on 03/03/24. -A second dose was documented as administered in March 2024. -There were no other doses documented as administered in March 2024. -There was a handwritten note that the resident expired on 03/04/24 at 12:37am.	D 392	Continued From page	88	D 392			
Review of Resident #8's incident report dated 03/04/24 at 12:20am revealed hospice came to assess the resident and the resident had expired. Review of Resident #8's controlled substance (CS) log for Morphine revealed: -There was only one CS log for Morphine with 30	D 392	administered for this of There was a second Morphine 100mg/5ml with a written date of 8:00am, 12:00pm, 4:0 and 4:00am. There was a handwr entry dated 03/03/24 instructions to admini -Morphine was docum on 03/02/24 at 12:00a at 12:00am and 4:00a asleep/no distress. Staff initials were circ and 8:00pm with no rethe medication. There was a third ha 100mg/5ml give 0.5m for 8:00am, 10:00am, 6:00pm, 8:00pm, 10:04:00am, and 6:00am. The first documented 10:00pm on 03/03/24 -A second dose was a administered at 12:00 -There were no other administered in Marcl -There was a handwr expired on 03/04/24 at 12:20am assess the resident # 03/04/24 at 12:20am assess the resident # (CS) log for Morphine	entry. handwritten entry for give 0.5ml every 4 hours 03/01/24 scheduled at 00pm, 8:00pm, 12:00am, itten note underneath the with an asterisk and ster if awake or asleep. hented as not administered am and 4:00am, on 03/03/24 am due to the resident cled on 03/01/24 at 8:00am leason for not administering indwritten entry for Morphine all every 2 hours scheduled 12:00pm, 2:00pm, 4:00pm, 00pm, 12:00am, 2:00am, didose was administered at . documented as leam on 03/04/24. doses documented as in 2024. itten note that the resident at 12:37am. 8's incident report dated revealed hospice came to ind the resident had expired. 8's controlled substance e revealed:	D 392			

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there was a direction change sticker placed over

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER PARKWOOD VILLAGE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S COMPLE	
			7 BOILBING.		R-	C
		HAL098030	B. WING		1	2/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PARKWO	OD VILLAGE		WOOD BLVD			
		WILSON, N	IC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	= 89	D 392			<u> </u>
	of the CS logThere were no doses as administered in Fe -The first dose docum 03/01/24 at 12:00pmThe last dose was do on 03/04/24 at 12:00a -There were 12 of 30 Morphine documente balance of 18 prefilled Review of Resident # records from 07/01/23 -The pharmacy dispe (15mls) of Morphine S 02/29/24The date the order w -The instructions were	nented as administered was cocumented as administered am. prefilled syringes of a sadministered, leaving a d syringes. 28's pharmacy dispensing 3 - 03/20/24 revealed: ensed 30 prefilled syringes Sulfate 100mg/5ml on was written was 02/28/24. The to take 0.5ml (10mg) every or pain or shortness of				
	returns/discards audit 03/21/24 revealed the	t report dated 07/01/23 - ere was no documentation of d syringes being returned to				
	Prescription Returned documented by facilit revealed: -There was an entry f a quantity returned do resident expiredThe form was signed.	for Morphine 100mg/5ml with ocumented as 18. cumented for return was the				
		macy signature was blank.				

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of 03/04/24 at 9:55am.

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	SURVEY PLETED
			A. BUILDING:	COMF F TATE, ZIP CODE		
		HAL098030	B. WING			R-C / 22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
		1730 PAR	KWOOD BLVD			
PARKWO	OD VILLAGE	WILSON,	NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETE DATE
D 392	Continued From page	90	D 392			
	at the facility's contrar at 5:00pm revealed: -They received an ord Morphine on 02/28/24 -The order was proce because there was no 7:00pm to process or -Resident #8's Morph 02/29/24 with 15ml di syringes of 0.5ml eac -The 30 prefilled syrindelivered to the facilities -She did not see a refipharmacy computer is MorphineThe pharmacist who at the pharmacy toda Telephone interview wo 03/22/24 at 10:57am -She thought Resider been returned to the fipharmacy after the reshe just emailed son contracted pharmacy Morphine and attaches substance return sheeshe had not received pharmacy yet. Telephone interview wo the facility's contracted 12:41pm revealed: -The Morphine Sulfate for Resident #8 was relast seven days and contracted of the substance return sheeshe had not received pharmacy yet.	a after 7:00pm. ssed the next day, 02/29/24, o one at the pharmacy after ders. ine was dispensed on spensed in 30 prefilled h. ages of Morphine were y on 02/29/24 at 4:08pm. turn process in the system for the resident's processed returns was not y, 03/21/24. with the Administrator on revealed: at #8's Morphine Sulfate had facility's contracted sident passed. about Resident #8's about Resident #8's ad a copy of the controlled et. d a response from the with the General Manager at ad pharmacy on 03/22/24 at ereturned from the facility eceived "likely" within the lid not get processed and				
	for Resident #8 was r last seven days and c	eceived "likely" within the lid not get processed and acy system by the pharmacy				

