

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034069	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/14/2015
NAME OF PROVIDER OR SUPPLIER THE BRADFORD VILLAGE OF KERNERSVILLE - WES			STREET ADDRESS, CITY, STATE, ZIP CODE 602 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
(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 on 10/13/15 and 10/14/15.	D 000	Addendum: Pbc approved following conversation with Tony Goodman, Rcc on 11/20/15 @ 1100 am. latest date of correction for all non-compliance is 10/18/15.		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to assure the environment was free of hazards, as related to safe storage of oxygen cylinders. The findings are: Observation of Resident Room 22 during the initial tour of the facility on 10/13/15 between 10:20 am and 11:30 am revealed: -An oxygen concentrator that was not running located to the right of a resident's bed. -A total of 15 oxygen cylinders were located to the right of the resident's bed against the wall to the right of the room entrance. -Two 165 liter oxygen cylinders were stored in metal stands. -Four 165 liter oxygen cylinders and a smaller oxygen cylinder were stored in a metal crate.	D 079			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

ZPQE11

If continuation sheet 1 of 15

Gloria Tiger Administrator 11-11-15

Reviewed + approved Schenck 10/20/15

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THE BRADFORD VILLAGE OF KERNERSVILLE - WES

**602 PINEY GROVE ROAD
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D 079	Continued From page 1 -Seven free standing 165 liter oxygen cylinders standing two to three deep against the bedroom wall. -One larger free standing oxygen cylinder was between the resident's nightstand and head of the bed. -Nine of the tanks were full and unopened with plastic guards intact. -Two of the 7 free standing oxygen cylinders had a gauge attached. -None of the oxygen cylinders were attached to the oxygen concentrator. -One resident was awake in the room. -The resident using oxygen was not in the room. Observation of Room 22 on 10/13/15 at 5:25 pm revealed: -A resident seated in a wheelchair between the bed and oxygen tanks. -A portable oxygen tank was stored on the back of the resident's wheelchair. -The resident was attempting to apply the nasal cannula that was lying in her lap. Interview on 10/13/15 at 5:25 pm with the resident utilizing the oxygen revealed: -She needed portable oxygen because she was out of her room a lot. -She had been using more portable oxygen recently during the day instead of the concentrator. -She did not know tanks were to be stored in crates or on stands. -The company that provided the oxygen had delivered oxygen to the resident's room on 10/11/15. Observation on 10/14/15 at 10:45 am revealed: -The resident propelling in the wheelchair in the hallway with a portable tank of oxygen on the	D 079		

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D 079	Continued From page 2 back of the wheelchair. -The resident was crying about "my partner who is mean" and saying she was leaving anyway. -The resident appeared agitated with confusion. Interview on 10/13/15 at 5:40 pm with the Resident Care Coordinator (RCC) revealed: -The facility's policy was for oxygen to be stored in crates or portable stands. -The durable medical equipment (DME) company did not always provide crates for the oxygen. -The resident was sometimes confused, especially wanting to find her way home in the mornings. -The resident seemed to "feel more secure" with using the portable oxygen tanks. -The resident used the oxygen concentrator at night. -The facility contacted the DME company each Monday to request oxygen be delivered on Tuesday. -She would contact the DME company to request crates for oxygen tank storage in the resident's room. Interview with the Administrator on 10/14/15 at 10:35 am revealed: -The facility's policy was oxygen cylinders be stored in crates or in the metal stands. -Oxygen cylinders for residents were currently stored in resident's rooms. -She had requested crates from the DME company several times and they had not been delivered. -The DME company would deliver oxygen cylinders and not remove the empty oxygen cylinders. -"I keep getting told different things about using crates for storage". -She had been told "by our maintenance person"	D 079			

