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	HAL053004	A. BUILDING: _____ B. WING _____	01/15/2025

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PARKVIEW RETIREMENT CENTER	1801 WICKER STREET EXT SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey from 01/14/25 to 01/15/25.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure water temperatures were maintained between 100 to 116 degrees Fahrenheit (F) in residents' bathrooms as evidenced by 8 of 11 fixtures with water temperatures ranging from 117.7 to 127.6 degrees F. The findings are: Review of the facility's census on 01/14/25 revealed there were 68 residents in the facility. Review of the facility's establishment inspection report dated 12/30/24 revealed the hot water temperatures in the facility ranged between 80 degrees Fahrenheit (F) and 111 degrees F. Observation of the facility's left rear hallway water temperatures on 01/14/25 from 9:15am to 9:38am revealed: -The hot water temperature in the bathroom sink	D 113		

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in the shower room was 127.6 degrees F.
-There was visible steam coming from the sink in the shower room while the faucet was running.
-The hot water temperature in the shower stall in the shower room was 119.2 degrees F.
-The hot water temperature in the bathroom sink in room 1 was 126.8 degrees F.
-The hot water temperature in the bathroom sink in room 6 was 126.5 degrees F.
-The hot water temperature in the bathroom sink in room 11 was 123.1 degrees F.

Observation of the facility's 500 hall water temperatures on 01/14/25 from 9:00am to 9:30am revealed:
-The hot water temperature in the bathroom sink in room 501 was 122.2 degrees F.
-The hot water temperature in the bathroom sink in room 502 was 121.3 degrees F.
-The hot water temperature in the bathroom sink in room 507 was 117.7 degrees F.

Interview with the resident in room 6 on 01/14/25 at 9:18am revealed:
-The water in her bathroom seemed to take a while to get warm.
-She had not noticed the water temperature being too hot.
-She could adjust the water if she thought it felt too warm.
-The facility staff assisted her with bathing, and she had not been burned by the water temperature.

Interview with the resident in room 11 on 01/14/25 at 9:31am revealed:
-The water in her bathroom took a while to get warm.
-She had not noticed the water temperature in her room being too hot.

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-The facility staff assisted her with bathing, sometimes in her bathroom, but usually in the shower room.
-The facility staff always adjusted the water temperature to a comfortable temperature for her showers.
-She could adjust the water in her bathroom if she thought it felt too hot.

Second observation of the facility's left rear hallway water temperatures on 01/15/24 from 8:12am to 8:37am revealed:
-The hot water temperature in the bathroom sink in the common shower room was 95.9 degrees F after letting the water run from 8:13am to 8:18am.
-The hot water temperature in the bathroom sink in resident room 1 was 96.1 degrees F after letting the water run from 8:19am to 8:24am.
-The hot water temperature in the bathroom sink in resident room 6 was 95.5 degrees F after letting the water run from 8:25am to 8:30am.
-The hot water temperature in the bathroom sink in resident room 11 was 96.3 degrees F after letting the water run from 8:31am to 8:36am.

Second interview with the resident in room 11 on 01/15/24 at 8:25am revealed:
-The water in her bathroom sink took a longer time to become warm this morning.
-The water seemed colder than usual when she used her bathroom sink this morning.

Interview with a personal care aide (PCA) on 01/14/25 at 9:46am revealed:
-She was assigned to the left rear hallway on each shift she worked.
-There were currently 11 residents residing on the left rear hallway and each resident required assistance with bathing.
-She had not noticed any issues with the water

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temperature in the facility being too hot.
-She had not heard any residents complain about the water temperature in the facility.
-She always let the water run for a few minutes, then tested the water temperature with her arm before she assisted a resident into the shower.