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STATE FORM 6899 N1S211 If continuation sheet 91 of 104

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND I LAN OI	CONNECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COWII LETED
		HAL098030	B. WING		R-C 03/22/2024
NAME OF PRO	OVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
PARKWOOI	O VILLAGE	1730 PAR WILSON,	KWOOD BLVD NC 27895		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTE
- s t t s s s t t s s s s t t s s s s t t s s s s t t s s s s s t t s s s s s t t s	seven milliliters (mls) total of 14 prefilled syntotal ontracted pharmacy revealed: He was able to review regarding the Morphin Resident #8. On 02/29/24, Morphine facility, a quantity or filled syringes of 0. Second telephone into Manager at the facility of 15 prefilled syringes of Morphine of 15 prefilled syringes of Morphine of 16 prefilled syringes of Morphine of 16 prefilled syringes of Morphine of 17 prefilled syringes of Morphine of 18 prefilled syringes of 18 prefilled	ician keyed in receiving of morphine sulfate for a ringes. with the Operational Pharmacist at the facility's on 03/22/24 1:13pm with the electronic database in Sulfate dispensed for in Sulfate was dispensed to of 15mls for a total of 30 in Sml each. erview with the General Pharmacy on evealed: Inly located a return of 14 in Indian	D 392		

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STATE FORM 6899 N1S211 If continuation sheet 92 of 104

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL098030	B. WING		R-C 03/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
PARKWO	OD VILLAGE		KWOOD BLVD NC 27895		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 392	writing up the return rewere 18 prefilled syrin returned to the pharm of the last dose of Morwas administered at a remaining count of 18 syringes. Telephone interview was:30pm revealed: -When she prepared return to the pharmac medication return form medication, and place medications and medications a	MA that she remembered nedication form and there ages of Morphine Sulfate lacy on 03/04/24. phine Sulfate administered 12:00am on 03/04/24 with a Morphine Sulfate prefilled with the MA on 03/22/24 at controlled medications for ey, she completed the m, counted every ed the controlled ication count sheet in a lastic bag. olled medications in the edication cart.	D 392		
D 399	10A NCAC 13F .1008 (h) The facility shall ediversions are reported enforcement agency are Registry as required by	s (h) Controlled Substance Controlled Substance Consure that all known drug and to the pharmacy, local law and Health Care Personnel by state law, and that all	D 399		
	pharmacy. There sha contact and action tal This Rule is not met				

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STATE FORM 6899 N1S211 If continuation sheet 93 of 104

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING			
		HAL098030	B. WING		I	R-C 8 /22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E ZIP CODE		
			RKWOOD BLVD	_,		
PARKWO	OD VILLAGE		, NC 27895			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	ECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETE DATE
D 399	Continued From page	93	D 399			
	used to treat anxiety	e a suspected drug s of a controlled substance and agitation by Staff A was 's contracted pharmacy in				
	The findings are:					
	Registry (HCPR) Initial A revealed: -The accused employ medication aide (MA) -Staff A's date of hire 06/19/23The allegation was defined the incident was docume 12:45pmThe allegation details	. was documented as liversion of resident drugs. ent was documented as facility became aware of the				
	log for the medication facility.	s. controlled substance (CS) was missing from the				
	contacted the Adminis was reported to the A facility was missing of was stolen by an emp	njury/harm was documented time. here was reasonable and the incident was				
	11/03/23 at 3:22pm.	nentation the suspected drug				

