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Division of Health Service Regulation

JUL 15 2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034069	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ADULT CARE LICENSURE SECTION RALEIGH B. WING _____	(X3) DATE SURVEY COMPLETED R 05/16/2019
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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
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D 000	Initial Comments The Adult Care Licensure Section conducted an Annual and Follow-up survey and Complaint Investigation from 05/14/19 through 05/16/19. The Complaint Investigation was initiated by the Adult Care Licensure Section on 05/14/19.	D 000		
D 150	10A NCAC 13F .0501 Personal Care Training And Competency 10A NCAC 13F .0501 Personal Care Training And Competency (a) An adult care home shall assure that staff who provide or directly supervise staff who provide personal care to residents successfully complete an 80-hour personal care training and competency evaluation program established by the Department. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties. Copies of the 80-hour training and competency evaluation program are available at the cost of printing and mailing by contacting the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. (b) The facility shall assure that training specified in Paragraph (a) of this Rule is successfully completed within six months after hiring for staff hired after September 1, 2003. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 3 sampled staff (Staff B) who provided personal care to residents had	D 150	Employee Files will be Audited Monthly to make sure all personal Care Training is accurate The Resident Care Coordinator and Staffing Coordinator will be responsible for auditing employee charts. <i>Keisha Banks</i> 07/23/19	6/30/19

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

TITLE

(X6) DATE

Michael L. L...

ED

6-27-19

STATE FORM

6899

041B11

If continuation sheet 1 of 80

Addendum p.1

Received and Accepted

Keisha Banks

07/23/19

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D 150	Continued From page 1 documentation of successful completion of an 80 hour personal care training and competency evaluation program. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired as a Medication Aide (MA), Supervisor, and Personal Care Aide (PCA) on 10/25/18. -There was no documentation of completion of personal care training for Staff B. Interview with Staff B on 05/16/19 at 6:45pm revealed: -She had worked as a MA since 2013, but she was not a certified nursing assistant. -Her job responsibilities included administering medication to residents and providing personal care as needed. -She had completed personal care training, but she did not remember when. -She thought she had given her personal care training to the Resident Care Coordinator (RCC). -The RCC was responsible for assuring personal care training was completed. Interview with the Administrator on 05/16/19 at 7:10pm revealed: -The RCC, who was out of town, was responsible for assuring personal care training was completed for staff. -He was not certain if PCS training was completed for Staff B, but he would look for it. Documentation of completion of personal care training for Staff B was not provided prior to exit on 05/16/19.	D 150			

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D 270	Continued From page 2	D 270	D 270	6-30
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to provide supervision for 1 of 5 sampled residents (Resident #1) with diagnoses of dementia, a history of repeated falls, and a history of a femur fracture. The findings are: Review of the facility's fall policy revealed: -Identify residents at risk for falls and implement a fall prevention approach to reduce the risk of falls and possible injury. -Every resident would be evaluated for falls upon admission and subsequently thereafter when the resident's condition changed or at least annually. -The falls prevention approach would be evaluated by staff to determine the effectiveness of the approach. Review of Resident #1's current FL2 dated 01/02/19 revealed:	D 270	Community will follow attached fall policy. Any resident with more than 3 falls in a month will have bed/chair alarm put in place. If a fall should happen after a fall mat will be put in place. Fall committee will meet weekly to review falls and implement appropriate procedures. Resident will have increased supervision for 72 hours after each fall. Will also have physician follow- up on resident. <i>Fall Committee will include Rcc, supervisor, staff coordinator, and administrator</i>	-19 6/30/19

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D 270	Continued From page 3 -Diagnoses included presence of artificial hip joint, unspecified fall, muscle weakness, cerebral infarction, unspecified fracture of the lower end of the left femur, cognitive social or emotional deficit, dysphagia following cerebral vascular accident; and schizophrenia. -The resident was intermittently disoriented. -The resident was semi-ambulatory. -There was a physician's order for physical therapy. Review of Resident #1's Resident Register revealed she was admitted on 06/05/17. Review of Resident #1's care plan dated 01/04/19 revealed: -Resident #1 required limited assistance with transfers. -Resident #1 required limited assistance with ambulation and used a wheelchair. Review of Resident #1's care plan dated 03/26/19 revealed: -Staff noted Resident #1 had a significant change on 03/20/19. -Resident #1 required limited assistance with transfers. -Resident #1 required extensive assistance with ambulation and used a wheelchair. Review of Resident #1's physical therapy notes revealed: -Physical therapy services were initiated on 01/05/19. -Physical therapy was ordered for transfers, gait, wheelchair mobility, and fall prevention. -Physical therapy services were discontinued on 02/26/19. Review of Resident #1's accident/incident reports	D 270			

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D 270	Continued From page 4 and increased supervision worksheets reports for October 2018: -On 10/06/18 at 7:00 pm, Resident #1 slid off of the bed. No injuries were noted. Staff continued increased supervision every 30 minutes for 72 hours. -On 10/24/18 at 6:00 am, Resident #1 had an unwitnessed fall in her bedroom. Resident #1 was trying to stand without assistance and fell in the floor. No injuries were noted. Staff continued increased supervision every 30 minutes for 72 hours. -Staff notified Resident #1's primary care physician (PCP) and the power of attorney (POA) after falls. Review of Resident #1's record revealed: -Resident #1 had a fall on 11/14/18. -Resident #1 was sent to the hospital for evaluation due to complaints of knee pain. -The fall resulted in a femur fracture. -Resident #1 was sent to a skilled facility for rehab after her hospital stay. -Resident #1 returned to the facility on 01/04/19. Review of Resident #1's accident/incident reports and increased supervision worksheets reports for January 2019 revealed: -On 01/08/19 at 10:30 pm, Resident #1 had an unwitnessed fall in her bedroom. Resident #1 attempted to get out of bed without assistance. No injuries were noted. Staff continued increased supervision every 30 minutes for 72 hours. -On 01/12/19 at 2:00 pm, Resident #1 slid out of the wheelchair onto the floor. No injuries were noted. Staff continued increased supervision every 30 minutes for 72 hours. -On 01/16/19 at 10:00 am, Resident #1 had an unwitnessed fall in her bedroom. Resident #1 was found between the bed and the wheelchair.	D 270			