Interview with the Personnel Manager (PM) on 01/14/25 at 10:46am revealed:
-She was responsible for checking the water temperatures on the facility's 100 hall, 200 hall, 300 hall, kitchen, and the left rear hallway.
-Another staff member was responsible for checking water temperatures on the facility's 500 hall.
-She checked a minimum of 4 fixtures daily and recorded them on a water temperature log.
-The facility had one contracted plumber, and he came to facility on a regular basis for various repairs.
-The plumber installed a new mixing valve on the water heater sometime in the last few months.
-The plumber was at the facility sometime in the last 2-3 weeks.
-Water temperatures should be between 105 degrees F and 116 degrees F.
-She was not concerned about any residents being burned by hot water in the facility because she felt the residents could adjust the temperature if needed.
-She had not had any recent water temperatures out of range.
-She had not checked water temperatures today, 01/14/25.
-She thought someone may have adjusted the water heater and that was the reason the temperature was higher than normal.
-She was going to attempt to adjust the temperature on the water heater.
-The 100 hall, 200 hall, 300 hall, left rear hall, and

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kitchen each had 1 water heater for each area, and the 500 hall had 2 water heaters.
-She would contact the facility's contracted plumber if there were any issues with the water temperatures.

Interview with a second PCA on 01/14/25 at 11:21am revealed:
-She was responsible for checking the water temperature on the 500 hall and recording the temperatures on a temperature log.
-She checked 1 fixture on the 500 hall daily.
-She had not had any water temperatures greater than 116 degrees F on the 500 hall.

Review of the facility's November 2024 water temperature logs revealed:
-A minimum of 5 water temperatures were recorded daily from 11/01/24 to 11/30/24.
-The facility's water temperatures ranged from 107.6 degrees F to 114 degrees F.

Review of the facility's December 2024 water temperature logs revealed:
-A minimum of 5 water temperatures were recorded daily from 12/01/24 to 12/31/24.
-The facility's water temperatures ranged from 107.5 degrees F to 113 degrees F.

Review of the facility's January 2025 water temperature logs revealed:
-A minimum of 4 water temperatures were recorded daily from 01/01/25 to 01/13/25.
-The facility's water temperatures ranged from 107.6 degrees F to 112 degrees F.

Interview with the Administrator on 01/14/25 at 11:01am revealed:
-The PM and another staff member were assigned to check water temperatures in the

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facility daily.
-The water temperature range in the facility should be 105-116 degrees F.
-The facility had a recent health inspection on 12/30/24, and the water temperatures in the facility were too cold.
-She contacted the facility's contracted plumber, and he came to the facility on 12/31/24 to adjust the water temperatures.
-She had not received any complaints from residents about the water being too warm.
-None of the residents had been burned by the hot water temperatures in the facility.

Second interview with the Administrator on 01/15/25 at 8:40am revealed:
-The plumber must have turned the temperature on the water heater down too low on 01/14/25.
-She would call the plumber and have him recheck the water heaters.

Interview with the plumber on 01/14/25 at 1:02pm revealed:
-He came to the facility often for repairs on various equipment.
-He installed new mixing valves on the water heaters at the facility sometime in 2024.
-He adjusted the temperatures on the water heaters for the left rear hall and the 500 hall on 01/14/25.

Second interview with the plumber on 01/15/25 at 9:02am revealed:
-He adjusted the temperature on the water heater again this morning, 01/15/25.
-The water was starting to get warmer but may take a few minutes due to the colder temperature outside.
-All the water pipes in the facility were in the attic.
-The colder outside temperature impacted the

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D 113	Continued From page 6 temperature of the attic, so the water needed to run for a couple minutes to get warm.	D 113		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure quarterly Licensed Professional Health Support evaluations (LHPS) were completed by a LHPS nurse for 3 of 5 sampled residents (#1, #4, #5) who had tasks including fingerstick blood sugar checks (FSBS), insulin injections and transfers with two person	D 280		

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assist (#1), transfers one person assist (#4), and transfers with two person assist and ambulation using a wheelchair (#5).

The findings are:

1. Review of Resident #1's current FL-2 dated 01/14/25 revealed:
-Diagnoses included aphasia following cerebral infraction, chronic kidney disease stage 4, major depressive disorder, and type 2 diabetes mellitus.
-Resident #1 was semi-ambulatory.
-Resident #1 was incontinent of bladder and bowel.

Review of Resident #1's Resident Register revealed she was admitted to the facility on 06/25/24.

Review of Resident #1's record revealed:
-Resident #1 had tasks including fingerstick blood sugar checks (FSBS), insulin injections and transfers with two person assist.
-There was a quarterly Licensed Professional Health Support (LHPS) evaluation dated 12/25/24 signed by a licensed practical nurse (LPN).
-There was a quarterly LHPS evaluation dated 09/25/24 signed by a LPN.