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DIVISION	n nealth Service Negu	ialion			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL098030	B. WING		03/22/2024
		TIALU30030			03/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
DADKWO	OD VILLAGE	1730 PAR	KWOOD BLVD		
PARRIVO	OD VILLAGE	WILSON,	NC 27895		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	JAIE DAIE
				,	
D 399	Continued From page	94	D 399		
	diversion was reporte	d to the facility's contracted			
	pharmacy.				
	-The report was signe	ed by the Administrator and			
	dated 11/03/23.				
	Paviou of a 5 day UC	CPR Investigation Report for			
	Staff A revealed:	CFR investigation Report for			
		vee was Staff A, a MA.			
		liversion of resident drugs.			
	•	ent was documented as			
	11/03/23.	on was assumented as			
	-There were no witne	sses documented.			
		ary included 3 paragraphs of			
	an investigation sumr				
	•	ent's Xanax was ordered			
		nacy and delivered to the			
	facility at 12:02am on				
	-	ed in by a third shift MA and			
		assisted on signing in the			
	medications and putti	ng them up.			
	-The resident's order	was to take Xanax every			
	night at 8:00pm.				
	-When the medication	n arrived on 10/11/23, the			
	•	ls remaining in the current			
	package.				
		were given as ordered.			
	-On 10/18/23, there w	vas no Xanax in the			
	medication cart for the				
		as notified on 11/03/23 upon			
		that the 30 Xanax pills that			
		/11/23 were missing and			
	they were stolen by S				
	-The Administrator im	mediately began an			
	investigation.				
		ord review, and observation,			
	the allegation was un				
		confirmed delivered and the			
	medication was not fo				
	 No witnesses of Staf 	f A stealing the medication			

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was documented and Staff A did not work when

STATE FORM 6899 N1S211 If continuation sheet 95 of 104

STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S COMPLE	
					R-	_
		HAL098030	B. WING		03/2	2/2024
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
PARKWO	OD VILLAGE		WOOD BLVD			
1		WILSON, N	IC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 399	Continued From page	95	D 399			
D 399	the medication was destaff A did not work to medication was delived seeing the medication -All MAs were intervied Resident Care (DRC) training on Narcotic Ceror investigative action substantiated and the terminated. The incident was reputed because of the could not local law enformediversion was reported pharmacy. The report was signed dated 11/13/23. Telephone interview was 10:57am revealed: She or the Administration of the facility's provider about an allest the facility. She called the facility's provider about an allest facility. She called the facility during the alleged drug and spoke with some out when the Xanax was she did not recall when the Xanax was she did not recall when the Xanax was she was not sure if so with the facility's contact with the pharmace interview.	delivered. until 3 days after the ered and she did not recall in on the cart. ewed and the Director of its would be completing a count Guidelines for all MAs. its accused employee was not exacused by the Administrator and employee was not exacused employee	D 399			
		harmacy about the allegation				

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Telephone interview with the Administrator on

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R-C	
		HAL098030	B. WING		03/22/2	2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DA DKWO	OD VILLAGE	1730 PARK	WOOD BLVD			
PARKWO	OD VILLAGE	WILSON, N	C 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 399	reporting suspected of facility's contracted plushe had not been at documentation by facility's contracted plushe knew the DRC in facility's contracted plushe suspected drug diversion at the facility because she assume pharmacy. She contacted the facility because she assume pharmacy. She contacted the facility because she assume pharmacy. She contacted the facility because she assume pharmacy. When she contacted pharmacy, she was pfor the Xanax and she medication had not be facility. Telephone interview with facility's contracted pharmacy. She was the pharmacy. She was the pharmacy. She had not received of drug diversion at the facility could have Servicing Department diversion.	revealed: C were responsible for large diversions to the narmacy. The latest of the latest of the latest of the narmacy. The latest of the narmacy. The latest of the narmacy and been talking with the narmacy about the sion of 30 Xanax tablets in the latest of	D 399			
	Telephone interview v Servicing Department	vith the Operational t Pharmacist at the facility's				