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D 270	Continued From page 5 Resident #1 attempted to get into bed without assistance. No injuries were noted. Staff continued increased supervision every 30 minutes for 72 hours. -On 01/18/19 at 6:15 am, Resident #1 slid out of the bed trying to stand without assistance. No injuries were noted. Staff continued increased supervision every 30 minutes for 72 hours. -Staff notified Resident #1's PCP and POA after each fall. -Documentation did not indicate the hospital bed was in the low position or a fall mat was in place. Review of Resident #1's accident/incident reports and increased supervision worksheets reports for February 2019 revealed there was no documentation of falls. Review of Resident #1's accident/incident reports and increased supervision worksheets reports for March 2019 revealed: -On 03/04/19 at 3:30pm, Resident #1 had an unwitnessed fall in her bedroom. Staff implemented increased supervision every 30 minutes for 72 hours. -On 03/06/19 at 7:00pm, Resident #1 slid out of her bed. No injuries were noted. Staff continued increased supervision every 30 minutes for 72 hours. -On 03/08/19 at 7:00pm, Resident #1 had an unwitnessed fall in her bedroom. No injuries were noted. Staff continued increased supervision every 30 minutes for 72 hours. -On 03/14/19 at 4:40pm, Resident #1 had an unwitnessed fall in her bedroom. -On 03/16/19 at 4:00pm, Resident #1 was found sitting on the floor. Resident #1 had an unwitnessed fall in her bedroom. Staff continued increased supervision every 30 minutes for 72 hours.	D 270			

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D 270	Continued From page 6 -On 03/19/19 at 3:00pm, Resident #1 had an unwitnessed fall in her bedroom. No injuries were noted. Staff continued increased supervision every 30 minutes for 72 hours. -On 03/19/19 at 6:40pm, Resident #1 slid out of her bed. No injuries were noted. Staff continued increased supervision every 30 minutes for 72 hours. -On 03/22/19 at 4:53am, Resident #1 slid out of her bed. No injuries were noted. Staff continued increased supervision every 30 minutes for 72 hours. -On 03/22/19 at 3:30pm, Resident #1 was trying to stand without assistance and fell in the living room. No injuries were noted. Staff continued increased supervision every 30 minutes for 72 hours. -On 03/26/19 at 1:23am, Resident #1 slipped and fell in her bedroom. No injuries were noted. Resident complained of pain all over. Staff continued increased supervision every 30 minutes for 72 hours. -On 03/30/19 at 8:42pm, Resident #1 was trying to stand without assistance and fell in the living room. Staff continued increased supervision every 30 minutes for 72 hours. -Staff notified Resident #1's PCP and POA after each fall. -Documentation did not indicate the hospital bed was in the low position or a fall mat was in place. Review of Resident #1's accident/incident reports and increased supervision worksheets reports for April 2019 revealed: -On 04/02/19 at 3:20am, Resident #1 attempted to get out of bed without assistance and slid out of the bed onto the floor. Staff continued increased supervision every 30 minutes for 72 hours. -On 04/03/19 at 3:37am, Resident #1 attempted	D 270			

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D 270	Continued From page 7 to get out of bed without assistance and slid out of the bed onto the floor. No injuries noted. Staff continued increased supervision every 30 minutes for 72 hours. -On 04/04/19 at 6:00am, Resident #1 attempted to get out of bed without assistance and slid out of the bed onto the floor. No injuries noted. Staff continued increased supervision every 30 minutes for 72 hours. -On 04/05/19 at 3:14am, Resident #1 attempted to get out of bed without assistance and slid out of the bed onto the floor. Resident #1 was found sitting on the floor. No injuries noted. Staff continued increased supervision every 30 minutes for 72 hours. -On 04/07/19 at 2:30pm and 2:50pm, Resident #1 slid out of wheelchair onto the floor. No injuries noted. Staff provided redirection and continued increased supervision every 30 minutes for 72 hours. -On 04/13/19 at 4:30pm, Resident #1 had an unwitnessed fall in her bedroom. No injuries noted. Staff continued increased supervision every 30 minutes for 72 hours. -On 04/14/19 at 2:30pm and 11:45pm, Resident #1 was found in her bedroom floor beside the bed. Resident was attempting to go to the bathroom without assistance. Staff encouraged resident to ask for assistance when getting out of bed. No injuries noted. Staff continued increased supervision every 30 minutes for 72 hours. -On 04/17/19 at 3:05am, Resident #1 attempted to get out of bed without assistance and slid out of the bed onto the floor. No injuries noted. Staff continued increased supervision every 30 minutes for 72 hours. -On 04/18/19 at 9:00pm, Resident #1 slid out of the bed and sustained a small skin tear to the right arm. No complaints of pain or sever injuries noted. Staff continued increased supervision	D 270		

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D 270	Continued From page 8 every 30 minutes for 72 hours. -On 04/24/19 at 12:09am, Resident #1 attempted to get out of bed without assistance and slipped on the floor. No injuries noted. Staff continued increased supervision every 30 minutes for 72 hours. -On 04/25/19 at 2:16am, Resident #1 attempted to get out of bed without assistance and slid out of the bed onto the floor. Staff continued increased supervision every 30 minutes for 72 hours. -On 04/25/19 at 4:43am, Resident #1 attempted to get out of bed without assistance and slid out of the bed onto the floor. No injuries noted. Staff continued increased supervision every 30 minutes for 72 hours. -On 04/29/19 at 3:36am, Resident #1 had an unwitnessed fall in her bedroom. Resident #1 was found on the floor. No injuries noted. Staff continued increased supervision every 30 minutes for 72 hours. -Staff notified Resident #1's PCP and POA after each fall. -Documentation did not indicate the hospital bed was in the low position or a fall mat was in place. Review of Resident #1's accident/incident reports and increased supervision worksheets reports for May 2019 revealed: -On 05/02/19 at 11:00am, Resident #1 fell in the living room. Resident #1 was trying to get up from wheelchair without assistance and tripped over the wheel chair pedals. No injuries noted. Staff continued increased supervision every 30 minutes for 72 hours. -On 05/03/19 at 11:30pm, Resident #1 fell in the hallway. Resident #1 tried to stand from the wheel chair without assistance. Resident #1 sustained a skin tear to the right arm. Staff continued increased supervision every 30 minutes for 72	D 270		