Refer to the interview with the Resident Care Coordinator (RCC) on 01/15/25 at 10:05am.

Refer to the interview with the Administrator on 01/15/25 at 11:15am.

2. Review of Resident #4's current FL-2 dated 12/14/24 revealed:
-Diagnoses included mantle cell lymphoma, falls, asthma, and osteoporosis.
-Resident #4 was semi-ambulatory.

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D 280	Continued From page 8 -Resident #4 was continent of bladder and bowel. Review of Resident #4's Resident Register revealed she was admitted to the facility on 02/21/22. Review of Resident #4's record revealed: -Resident #4 had transfers one person assist. -There was a quarterly Licensed Professional Health Support (LHPS) evaluation dated 01/01/25 signed by a licensed practical nurse (LPN). -There was a quarterly LHPS evaluation dated 10/11/24 signed by a LPN. Refer to the interview with the Resident Care Coordinator (RCC) on 01/15/25 at 10:05am. Refer to the interview with the Administrator on 01/15/25 at 11:15am. 3. Review of Resident #5s current FL-2 dated 07/29/24 revealed: -Diagnoses included cervical disk disorder, chronic atrial fibrillation. -Resident #5 was non-ambulatory. -Resident #5 was incontinent of bladder and bowel. Review of Resident #5's Resident Register revealed she was admitted to the facility on 11/06/23. Review of Resident #5's record revealed: -Resident #5 had transfers with two person assist and ambulation using a wheelchair. -There was a quarterly Licensed Professional Health Support (LHPS) evaluation dated 01/07/25 signed by a licensed practical nurse (LPN). -There was a quarterly LHPS evaluation dated 10/31/24 signed by a LPN.	D 280		

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D 280	Continued From page 9 Refer to the interview with the Resident Care Coordinator (RCC) on 01/15/25 at 10:05am. Refer to the interview with the Administrator on 01/15/25 at 11:15am. _____ Interview with the ResidentCare Coordinator (RCC) on 01/15/25 at 10:05am revealed: -She completed the Licensed Professional Health Support (LHPS) evaluations for the residents in the facility. -She completed the LHPS evaluations quarterly for each resident. -She was a licensed practical nurse (LPN). -She was not aware that the LHPS evaluations needed to be completed by a registered nurse (RN), physical therapist (PT), or occupational therapist (OT). Interview with the Administrator on 01/15/25 at 11:15am revealed: -The RCC and herself completed the LHPS evaluations for the residents. -The LHPS evaluations were completed quarterly. -She was a registered nurse (RN). -She was not aware that the LHPS evaluations needed to be completed by a registered nurse (RN), physical therapist (PT), or occupational therapist (OT).	D 280		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments	D 358		

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by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 4 residents (#1) observed during the medication pass including a medication used to control blood sugar levels and a medication used to treat or prevent vitamin deficiency.

The findings are:

The medication error rate was 8% as evidenced by 2 errors out of 25 opportunities during the 8:00am medication pass on 01/15/25.

Review of Resident #1's current FL2 dated 01/13/25 revealed diagnoses included aphasia following cerebral infarction, type 2 diabetes mellitus, chronic kidney disease, major depressive disorder, and hypertension.

a. Review of Resident #1's current FL2 dated 01/13/25 revealed there was an order for Semglee insulin pen inject 7 units subcutaneously twice daily (Semglee insulin pen is a long-acting injectable medication used to control blood sugar levels. According to the manufacturer, the Semglee insulin pen should be primed with a 2-unit air dose before each use to assure the insulin is flowing through the needle and to remove any air bubbles prior to administration. For administration of Semglee insulin pen, when the injection button is depressed and the dosing window reads zero, the manufacturer advises