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		A. BOILDING		R-C		
		HAL098030	B. WING		03/22/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
PARKWO	OD VILLAGE	1730 PAI	RKWOOD BLVD			
			, NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
D 399	Continued From page	97	D 399			
	contracted pharmacy on 03/22/24 1:13pm revealed he did not have any records of notification of suspected drug diversion at the facility.					
D 438	10A NCAC 13F .1205 Registry	Health Care Personnel	D 438			
	10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION					
	Based on interviews and record reviews, the facility failed to ensure residents were protected from harm while a Health Care Personnel Registry (HCPR) investigation was in progress for 1 of 1 staff (Staff A), a medication aide who allegedly diverted a controlled substance was not suspended but continued to administer medications, including controlled substances at the facility, while the facility was also aware Staff A had criminal drug charges pending.					
	The findings are: Review of a 24-hour Health Care Personnel Registry (HCPR) Initial Allegation Report for Staff A revealed: -The accused employee was Staff A, a medication aide (MA). -Staff A's date of hire was documented as 06/19/23. -The allegation was diversion of resident drugs. -The date of the incident was documented as					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	HAL098030	B. WING		R-C 03/22/2024	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
	1730 PAR	KWOOD BLVD			
PARKWOOD VILLAGE	WILSON,	NC 27895			
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 438 Continued From page	98	D 438			
11/03/23The date at time the incident was document 12:45pmThe allegation details medication, Xanax (a to treat anxiety) preso delivered on 10/10/23The Xanax and the colog for the medication facilityThe local county Adu contacted the Administ was reported to the Adfacility was missing or was stolen by an empenyical or Mental in as none noted at this lit was documented the suspicion of a crime a reported to the local period to the l	facility became aware of the need as 11/03/23 at a sincluded a resident's controlled substance used ription was showing a controlled substance (CS) was missing from the a strator and notified her that it and the substances, and it alloyee at the facility, jury/harm was documented time. The incident was a solice department on the strator and strator and strator and strator was faxed to the 4:32pm. The incident did not result in the incident did not result in yor mental anguish.	D 438			

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					D 0
		HAL098030	B. WING		R-C 03/22/2024
		HALU90030			03/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
DADKWO	OD VILLAGE	1730 PARI	KWOOD BLVD		
PARKWO	OD VILLAGE	WILSON, I	NC 27895		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE
			+	,	
D 438	Continued From page	∍ 99	D 438		
	-On 10/10/23, a resid	ent's Xanax was ordered			
		nacy and delivered to the			
	facility at 12:02am on	-			
	_	ed in by a third shift MA and			
		assisted on signing in the			
	medications and putti	0 0			
		was to take Xanax every			
	night at 8:00pm.	was to take Adriax every			
		n arrived on 10/11/23, the			
		Is remaining in the current			
	package.	ie remaining in the earrent			
		s were given as ordered.			
	-On 10/18/23, there w				
	medication cart for the				
		as notified on 11/03/23 upon			
		that the 30 Xanax pills that			
		/11/23 were missing and			
	they were stolen by S				
	-The Administrator im				
	investigation.	, ,			
	-After interviews, reco	ord review, and observation,			
	the allegation was un	substantiated.			
	-The medication was	confirmed delivered and the			
	medication was not for	ound.			
	-No witnesses of Staf	f A stealing the medication			
	were documented an	d Staff A did not work when			
	the medication was d				
	-Staff A did not work เ	<u>.</u>			
		ered and she did not recall			
	seeing the medication				
		ewed and the Director of			
		RC) would be completing a			
	_	Count Guidelines for all MAs.			
		ons, the allegation was not			
		e accused employee was not			
	terminated.				
		ported to the local county			
	I	Services (DSS) on 11/03/23			
	and to local law enfor	cement on 11/03/23.	1		

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-The accused was not charged with any crime

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED			
74401 2744	or connection	A. BUILDING:			JOHN LETED				
	HAL098030		B. WING		I	R-C 8 /22/2024			
			l		1 00	0/22/2024			
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STATE	E, ZIP CODE					
PARKWO	PARKWOOD VILLAGE								
	WILSON, NC 27895								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE			
D 438	Continued From page	2 100	D 438						
	related to the facility allegationThe report was signed by the Administrator and dated 11/13/23.								
	_	s fax confirmation sheet vestigation report was faxed 3/23 at 12:28pm.							
	Review of a letter from the NC HCPR Investigations dated 11/29/23 revealed: -The incident referenced was Staff A allegedly misappropriated a resident's property on or about 11/03/23.								
	the Department had o	ring the reported allegation, letermined that an ot be conducted in this case.							
	Review of the residents' CS logs revealed: -Staff A documented administration of medications, including controlled substances, during the investigation (conducted from 11/03/23 - 11/13/23) into allegations of drug diversion by Staff AStaff A documented administration of controlled substances to residents on 11/06/23, 11/08/23,								
	11/09/23, and 11/10/2 Telephone interview v	vith the Administrator on							
	-She was not sure if t suspending named en reported to the HCPR	he facility had a policy on mployees with allegations							
	just did what the corp (HR) staff told her to	address suspensions, she oration's Human Resources							
	named staff during ar it was more toward th	n investigation if needed but e end of the investigation. hour report to HCPR, she							