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D 270	Continued From page 9 hours. -On 05/04/19 at 1:50am, Resident #1 slid to the floor. No injuries noted. Staff continued increased supervision every 30 minutes for 72 hours. -On 05/06/19 at 7:50am, Resident #1 slid out of her wheel chair onto the floor in the dining room. Staff noted Resident #1's right big toe nail came off. Staff continued increased supervision every 30 minutes for 72 hours. -Staff notified Resident #1's PCP and POA after each fall. -Documentation did not indicate the hospital bed was in the low position or a fall mat was in place. Review of Resident #1's care notes revealed the facility did not have accident/incident reports related to the falls that occurred on 10/18/18, 11/14/18, 01/10/19, 01/17/19, 01/24/19, 03/05/19, 03/20/19, 03/29/19, 04/03/19, 04/06/19, 04/15/19, 04/20/19, 04/22/19, and 04/28/19. Observation of Resident #1 on 05/14/19 at 2:50pm revealed Resident #1 was sitting in her wheelchair in the living room pulling herself around with her feet and mumbling. Observation of Resident #1 on 05/15/19 from 10:47am to 10:58am revealed: -Staff brought Resident #1 in her wheelchair and placed the wheelchair in the hallway in front of the bathroom door. -Resident took her socks off and attempted to stand without assistance. -Staff was at the front desk. -Resident #1 was not in sight of staff. -Staff responded after someone alerted Resident #1 was trying to stand. Interview with Resident #1 on 05/14/19 at 1:20pm revealed:	D 270			

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D 270	Continued From page 10 -She had multiple falls. -Staff encouraged her to ask for assistance when getting up, but she would forget. -Most of her falls resulted in bruising and occasionally skin tears. Interview with the first shift medication aide (MA) on 05/14/19 at 11:35am revealed: -She knew Resident #1 had many falls, but did not know how many. -She considered Resident #1 a high risk for falls. -Resident #1 had anxiety and hallucinations (seeing family that had passed and trying to get to them) which caused her to fall. -She knew Resident #1 had a fall in November 2018 at the facility resulting in a femur fracture. -When Resident #1 was left in her room alone she would get up without assistance. -Staff would always make sure the call bell was within reach and encouraged Resident #1 to use the call bell to ask for assistance. -She had encouraged the Resident #1 to ask for assistance when getting up, but Resident #1 would forget and did not ask. -Most of Resident #1's falls occurred on second shift. -Staff kept Resident #1 up front in the living room to keep a closer eye on her. -The facility placed a fall mat beside the bed in Resident #1's room, but the family member wanted it removed and requested the mattress be placed on the floor until the hospital bed arrived. -The fall mat was removed. -A hospital bed was ordered so the facility could lower the bed, but the family member did not prefer the bed in the lowest position. -Resident #1 had physical therapy in January and February 2019. -After each of Resident #1's falls increased supervision for 72 hours was implemented.	D 270			

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D 270	Continued From page 11 Interview with a second shift MA on 05/16/19 at 12:40pm revealed: -Resident #1 was considered a high fall risk. -She did not remember Resident #1's falls specifically. -She knew Resident #1 had constant anxiety and attempted to get up without assistance even after staff encouraged her to ask for assistance. Interview with a personal care aide (PCA) on 05/16/19 at 11:45am revealed: -Resident #1 was a high fall risk. -Staff redirected Resident #1 and encouraged her to use the call bell when in her room but she continued to attempt to get up without assistance. -Resident #1 required assistance with all transfers and ambulation. Interview with the Administrator on 05/14/19 at 1:00pm revealed: -After any fall the staff should complete an incident report, notify the physician, notify the family, and implement increased supervision to every 30 minutes for 72 hours. -Staff monitored on every resident at least every 2 hours, if not on increased supervision after an incident. -The facility was a restraint free facility. -If a resident hit their head during a fall the staff always sent the resident to the hospital to be evaluated. -Resident #1 went to rehab after her femur fracture on 11/14/18. -When Resident #1 returned to the facility in January physical therapy was ordered, but was discontinued in February due to goals met. -The facility also placed a fall mat in her room upon readmission and then placed her mattress on the floor until a hospital bed was ordered on	D 270			

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D 270	Continued From page 12 01/14/19. -The hospital bed arrived 01/17/19. -Staff attempted to keep Resident #1 involved in all activities offered to help keep her occupied and prevent falls. -Resident #1 was kept up front in the living room as often as possible. -Staff constantly redirected and encouraged Resident #1 to ask for assistance when getting up, but she did not remember to ask for assistance. -Most of Resident #1's falls occurred in her bedroom. -On 03/19/19, he and staff met with Resident #1's family member to discuss Resident #1's care plan and he expressed the need for a high level of care or the need for a private sitter to provide one on one supervision due to high risk for falls. -The facility placed a bed and chair alarm on 05/15/19. Interview with the Resident Care Coordinator on 05/15/19 at 5:07pm revealed: -After a fall the MA should perform range of motion, complete an incident report, complete the physician notification form, and notify the family. -If a resident fell and hit their head the staff would send the resident to the hospital for evaluation. -She knew Resident #1 had multiple falls and was a high fall risk. -Resident #1 was instructed and redirected by staff often. -Staff encouraged Resident #1 to ask for assistance before getting up, but she would constantly get up without assistance from staff. -Staff implemented increased supervision every 30 minutes for 72 hours after each of Resident #1's falls. -The staff would check on the resident at least every 30 minutes to make sure she was not trying	D 270			

