

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/19/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G145	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/19/2024
NAME OF PROVIDER OR SUPPLIER PARK AVENUE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 105 PARK AVENUE CREEDMOOR, NC 27522		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 189	<p>STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1)</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure staff were sufficiently trained in medication administration. This affected 1 of 3 audit clients (#1). The finding is:</p> <p>During morning administration administration in the home on 3/19/24 at 7:30am, Staff A did not inform client #1 what medications she was consuming and what they were for.</p> <p>During an immediate interview Staff A stated that it slipped his mind to inform client #1 what medications she was taking and what they were for. Staff A also revealed he was trained to inform the clients what medications they are taking and what they are for.</p> <p>During an interview on 3/19/24, the Home Manager (HM) revealed staff have been trained to inform the clients what medications they are taking and what they are for.</p> <p>During an interview in 3/19/24, the facility's nurse stated staff have been trained to inform clients what medications they are they and why.</p>	W 189			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.