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED			
			A. BUILDING:	A. BUILDING:					
	HAL098030 B. WING			R-C 8/ 22/2024					
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS CITY STATE	ZIP CODE					
PARKWO	PARKWOOD VILLAGE 1730 PARKWOOD BLVD WILSON, NC 27895								
	T		, NC 27095						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE			
D 438	Continued From page	e 101	D 438						
D 438	started on the investig staff to determine who continued to work or vinvestigation. -An employee would an arrest or if abuse well an arrest or if abuse well when asked if an employee that staff and the stated there was suspend an employee that staff. -The facility would not to work if a resident we someone was abusing to remove that staff frestaff were diverting suspended and they would pure the facility would pure medications and that medications from the investigation until the staff A was not suspended until the staff A was not suspended uning the investigation interviewed were say all hearsay; there were she could not recall the Staff A called the DR gotten arrested for drug she could not recall the staff of the allegation of drug she could not recall the staff of the could not recall the staff of the allegation of drug she could not recall the staff of the could not recall the staff of the could not recall the staff of t	gation and worked with HR ether the employee was suspended during the be suspended if there was was involved. Inployee would be regation of drug diversion, not a list of reasons to re and she just worked with It let a staff person continue was at risk for harm; if g a resident they would want rom the facility. If drugs, they would be would immediately look at all It that MA from administering MA would not administer beginning of the end of the investigation. If work in the facility unless rwise. Rended on 11/03/24. Red on 11/10/23 because on some of the staff ring it was Staff A but it was re no witnesses. Resident they would be staff A was sted for drug charges but ne date. Cand reported that she had red charges (not related to diversion at the facility) but ne date.	D 438						
		•							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					 R-0	c
		HAL098030	B. WING		1	2/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PARKWO	OD VILLAGE		WOOD BLVD			
		WILSON, N	C 27895		. 1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 438	Continued From page	2 102	D 438			
	-Staff A should not had medications during the she was concerned medications during the did not know if she had 10:57 am revealed: -She thought Staff A vinvestigationShe remembered tel received allegations a have to do an investighave to stay home duestif A was still on the receiving benefitsShe did not document did not recall her exaction and the staff A was still on the receiving benefitsShe did not document did not recall her exaction as should be one in Staff was suspendedShe had no explanate	ve administered e investigation. Staff A administered e investigation because they ad taken the Xanax or not. vith the DRC on 03/22/24 at vas suspended during the ling Staff A they had against her and they would gation and Staff A would uring the investigation. e employee roster and nt the conversation and she et words to Staff A. spension form and there f A's personnel record if she lion for Staff A administering g controlled substances				
	Review of Staff A's personnel record on 03/21/24 revealed there was no suspension of employment form in her record.					
	to her returning to wo -She took a leave from issueShe requested the le -She had never been -She had not done an	evealed: ne facility on 11/19/23 prior rk 01/25/24. m work due to a personal				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL098030	B. WING		R-C 03/22/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	-	
PARKWO	OD VILLAGE	1730 PAR	WOOD BLVD			
	T	WILSON, N	IC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 438	Continued From page	e 103	D 438			
	to protect residents fr conducted a Health C (HCPR) investigation diversion by Staff A. Care (DRC) was notif HCPR investigation than diversion at the Administrator was awwhile she was conduction for the all a resident's controlled Staff A continued to a including controlled since the facility on 4 days. This failure of the facility and we constitutes a Type B. The facility provided a accordance with G.S. this violation.	om harm while the facility care Personnel Registry for an allegation of drug The Director of Resident fied by Staff A during the nat she had been arrested g charges (unrelated to the ne facility). The rare of the drug charges cting the 5-day HCPR allegation of Staff A diverting d substance at the facility. dminister medications, substances, to residents at during the investigation. The investigation of the residents and Violation.				

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