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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		
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D 270	Continued From page 13 to get up without assistance and needs were met. -All residents were checked on at least every 2 hours. -Resident #1 was ordered physical therapy when she returned to the facility after rehab in January. -Physical therapy discharged Resident #1 from services after about one month because she had reached her maximum potential due to dementia. -Staff encouraged Resident #1 to use the call bell. -Resident #1 did not always remember to use the call bell and when she did by the time staff got to the room Resident #1 was already in the floor. -The facility did not relocate Resident #1 closer to the front of the facility because the family refused. -The facility did not consider a bed or chair alarm for Resident #1. -Resident #1 had a fall mat in the past. -The mattress was placed on the floor until a hospital bed was delivered. -When the mattress was placed on the floor Resident #1's family member did not want the fall mat any longer. -A hospital bed was ordered so the bed could be lowered to prevent falls. -Most of Resident #1's falls resulted from slipping out of the bed or chair. -Staff included Resident #1 in activities provided to keep her occupied and increase supervision. -Resident #1 had anxiety in the evening and into the night. -Resident #1's lorazepam was adjusted several times. -Many of Resident #1's falls occurred on third shift. -Staff would place Resident #1 up front to provide increased supervision. -The facility assigned a staff member to sit with Resident #1 during meals to prevent Resident #1 from getting up without assistance.	D 270			

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D 270	Continued From page 14 -On 03/19/19, staff met with Resident #1's family member to discuss the care plan and informed Resident #1's family member Resident #1 needed a higher level of care or Resident #1 would need a sitter to provide one on one supervision to prevent falls. Telephone interview with Resident #1's family member on 05/16/19 at 2:30pm revealed: -The facility did not call her after each fall in January, February, March of 2019. -She noticed bruising during visits and staff would inform her the resident fell. She visited frequently throughout the week. -The facility placed a bed and chair alarm on 05/15/19, but these interventions were not offered prior to 05/15/19. -The staff kept Resident #1 up front most of the day to provide increased supervision. Interview with Resident #1's primary care physician (PCP) on 05/15/19 at 3:50pm revealed: -The facility has notified her regarding Resident #1's multiple falls over the recent months. -She did not know if she was notified of all of Resident #1's falls. -She felt Resident #1's falls were due to her cognitive decline and the resident did not remember to ask for assistance when getting up. -She expected staff to notify her after each fall. -Resident #1 was last seen at the end of April. -She was not aware of any safety measures put into place to prevent falls. The facility failed to provide supervision for 1 of 5 sampled residents (Resident #1), with a diagnosis of dementia, a history of frequent falls and a history of a femur fracture. The facility's failure to provide supervision was detrimental to the health, and safety of the resident and constitutes a Type	D 270			

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D 270	Continued From page 15 B Violation. The facility provided a plan of protection on 05/14/19 in accordance with G.S. 131D-34. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 30, 2019.	D 270			
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure physician notification for 1 of 5 sampled residents (Residents #3) related to medication not being administered when a resident signed out of the facility. The findings are: 1. Review of Resident #3's current FL2 dated 02/06/19 revealed diagnoses included hypertension, hyponatremia, cerebral palsy, allergic rhinitis, hypothyroid, osteoarthritis, urinary retention, and peripheral edema.	D 273	RCC will assure referral and follow- up to meet routine care needs of Residents as necessary	6/30/19	

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D 273	Continued From page 16 a. Review of Resident #3's current FL2 dated 02/06/19 revealed a physician's order for atrovent inhaler inhale 2 puffs twice daily (used to treat symptoms of asthma, colds, and allergies). Review of Resident #3's electronic Medication Administration Record (eMAR) for March 2019 revealed: -There was an entry for Atrovent inhaler inhale 2 puffs twice daily and scheduled for administration at 9:00am and 5:00pm. -Atrovent inhaler was documented as not administered at 9am on 03/10/19 and at 5:00pm on 03/06/19, 03/12/19, and 03/19/19, 03/27/19 due to "Out of Facility." Review of Resident #3' eMAR for April 2019 revealed: -There was an entry for Atrovent inhaler inhale 2 puffs twice daily and scheduled for administration at 9:00am and 5:00pm. -Atrovent inhaler was documented as not administered at 5:00pm on 04/02/19, 04/09/19, 04/14/19-04/16/19, 04/18/19, 04/19/19, 04/27/19, 04/30/19 due to "Out of Facility." Review of Resident #3' eMAR for May 2019 revealed: -There was an entry for Atrovent inhaler inhale 2 puffs twice daily and scheduled for administration at 9:00am and 5:00pm. -Atrovent inhaler was documented as not administered at 9am on 05/06/19 due to "Out of Facility" and at 5:00pm on 05/01/19, 05/02/19, 05/04/19, 05/07/19, and 05/10/19 due to "Out of Facility." Refer to interview with Resident Care Coordinator (RCC) on 05/15/19 at 4:46pm.	D 273			

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D 273	Continued From page 17 Refer to interview with a Supervisor on 05/15/19 at 6:03pm. Refer to interview with a Medication Aide (MA) on 05/16/19 at 10:21am. Refer to interview with a second MA on 05/16/19 at 12:46pm. Refer to interview with a medical assistant with Resident #3's Primary Care Provider's (PCP) office on 05/16/19 at 3:07pm. Refer to interview with Resident #3 on 05/16/19 at 5:25pm. Refer to interview with Resident #3's family member on 05/16/19 at 6:32pm. Refer to interview with the Administrator on 05/16/19 at 7:21pm. b. Review of Resident #3's physician's orders revealed a physician's order dated 04/10/19 for Colace 100mg twice daily (used to treat constipation). Review of Resident #3' electronic Medication Administration Record (eMAR) for April 2019 revealed: -There was an entry for docusate sodium 100mg take 1 capsule twice daily and scheduled for administration at 9:00am and 5:00pm. -There was documentation docusate sodium was not administered at 5:00pm on 04/14/19-04/16/19, 04/18/19, 04/19/19, 04/27/19, and 04/30/19 due to "Out of Facility." Review of Resident #3's eMAR for May 2019	D 273			