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D 358	Continued From page 11 counting to 10 before removing the needle from the skin to ensure the full dose is administered). Observation of the 8:00am medication pass on 01/15/25 from 7:10am to 7:47am revealed: -The medication aide (MA) removed Resident #1's Semglee insulin pen from the medication cart and attached a new needle to the end of the insulin pen. -The MA dialed the dose selector to 7 units. -The MA did not perform a 2-unit air shot prior to dialing the Semglee insulin pen to 7 units to ensure no air bubbles were present and insulin was flowing from the pen. -The MA entered Resident #1's room and administered his oral medications at 7:30am. -The MA cleaned an area on Resident #1's left upper arm with an alcohol swab. -The MA injected the Semglee insulin in Resident #1's left upper arm at 7:31am. -The MA pressed the injector button until the dosing window read zero and immediately removed the needle from Resident #1's left upper arm without counting to 10 before removing the needle. Review of Resident #1's January 2025 medication administration record (MAR) revealed: -There was an entry for Semglee insulin pen inject 7 units subcutaneously twice daily scheduled for 8:00am and 8:00pm. -Semglee insulin pen 7 units was documented as administered daily at 8:00am from 01/01/25 to 01/15/25, and at 8:00pm from 01/01/25 to 01/14/25. Interview with the MA on 01/15/25 at 11:01am revealed: -She had been working at the facility for 30 years but started working as a MA about 15 years ago.	D 358		

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-The MAs had medication training at least every year, which included training on how to administer insulin pens.
-The Administrator usually conducted the annual medication training with the MAs.
-She was not aware that she should have primed Resident #1's Semglee insulin pen with a 2-unit air shot prior to administering the insulin.
-She was not aware that she should leave Resident #1's Semglee insulin pen in place for a count of 10 after the insulin was injected and the pen read zero in the dosing window.
-She was unsure if she received training on how to prime insulin pens.
-She was unsure if she received training on leaving insulin pens in place for a few seconds after injecting the insulin and the dosing window read zero.

Interview with the Resident Care Coordinator (RCC) on 01/15/25 at 11:13am revealed:
-The MAs had medication administration training at least annually with the Administrator.
-The medication administration training included how to administer an insulin pen.
-The MA should have dialed the dose selector on Resident #1's Semglee insulin pen to 2, then primed the pen before administering the prescribed dose.
-Priming the pen helped to remove the air from the needle and ensure Resident #1 received the correct dose of insulin.
-The MA should have held the pen in place for a few seconds after the injection was administered to Resident #1.

Interview with the Administrator on 01/15/25 at 11:24am revealed:
-She was a registered nurse (RN).
-She conducted annual medication administration

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training with the MAs in the facility.
-Insulin administration was included in the yearly medication administration training.
-MAs were trained to prime insulin pens with a 2-unit air shot prior to administering the prescribed dose of insulin.
-The MA should have primed Resident #1's insulin pen prior to administering the prescribed dose of insulin to ensure the pen was working properly.
-The MA should have held Resident #1's insulin pen in place for a few seconds after the injection was administered.

Telephone interview with a medical assistant at Resident #1's primary care provider's (PCP) on 01/15/25 at 1:46pm revealed:
-The MA should have primed Resident #1's Semglee insulin pen before administering Semglee 7 units.
-The MA should have held Resident #1's Semglee insulin pen in place after the dosing window read zero to ensure Resident #1 received the full dose of the medication.

Telephone interview with a pharmacist at Resident #1's pharmacy on 01/15/25 at 1:23pm revealed:
-The 2-unit air shot should be performed prior to administering an insulin pen to ensure the pen was working properly and the correct dose was administered.
-The manufacturer recommended holding the pen in place after pressing the injection button and counting to 10 before removing the needle from the skin.
-MAs should administer Semglee insulin pen according to the manufacturer's guidelines to ensure Resident #1 received the correct dose to help maintain his blood sugar at a normal level.

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	HAL053004	A. BUILDING: _____ B. WING _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 14 Attempted interview with Resident #1's primary care provider (PCP) on 01/15/25 at 1:44pm was unsuccessful. b. Review of Resident #1's current FL-2 dated 01/13/25 revealed there was an order for Vitamin D3 2000 units 2 capsules daily. Observation of the 8:00am medication pass on 01/15/25 from 7:10am to 7:47am revealed: -The medication aide (MA) prepared Resident #1's oral medications. -The MA removed 1 Vitamin E 2000 unit capsule from a medication bottle and placed the capsule in the medication cup. -There were 8 tablets and 1 Vitamin E capsule in the medication cup. -The MA entered Resident #1's room and administered his oral medications at 7:30am. Review of Resident #1's January 2025 medication administration record (MAR) revealed: -There was an entry for Vitamin D3 2000 units take 2 capsules every day scheduled for 8:00am. -Vitamin D3 2000 units 2 capsules was documented as administered at 8:00am daily from 01/01/25 to 01/15/25. Interview with the MA on 01/15/25 at 11:01am revealed: -She followed the instructions on the MAR when administering medications. -She was not aware that she administered Resident #1 Vitamin D3 2000 units 1 capsule instead of Vitamin D3 2000 units 2 capsules. -She was unsure why she administered 1 capsule of Vitamin D3 2000 units to Resident #2 instead of Vitamin D3 2000 units 2 capsules as ordered.	D 358		