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D 079	Continued From page 3 that the sanitation department said we could not have crates for oxygen storage. -She would contact the DME company immediately and create a storage area for oxygen tanks. Observation of Resident Room #22 on 10/14/15 at 2:20 pm revealed no oxygen cylinders stored in the room. Observation on 10/14/15 at 2:45 pm revealed: -The oxygen cylinder from Room #22 had been relocated to a storage room located beside the nursing office. -The oxygen cylinders were stored in crates and labeled with the resident's name. -A sign was attached to the entry door of the storage room to identify oxygen storage area. Interview on 10/14/15 at 2:45 pm with the RCC revealed the DME company had been contacted by the facility Administrator and had delivered additional crates for storage of the oxygen cylinders. The facility provided the following Plan of Protection on 10/14/15: -The facility would contact the DME company immediately to request crates for storage of oxygen tanks. -All oxygen tanks would be removed from any residents' rooms and be stored in a storage room. -The Administrator, RCC, and Maintenance staff would monitor monthly. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 30, 2015.	D 079	D19: Oxygen tanks will now be stored in a storage room. A sign was placed on the storage room door. All staff have been notified that <u>NO</u> oxygen tanks are to be stored in a residents room. All tanks were removed from any residents room who had oxygen tanks and the tanks were placed in storage room marked with resident name. -The Pdc, Administrator, and Maintenance Director will be responsible for assuring this is done routinely. -Routine monitoring will be done monthly.		10/14/15 10/14/15 10/14/15

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D 307	Continued From page 4	D 307			
D 307	10A NCAC 13F .0904(e)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (e) Therapeutic Diets in Adult Care Homes: (1) All therapeutic diet orders including thickened liquids shall be in writing from the resident's physician. Where applicable, the therapeutic diet order shall be specific to calorie, gram or consistency, such as for calorie controlled ADA diets, low sodium diets or thickened liquids, unless there are written orders which include the definition of any therapeutic diet identified in the facility's therapeutic menu approved by a registered dietitian. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure there was a written physician's diet order for 1 of 7 sampled residents (Resident #8). The findings are: Review of Resident #8's current FL-2 dated 2/24/15 revealed: -Diagnoses included dementia, dysphagia, diabetes mellitus, hypertension, coronary artery disease. -The form was marked "yes" for therapeutic diet and special nutritional needs although no diet was specified for Resident #8. Review on 10/13/15 at 11:35 am of the therapeutic diet list posted on the refrigerator in the kitchen revealed: -A handwritten list dated 4/21/15 with resident names added or crossed out in black marker. -Resident #8 was to be served a pureed diet.	D 307			

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D 307	Continued From page 5 Review of Resident #8's record revealed: -There was no current diet order. -A Facility Diet Order form signed by a Nurse Practitioner (NP) and dated 6/01/15 without a diet specified. -A Licensed Health Professional Support dated 9/30/15 with pureed diet documented for personal care task provided. -A physician Order Form dated 4/09/15 with a verbal order from the NP to "encourage resident to drink protein milk shakes three times a day between meals as previously ordered"; "resident does not like thick it in his liquids", but no current diet order. Interview on 10/13/15 at 12:40 pm with the Dietary Manager (DM) revealed: -She had worked at the facility for 1 year as the day Cook and had been the DM for 6 months. -She used the therapeutic diet menus and the weekly menus at a glance as guidance for preparing meals. -All residents' names were on the therapeutic diet list posted on the refrigerator for staff reference to the diet ordered for the resident. -If diet orders were changed, the Resident Care Coordinator (RCC) would send the order to the kitchen and the Cook on duty would make the correction on the therapeutic diet list posted in the kitchen. -Resident #8 was to be served a pureed diet. Interview on 10/13/15 at 3:50 pm with Resident #8 revealed he was served a pureed diet. Observation on 10/13/15 at 6:05 pm of the dinner meal served to Resident #8 in his room revealed: -A pureed diet was served as per the pureed diet menu.	D 307		

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D 307	Continued From page 6 -The Resident consumed 100% of his diet and liquids without any difficulty swallowing. Interview on 10/13/15 at 6:30 pm with the RCC revealed: -She was not aware there was no current diet order in Resident #8's record, but would contact the Nurse Practitioner (NP) to obtain an order. -When diet orders changed, she would take the changes to the kitchen for the Cook on duty to update the therapeutic diet menu list. It was posted for several days for all staff to see. Interview on 10/13/15 at 6:30 pm with the Administrator revealed she was aware therapeutic diets were posted in the kitchen for the staff to reference, but was not aware how often they were updated. Review of Resident #8's facility Diet Order Form at 10/13/15 at 6:35 pm revealed a signed NP order dated 10/13/15 for pureed diet, no thickened liquids. Second interview on 10/14/15 at 8:20 am with the DM revealed: -An updated diet order for Resident #8 for pureed no thickened liquids was posted in the kitchen when she arrived this morning. -Diet order changes were posted in the kitchen for several days to assure all staff saw them, and then were placed in a notebook kept in the kitchen. -The resident therapeutic diet list was last written by the RCC, but was updated by the Cook staff as necessary. There was no set time for how often the therapeutic diet list was updated. Observation on 10/14/15 at 8:20 am of the kitchen area revealed a new diet order posted on	D 307		