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D 273	Continued From page 18 revealed: -There was an entry for docusate sodium 100mg take 1 capsule twice daily and scheduled for administration at 9:00am and 5:00pm. -There was documentation docusate sodium was not administered at 9:00am on 05/06/19 due to "Out of Facility." -There was documentation docusate sodium was not administered at 5:00pm on 05/01/19, 05/02/19, 05/04/19, 05/07/19, and 0/10/19 due to "Out of Facility." Refer to interview with Resident Care Coordinator (RCC) on 05/15/19 at 4:46pm. Refer to interview with a Supervisor on 05/15/19 at 6:03pm. Refer to interview with a Medication Aide (MA) on 05/16/19 at 10:21am. Refer to interview with a second MA on 05/16/19 at 12:46pm. Refer to interview with a medical assistant with Resident #3's Primary Care Provider's (PCP) office on 05/16/19 at 3:07pm. Refer to interview with Resident #3 on 05/16/19 at 5:25pm. Refer to interview with Resident #3's family member on 05/16/19 at 6:32pm. Refer to interview with the Administrator on 05/16/19 at 7:21pm. c. Review of Resident #3's current FL2 dated 02/06/19 revealed a physician's order for gabapentin 100mg 1 capsule twice daily (used to	D 273			

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D 273	Continued From page 19 prevent and control seizures). Review of Resident #3's electronic Medication Administration Record (eMAR) for March 2019 revealed: -There was an entry for gabapentin 100mg take 1 capsule twice daily and scheduled for administration at 9:00am and 9:00pm. -There was documentation gabapentin was not administered at 9:00am on 03/10/19 due to "Out of Facility" and "left for church." -There was documentation gabapentin was not administered at 9:00pm on 03/06/19, 03/12/19, and 03/19/19 due to "Out of Facility." Review of Resident #3's eMAR for April 2019 revealed: -There was an entry for gabapentin 100mg take 1 capsule twice daily and scheduled for administration at 9:00am and 9:00pm. -There was documentation gabapentin was not administered at 9:00pm on 04/02/19, 04/09/19, 04/14/19-04/16/19, 04/18/19, 04/19/19, 04/27/19, and 04/30/19 due to "Out of Facility." Review of Resident #3's eMAR for May 2019 revealed: -There was an entry for gabapentin 100mg take 1 capsule twice daily and scheduled for administration at 9:00am and 9:00pm. -There was documentation gabapentin was not administered at 9:00am on 05/06/19 due to "Out of Facility." -There was documentation gabapentin was not administered at 9:00pm on 05/01/19, 05/02/19, 05/04/19, 05/07/19, and 05/10/19 due to "Out of Facility." Refer to interview with Resident Care Coordinator (RCC) on 05/15/19 at 4:46pm.	D 273			

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D 273	Continued From page 20 Refer to interview with a Supervisor on 05/15/19 at 6:03pm. Refer to interview with a Medication Aide (MA) on 05/16/19 at 10:21am. Refer to interview with a second MA on 05/16/19 at 12:46pm. Refer to interview with a medical assistant with Resident #3's Primary Care Provider's (PCP) office on 05/16/19 at 3:07pm. Refer to interview with Resident #3 on 05/16/19 at 5:25pm. Refer to interview with Resident #3's family member on 05/16/19 at 6:32pm. Refer to interview with the Administrator on 05/16/19 at 7:21pm. d. Review of Resident #3's current FL2 dated 02/06/19 revealed a physician's order for naproxen 500mg 1 tablet twice daily (used to treat pain and inflammation). Review of Resident #3's electronic Medication Administration Record (eMAR) for March 2019 revealed: -There was an entry for naproxen 500mg 1 tablet twice daily and scheduled for administration at 9:00am and 5:00pm. -There was documentation naproxen was not administered at 9:00am on 03/10/19 due to "Out of Facility" and "left for church." -There was documentation naproxen was not administered at 5:00pm on 03/06/19, 03/12/19, and 03/19/19 due to "Out of Facility."	D 273			

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D 273	Continued From page 21 Review of Resident #3's physician's orders revealed a physician's orders revealed a physician's order dated 04/10/19 to discontinue naproxen 500mg 1 tablet twice daily and start naproxen 500mg 1 tablet twice daily as needed. Review of Resident #3's eMAR for April 2019 revealed: -There was an entry for naproxen 500mg take 1 tablet twice daily and scheduled for administration at 9:00am and 5:00pm. -There was documentation naproxen was not administered at 5:00pm on 04/02/19 and 04/09/19 due to "Out of Facility." Refer to interview with Resident Care Coordinator (RCC) on 05/15/19 at 4:46pm. Refer to interview with a Supervisor on 05/15/19 at 6:03pm. Refer to interview with a Medication Aide (MA) on 05/16/19 at 10:21am. Refer to interview with a second MA on 05/16/19 at 12:46pm. Refer to interview with a medical assistant with Resident #3's Primary Care Provider's (PCP) office on 05/16/19 at 3:07pm. Refer to interview with Resident #3 on 05/16/19 at 5:25pm. Refer to interview with Resident #3's family member on 05/16/19 at 6:32pm. Refer to interview with the Administrator on 05/16/19 at 7:21pm.	D 273			

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D 273	Continued From page 22 Interview with the Resident Care Coordinator (RCC) on 05/15/19 at 4:46pm revealed: -There was no policy in place to contact the physician for missed medication administration throughout the month (other than for refusals 3 days in a row). -Resident #3 left the facility every day to visit her family member. -When Resident #3 was out of the facility she did not get her medication. -She had not contacted Resident #3's PCP regarding Resident #3 not getting her medication when she was out of the facility. Interview with a Supervisor on 05/15/19 at 6:03pm revealed: -She administered medication to residents who signed out of the facility if it was the proper time, if it was not the proper time and medication was not administered, she would document "Out of Facility." -Resident #3 left the facility every day with a family member. -Resident #3 did not get her medication every morning before she left the facility with her family member. -She had not sent any medication with Resident #3's family member when she left the facility and did not know if any other staff had. -If a resident had consistent missed medication administration, she would contact the resident's physician by fax and keep a copy of the notification in the Resident's record. -She had not contacted Resident #3's physician regarding any missed medication administration. Interview with a MA on 05/16/19 at 10:21am revealed: -Her primary responsibilities were to administer	D 273			