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D 358	Continued From page 15 Interview with the Resident Care Coordinator (RCC) on 01/15/25 at 11:13am revealed: -MAs should follow the instructions on the MAR when administering medications to residents. -MAs should refer to the medication orders in the resident's record or contact the resident's primary care provider (PCP) if there were questions about medication orders. Interview with the Administrator on 01/15/25 at 11:24am revealed: -MAs were supposed to follow the instructions on the residents' MARs when administering medications. -MAs should refer to the residents' MARs when preparing the medications to ensure accuracy. Telephone interview with a medical assistant at Resident #1's PCP office on 01/15/25 at 1:46pm revealed the facility staff should administer Resident #1's medications according to the instructions on Resident #1's MAR. Telephone interview with a pharmacist at Resident #1's pharmacy on 01/15/25 at 1:23pm revealed: -Vitamin D3 was prescribed to prevent or treat Vitamin D deficiency. -Vitamin D3 was essential for bone health and immunity. -MAs should administer Resident #1's medications as ordered on Resident #1's MAR. Attempted interview with Resident #1's primary care provider (PCP) on 01/15/25 at 1:44pm was unsuccessful.	D 358		
D 371	10A NCAC 13F .1004(n) Medication Administration	D 371		

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D 371	Continued From page 16 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure implementation of infection control measures during the medication pass as evidenced by a medication aide (MA) who dropped tablets for two residents on the top surface of the medication cart and returned the tablets to the medication bottle. The findings are: Observation of the 8:00am medication pass on 01/13/25 from 7:10am to 7:45am revealed: -At 7:18am, the medication aide (MA) donned gloves and began preparing a resident's medication. -The MA dropped a tablet on the top surface of the medication cart. -The MA picked up the tablet with a gloved hand and returned the tablet to the medication bottle. -The MA finished preparing the resident's medications. -The MA administered the resident's medication at 7:21am. -The MA returned to the medication cart, removed gloves, and sanitized her hands with alcohol-based hand sanitizer. -At 7:25am, the MA donned gloves and began preparing a second resident's medication. -The MA dropped a tablet on the top surface of	D 371		

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D 371	Continued From page 17	D 371		

the medication cart.
-The tablet rolled across a portion of the top surface of the medication cart.
-The MA picked up the tablet with a gloved hand and returned the tablet to the medication bottle.
-The MA finished preparing the resident's medications.
-The MA administered the resident's medications at 7:30am.

Interview with the MA on 01/15/25 at 11:01am revealed:
-She had been working at the facility for 30 years and began working as a MA about 15 years ago.
-She had infection control training a couple of months ago but was unsure of the date.
-She should have discarded the tablets that she dropped on the medication cart during the medication pass this morning on 01/15/25.
-She was unsure why she did not discard the tablets that were dropped on the medication cart during the medication pass.

Interview with the Resident Care Coordinator (RCC) on 01/15/25 at 11:13am revealed:
-The Administrator conducted infection control training in November 2024 and December 2024 with all facility staff.
-The MA should have discarded any tablets that she dropped on the top of the medication cart.
-The dropped medication was considered contaminated and should have been destroyed and not placed back in the residents' medication bottles.

Interview with the Administrator on 01/15/25 at 11:24am revealed:
-She was a registered nurse (RN).
-All facility staff received infection control training annually and she usually completed the infection

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D 371	Continued From page 18 control training course. -The facility staff were last trained on infection control measures in November 2024 and December 2024. -The MA should have destroyed the tablets that were dropped on the top of the medication cart. -Any tablets that were dropped or contaminated should be destroyed. Interview with a pharmacist at one of the facility's contracted pharmacies on 01/15/25 at 1:23pm revealed: -If a tablet was dropped on a surface, the tablet was considered contaminated. -The MA should have discarded the tablets dropped on the medication cart and not returned the tablets to the medication bottle.	D 371		