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STATE FORM

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D 309	Continued From page 8 A. Review of Resident #8's current FL-2 dated 2/24/15 revealed: -Diagnoses included dementia, dysphagia, diabetes mellitus, hypertension, coronary artery disease. -The FL2 was marked "yes" for therapeutic diet and special nutritional needs although no diet was specified for Resident #8. Review on 10/13/15 of the therapeutic diet list posted on the refrigerator in +the kitchen revealed: -A handwritten list dated 4/21/15 with resident names added or crossed out in black marker. -Resident #8 was to be served a pureed diet. Review of Resident #8's record revealed: -There was no current diet order. -A Facility Diet Order form signed by a Nurse Practitioner (NP) and dated 6/01/15 without a diet specified. -A Licensed Health Professional Support dated 9/30/15 with Pureed diet documented for personal care task provided. -A Physician Order Form dated 4/09/15 with a verbal order from the NP to "encourage resident to drink protein milk shakes three times a day between meals as previously ordered"; "resident does not like thick it in his liquids", but no current diet order. Interview on 10/13/15 at 12:40 pm with the Dietary Manager (DM) revealed: -She had worked at the facility for 1 year as the day Cook and had been the DM for 6 months. -She used the therapeutic diet menus and the weekly menus at a glance as guidance for preparing meals. -All residents' names were on the therapeutic diet list posted on the refrigerator for staff reference to	D 309		

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D 309	Continued From page 9 the diet ordered for the resident. -If diet orders were changed, the Resident Care Coordinator (RCC) would send the order to the kitchen and the Cook on duty would make the correction on the therapeutic diet list posted in the kitchen and place a copy in a notebook kept in the kitchen. -Resident #8 was to be served a pureed diet. Review of the kitchen notebook copy of the therapeutic diet orders on 10/13/15 revealed an order for Resident #8 dated 6/04/14 for pureed diet. Interview on 10/13/15 at 3:50 pm with Resident #8 revealed he was served a pureed diet. Observation on 10/13/15 at 6:05 pm of the dinner meal served to Resident #8 in his room revealed: -A pureed diet was served as per the pureed diet menu. -The Resident consumed 100% of his meal without any difficulty swallowing. Review of Resident #8's facility Diet Order Form revealed a signed NP order dated 10/13/15 for a pureed diet, no thickened liquids. Observation on 10/14/15 at 8:20 am of the kitchen area revealed a new diet order posted on the kitchen bulletin board dated 10/13/15 for Resident #8 for pureed without thickened liquids. Refer to interview on 10/13/15 at 6:30 pm with the RCC. Refer to interview on 10/13/15 at 6:30 pm with the Administrator. Refer to further interview on 10/14/15 at 8:20 am	D 309			

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D 309	Continued From page 10 with the DM. Refer to interview on 10/14/15 at 8:35 am with the RCC. B. Review of Resident #9's current FL-2 dated 8/06/15 revealed: -Diagnoses included gastro-intestinal bleeding, urinary tract infections, GERD (gastro-esophageal reflux disease), hypertension, dementia, hiatal hernia, and community acquired pneumonia. -There was no diet order on the FL-2. Review of Resident #9's record revealed: -A signed facility Diet Order Form dated 6/03/14 for a mechanical soft (processed) [MS] diet. -A signed facility Diet Order Form dated 6/01/15 for No Concentrated Sweets (NCS) with protein milk three times daily. Review on 10/13/15 of the therapeutic diet list posted on the refrigerator in the kitchen revealed: -A handwritten list dated 4/21/15 with resident names added or crossed out in black marker. -Resident #9 was to be served a processed meats diet. Review of the therapeutic lunch menu for 10/13/15 for NCS and MS diets revealed: -An attached letter of approval for the therapeutic menus signed by a registered dietician. -NCS diet was the same menu as a regular diet with the exception of skim milk, diet beverage and a sugar free dessert. Residents were to be served chicken tenders, broccoli, stewed tomatoes, roll, pudding. -MS diets referenced to serve ground meat. Observation of the lunch meal on 10/13/15 from	D 309			