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D 273	Continued From page 23 medication during her shift. -When a resident left the facility for more than a couple of hours, she sent medication with the family member. -She wrote down and counted all medications that were being sent. -Resident #3 left the facility every day after she was administered her morning medication. -Resident #3 was gone most of the day and the time she returned to the facility varied. -She had not sent any medication with Resident #3's family member because Resident #3 liked her medication in applesauce. -Sometimes if Resident #3 left the facility before she received her morning medication and if she came back to the facility before lunch, she received her morning medication. -Sometimes Resident #3 was at the facility and sometimes she was not at the facility for her 5:00pm medication. -When Resident #3 was not in the facility during her medication administration times, she documented on the eMAR the medication was not given due to "Out of Facility." -She had not contacted Resident #3's PCP regarding medications not administered because she usually only contacted the physician if there were three refusals of medication in a row. -She did not know if Resident #3's PCP knew she was leaving the facility daily and that she was not administered all prescribed medication daily due to being out of the facility. Interview with a second MA on 05/16/19 at 12:46pm revealed: -She usually prepackaged medication and sent it with family members when a resident left the facility with family members during medication administration times -Resident #3 left the facility every day with her	D 273			

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D 273	Continued From page 24 family member, but she did return to the facility during the day for incontinence care. - "If I can catch her before she goes back out, I'll give her medication in the afternoon." - She has never sent medication with Resident #3's family member when she left the facility. - She had not contacted Resident #3's PCP to inform her when she did not administer Resident #3's medication due to her being out of the facility. Interview with a medical assistant with Resident #3's Primary Care Provider's (PCP) office on 05/16/19 at 3:07pm revealed: - She knew Resident #3 was leaving the facility daily with her family member. - Staff should have administered medications to Resident #3 prior to her leaving the facility or sent the medication with her family member. - The PCP did not know medication was not being administered daily when Resident #3 left the facility. - The PCP would expect for medication to be administered as ordered. - The PCP would expect for staff to let her know if medication was not being administered as ordered. Interview with Resident #3 on 05/16/19 at 5:25pm revealed: - She did not know what medications she was administered, but thought her medication administration times were 9:00am, 5:00pm and 9:00pm. - She left the facility daily with her family member who lived in walking distance (within 500 feet) of the facility. - She usually left the facility in the morning after she received her morning medication and was usually gone until about 8:00pm or 9:00pm.	D 273		

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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 R 05/16/2019
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 273	Continued From page 25 -Her family member usually brought her back to the facility twice during the day for incontinence care. -She was sometimes administered medication when she came back to the facility for incontinence care, but not daily. -Sometimes she did not receive her 5:00pm medication because it was not time for them when she came back to the facility. -She had not been told by staff she needed to return to the facility at a certain time to take her medication. -Staff had never given her family member any of her medication to take while she was out of the facility. Interview with Resident #3's family member on 05/16/19 at 6:32pm revealed: -He signed Resident #3 out of the facility every morning and signed her back in to the facility in the evenings between 8:00pm and 9:00pm. -Staff never gave him any medication to administer to Resident #3 while she was out of the facility. -He brought Resident #3 back to the facility 2 to 3 times each day for incontinence care, but he did not know if she was administered any medication during that time. Interview with the Administrator on 05/16/19 at 7:21pm revealed: -Resident #3's family member signed her out of the facility every day. -He did not know Resident #3 was missing medication administration when she was out of the facility. -He expected medication to be administered as order by her physician. -If a resident was refusing or had missed medication administration, the protocol would be	D 273			

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D 273	Continued From page 26 to notify the doctor.	D 273		
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 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: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 2 of 5 sampled residents (Residents #1 and #5) with orders for an anxiety medication (#1), a long-acting insulin, an appetite stimulant, tiotropium bromide inhalation powder, and a rapid acting insulin (#5). The finding are: 1. Review of Resident #5's current FL2 dated	D 358	D 358 RCC will audit all mars for correct orders. Staff will check prior shifts "dashboard" to make sure all reports are 100% in compliance. Staff have been trained on medication administration/ document errors. RCC will Audit all Mars weekly to assure correct orders and administration of med techs.	6-30-19 6/30/19

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D 358	Continued From page 27 04/11/19 revealed diagnoses included diabetes mellitus 2 with circulatory complications, anemia, coronary artery disease, hypertension, and hyperlipidemia. a. Further review of Resident #5's current FL2 revealed an order for lantus insulin 100 units/mL inject 25 units at bedtime (used to treat type 2 diabetes). Review of Resident #5's Primary Care Provider's (PCP) visit summary revealed a physician's order dated 05/01/19 to discontinue lantus. Review of Resident #5's Resident Register revealed she was admitted to the facility on 04/23/19. Review of Resident #5's electronic Medication Administration Record (eMAR) for April 2019 revealed: -There was an entry for lantus 100 units/mL inject 25 units at bedtime at 8:00pm. -There was documentation lantus was not administered 6 of 7 opportunities at 8:00pm from 04/24/19 through 04/29/19 due to "physically unable to take" and "medication not available." Interview with Resident #5 on 05/16/19 at 5:56pm revealed: -She was diabetic and was on 2 different insulins. -She did not remember missing any doses of insulin. Interview with the Resident Care Coordinator (RCC) on 05/15/19 at 4:46pm revealed: -She did not know it was documented on the eMAR lantus was not administered to Resident #5 from 04/24/19 through 04/29/19 due to "physically unable to take" and "medication not	D 358			

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D 358	Continued From page 28 available." -She thought Resident #5 was admitted with her medications. Interview with a Supervisor on 05/16/19 at 10:21am revealed: -She documented Lantus was not administered on the eMAR on 04/28/19 due to "physically unable to take" and made a note "medication not available," but she did not contact the pharmacy to see why the medication had not been dispensed. -She did not remember if lantus was in the facility or not when she documented "physically unable to take" and "unavailable" on 05/28/19 Interview with a second supervisor on 05/16/19 at 12:46pm revealed she did not remember documenting lantus was not administered on 04/24/19, 04/25/19, and 04/26/19 due to "physically unable to take." Interview with a medical assistant with Resident #5's Primary Care Provider's (PCP) office on 05/16/19 at 3:07pm revealed: -She remembered getting documents from the pharmacy which indicated lantus was not covered by Resident #5's insurance. -Lantus was discontinued on 05/01/19 and changed to another medication covered by Resident #5's insurance. -The facility had not notified the PCP her lantus was not available in the facility for administration to Resident #5. -The PCP expected for medication to be administered as ordered. Interview with a representative from the facility contracted pharmacy on 05/16/19 at 3:37pm revealed:	D 358			

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D 358	Continued From page 29 -There was an active order dated 04/23/19 for lantus 100 unit/ml. -Lantus was not filled by the pharmacy because it was not covered by Resident #5's insurance. -A pharmacy representative sent a Third Party Medication Action Form to the PCP on 04/23/19 informing that lantus was not covered by the insurance. -The Third Party Medication Action Form required a physician's order for an alternative medication or other actions to be taken by the PCP. -The Third Party Medication Action Form had not been returned to the pharmacy so a pharmacy contacted the PCP on 04/26/19. -The pharmacy received confirmation on 05/01/19 to discontinue the order for lantus and start another insulin that was covered by Resident #5's insurance. Refer to interview with the Administrator on 05/16/19 at 7:21pm. b. Review of Resident #5's current FL2 dated 04/11/19 revealed a physician's order for mirtazapine 15mg 1 tablet at bedtime (used as an appetite stimulant). Review of Resident #5's electronic Medication Administration Record (eMAR) for March 2019 revealed: -There was an entry for mirtazapine 15mg take 1 tablet at bedtime at 8:00pm. -There was documentation mirtazapine 15mg was not administered 4 of 7 opportunities at 8:00pm on 04/24/19, 04/25/19, 04/26/19, and 04/28/19 due to "physically unable to take" and medication not available." Review of Resident #5's electronic Medication Administration Record (eMAR) for May 2019	D 358		

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D 358	Continued From page 30 revealed: -There was an entry for mirtazapine 15mg take 1 tablet at bedtime at 8:00pm. -There was documentation mirtazapine 15mg was not administered 3 of 9 opportunities at 8:00pm on 05/06/19, 05/07/19, and 05/09/19 due to "physically unable to take" and medication unavailable." Observation of Resident #5's medication on hand on 06/15/19 at 6:40pm revealed mirtazapine was not on the medication cart and was not available for administration. Interview with the Resident Care Coordinator (RCC) on 05/15/19 at 7:00 pm revealed: -She did not know when mirtazapine was last in the facility or if mirtazapine came with Resident #5 when she was admitted to the facility. -A Medication Aide (MA) told her today, 05/15/19, Mirtazapine was not on the medication cart and asked her if it had been ordered. -She did not know prior to today, 05/15/19, Mirtazapine was not available in the facility for administration. -She contacted the pharmacy today, 05/15/19, and was told 12 tablets would be dispensed to the facility because it was too early to bill Resident #5's insurance for a full prescription. -She expected staff to reorder medication for residents 10 days prior to the medication running out. Interview with a representative from the facility contracted pharmacy on 05/16/19 at 3:37pm revealed: -There was an active order for mirtazapine 15mg 1 tablet at bedtime. -Four tablets of mirtazapine were dispensed by the pharmacy on 04/23/19; 26 tablets were	D 358			

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D 358	Continued From page 31 dispensed on 04/27/19, and 30 tablets were dispensed on 05/15/19. -She did not know why mirtazapine had not been administered to Resident #5 because it had been dispensed to the facility. -Mirtazapine was usually kept in the top drawer of the medication cart and staff may not have been aware it was on the cart. Interview with Resident #5 on 05/16/19 at 5:56pm revealed: -She had her sleep medication, mirtazapine, when she was admitted to the facility. -She had mirtazapine last night (05/15/19), but she did not have it the four previous nights. -She had asked a MA for mirtazapine and was told it had been requested from the pharmacy. Interview with Resident #5's mental health provider on 05/16/19 at 3:37pm revealed: -She did not know mirtazapine was not available in the facility and had been documented as not administered by staff. -She had ordered mirtazapine to increase Resident #5's appetite. -She was scheduled to see Resident #5 tomorrow, 05/17/19, and would weigh her to see if mirtazapine had been effective. Refer to interview with the Administrator on 05/16/19 at 7:21pm. c. Review of Resident #5's current FL2 dated 04/11/19 revealed a physician's order for Spiriva 18 mcg inhaler inhale 1 capsule daily (used to treat bronchospasms). Review of Resident #5's physician's orders revealed an order dated 05/01/19 to discontinue Spiriva.	D 358			

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D 358	Continued From page 32 Review of resident #5's electronic Medication Administration Record for April 2019 revealed: -There was an entry for Spiriva 18 mcg inhaler inhale 1 capsule daily at 8:00am. -There was documentation Spiriva was not administered 3 of 7 opportunities at 8:00 am on 04/25/19, 04/27/19, and 04/28/19 due to "physically unable to take" and "medication not available." Interview with Resident #5 on 05/16/19 at 5:56pm revealed she did not remember being administered Spiriva after she was admitted to the facility. Interview with the RCC on 05/15/19 at 4:46pm revealed: -The RCC was responsible for reviewing medication orders when a resident was admitted to the facility. -There was not a medication reconciliation process for accounting for medication when new residents were admitted. -Sometimes residents were admitted with medication. -All medication orders were listed on the resident's FL2, but she did not count or document the number of each medication a resident came in with. -If residents did not have medication with them upon admission, she would send a request to the pharmacy for the medication. -If a resident did not have a medication in the facility, the Medication Aide (MA) should document on the eMAR "physically unable to take." Interview with a Supervisor on 05/15/19 at 6:03pm revealed:	D 358			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE BRADFORD VILLAGE OF KERNERSVILLE - WES