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D 309	Continued From page 11 12:05 pm to 12:30 pm revealed: -Resident #9 was served a white roll, stewed tomatoes, ground chicken tenders, broccoli cuts, pudding with whipped cream, 8 oz. water and 8 oz. milk. -She consumed 100% of her meal without any swallowing difficulty. Interview with Resident #9 at 10/13/15 at 12:35 pm revealed she was not aware if she was on a special diet and "just ate what was served". Interviewed on 10/13/15 at 12:40 pm with the Dietary Manager (DM) revealed: -She had worked at the facility for 1 year as the day Cook and had been the DM for 6 months. -She used the therapeutic diet menus and the weekly menus at a glance as guidance for preparing meals. -All residents' names were on the therapeutic diet list posted on the refrigerator for staff reference to the diet ordered for the resident. -If diet orders were changed, the Resident Care Coordinator (RCC) would send the order to the kitchen and the Cook on duty would make the correction on the therapeutic diet list posted in the kitchen. -Resident #9 was to be served a Processed Meats diet. -Processed meats were the same as a MS diet. She used a food processor to grind the meat until small, crumbly pieces. -The pudding served at lunch was sugar-free and was served to everyone in place of the fruit option for dessert. Interview on 10/13/15 at 3:25 pm with the Nurse Practitioner (NP) who was on site revealed: -She was not aware that Resident #9's current diet order did not specify processed meats.	D 309			

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D 309	Continued From page 12 -Resident #9 needed MS meats. -She would update the diet orders for Resident #9 and give them to the facility. Refer to interview on 10/13/15 at 6:30 pm with the RCC. Refer to interview on 10/13/15 at 6:30 pm with the Administrator. Refer to interview on 10/14/15 at 8:20 am with the DM. Refer to interview on 10/14/15 at 8:35 am with the RCC. Interview on 10/13/15 at 6:30 pm with the RCC revealed when diet orders changed, she would take the changes to the kitchen for the Cook on duty to update the therapeutic diet menu list. The changed diet was posted for several days for all staff to see. Interview on 10/13/15 at 6:30 pm with the Administrator revealed she was aware therapeutic diets were posted in the kitchen for the staff to reference, but was not aware how often they were updated. Interview on 10/14/15 at 8:20 am with the DM revealed: -Diet order changes were posted in the kitchen for several days to assure all staff saw them, and then were placed in a notebook kept in the kitchen. -The resident therapeutic diet list was last written by the RCC, but was updated by the Cook staff as necessary. There was no set time for how often the therapeutic diet list was updated. Interview on 10/14/15 at 8:35 am with the RCC	D 309			

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D 309	Continued From page 13 revealed. -The Cook usually wrote the therapeutic diet list posted in the kitchen, but she wrote the list that was currently posted. -The therapeutic diet list was "usually re-written after 2 or 3 new admissions with orders or if it was messy to make it more legible for staff". -The Cook made any update changes to the posted therapeutic diet list. -The therapeutic diet list was usually re-written every 3 to 4 months. -She was not aware the current list had not been re-written since 4/21/15.	D 309		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to assure resident had the right to receive care and services which are adequate, appropriate and in compliance with rules and regulations as related to storage of oxygen cylinders. The findings are: A. Based on observations and interviews, the facility failed to assure the environment was free of hazards, as related to safe storage of oxygen cylinders. [Refer to Tag 0079 10A NCAC 13G .0306 (a) (5) (Type B Violation)].	D912	Refer to corrective 10/14/15 Action on tag D079, which corrects tag D912.	

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER THE BRADFORD VILLAGE OF KERNERSVILLE - WES		STREET ADDRESS, CITY, STATE, ZIP CODE 602 PINEY GROVE ROAD KERNERSVILLE, NC 27284			
(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 309	Continued From page 13 revealed. -The Cook usually wrote the therapeutic diet list posted in the kitchen, but she wrote the list that was currently posted. -The therapeutic diet list was "usually re-written after 2 or 3 new admissions with orders or if it was messy to make it more legible for staff". -The Cook made any update changes to the posted therapeutic diet list. -The therapeutic diet list was usually re-written every 3 to 4 months. -She was not aware the current list had not been re-written since 4/21/15.	D 309			
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to assure resident had the right to receive care and services which are adequate, appropriate and in compliance with rules and regulations as related to storage of oxygen cylinders. The findings are: A. Based on observations and interviews, the facility failed to assure the environment was free of hazards, as related to safe storage of oxygen cylinders. [Refer to Tag 0079 10A NCAC 13G .0306 (a) (5) (Type B Violation)].	D912			

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