**602 PINEY GROVE ROAD
KERNERSVILLE, NC 27284**

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D 358	Continued From page 33 -She did not know if Resident #5 was admitted with all her medication. -Resident #5 had never been without medication to her knowledge. Interview with a second Supervisor on 05/16/19 at 9:42am revealed: -Resident #5 was recently admitted to the facility. -She thought the RCC and the staffing coordinator counted medication for residents upon admission. -She thought Resident #5 had all her medication except for a pain medication when she was admitted to the facility. Interview with a third Supervisor on 05/16/19 at 10:21am revealed: -If a medication was not in the facility she would document "physically unable to take" and make a note "medication unavailable" on the eMAR. -Sometimes when medication does not come in from the pharmacy, it could be issues with the resident's insurance. -If a medication was not available in the facility she would let the RCC know, but she would not contact the resident's physician because she did not know she was supposed to. -If a resident was admitted to the facility without medication, she would order medication from the pharmacy. Interview with a third supervisor on 05/16/19 at 12:46pm revealed: -She thought the staffing coordinator handled new residents and assumed she completed a medication reconciliation. -She did not know of any medication Resident #5 did not have when she was admitted. -Resident #5 was upset about not receiving a pain medication, but she did not know of any	D 358		

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D 358	Continued From page 34 others. Interview with a medical assistant with Resident #5's Primary Care Provider's (PCP) office on 05/16/19 at 3:07pm revealed: -She remembered getting documents from the pharmacy which indicated Spiriva was not covered by Resident #5's insurance. -Spiriva was discontinued on 05/01/19 and changed to a medication covered by Resident #5's insurance. -The facility had not notified the PCP her Spiriva was not available in the facility for administration to Resident #5. -The PCP expected for medication to be administered as ordered. Interview with a representative from the facility contracted pharmacy on 05/16/19 at 3:37pm revealed: -There was an active order dated 04/23/19 for Spiriva 18mcg inhaler inhale 1 capsule daily. -Spiriva was not filled by the pharmacy because it was not covered by Resident #5's insurance. -A pharmacy representative sent a Third Party Medication Action Form to the PCP on 04/23/19 informing that Spiriva was not covered by Resident #5's insurance. -The Third Party Medication Action Form required a physician's order for an alternative medication or other actions to be taken by the PCP. -The Third Party Medication Action Form had not been returned to the pharmacy so a pharmacy contacted the PCP on 04/26/19. -The pharmacy received confirmation on 05/01/19 to discontinue the order for Spiriva and start another insulin covered by Resident #5's insurance. Refer to interview with the Administrator on	D 358		

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D 358	Continued From page 35 05/16/19 at 7:21pm. d. Review of Resident #5's current FL2 dated 04/11/19 revealed: -There was a physician's order to check fingerstick blood sugars (FSBS) before meals and at bedtime. Review of Resident #5's physician's orders revealed there was a physician's order for Novolog 100 units/mL inject 8 units three times daily before meals, hold for FSBS less than 100 or if patient is not eating. Review of Resident #5's electronic Medication Administration Record (eMAR) for May 2019 revealed: -There was an entry for Novolog 100 units/mL flexpen inject 8 units 3 times daily before meals, hold for FSBS less than 100 or if patient is not eating. -On 05/05/19 at 7:30am FSBS was 71; 8 units were administered; 0 units should have been administered. -On 05/06/19 at 7:30am FSBS was 70; 8 units were administered; 0 units should have been administered. -On 05/07/19 at 7:30am FSBS was 76; 8 units were administered; 0 units should have been administered. -On 05/11/19 at 7:30am FSBS was 71; 8 units were administered; 0 units should have been administered. -On 05/12/19 at 7:30am FSBS was 97; 8 units were administered; 0 units should have been administered. Interview with a Supervisor on 05/16/19 at 9:42am revealed: -She administered medication, including insulin,	D 358		

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D 358	Continued From page 36 to Resident #5 during her shift. -Resident #5 had an order to inject 8 units of Novolog three times daily before meals, hold for FSBS less than 100 or if patient is not eating. -She did not know Resident #5's FSBS was documented as 71 on 05/05/19 and she documented administering 8 units of Novolog were administered. -Novolog should not have been administered if the FSBS was below 100. Interview with a second Supervisor on 05/16/19 at 10:21am revealed: -She administered medication, including insulin, to Resident #5 during her shift. -Resident #5 had an order for Novolog insulin inject 8 units three times daily before meals, hold for FSBS less than 100 or if patient is not eating. -She did not remember documenting 8 units of Novolog were administered on 05/06/19. -The 3rd shift medication aide (MA) or Supervisor documented checking Resident #5's FSBS as 70 and she administered the Novolog on 05/06/19. -She must have administered Novolog to Resident #5 without looking to see what number was documented for FSBS. -She must have overlooked the order on the eMAR to hold Novolog for FSBS less than 100. Interview with a medical assistant with Resident #5's Primary Care Provider's (PCP) office on 05/16/19 at 3:07pm revealed: -Resident #5 had an order for Novolog insulin inject 8 units three times daily before meals, hold for FSBS less than 100 if patient is not eating. -She did not know Resident #5 was administered Novolog when her FSBS was less than 100. -Unless there were orders to contact the physician if FSBS were outside of parameters, the primary care physician (PCP) should be	D 358		

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D 358	Continued From page 37 contacted when FSBS were outside of facility guidelines which thought to be greater than 400 or less than 60. -The PCP expected for medication to be administered as ordered. Interview with the Administrator on 05/16/19 at 7:21pm revealed: -He did not know there were errors with FSBS for Resident #5 prior to 05/16/19. -He expected staff to administer medication as ordered by the physician. Refer to interview wiht the Administrator on 05/16/19 at 7:21pm. Interview with the Administrator on 05/16/19 at 7:21pm revealed: -The RCC was responsible for reconciling and counting medication when new residents were admitted to the facility. -He thought a form would be completed, but he was not sure. -He expected staff to contact the pharmacy to reorder medication if the medication was within 5 days of running out or if the medication was not in the facility. -He expected staff to notify the physician if a resident was not administered medication consistently. -He expected for each shift to sign off on medication prior to leaving the facility. -If there was no documentation whether a medication was administered or not, he expected for the oncoming shift to find out whether the medication had been administered or not. -He expected medication to be administered as order by the physician. 2. Review of Resident #1's current FL2 dated	D 358		

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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 R 05/16/2019
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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
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(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 358	Continued From page 38 01/02/19 revealed: -Diagnoses included presence of artificial hip joint, unspecified fall, muscle weakness, cerebral infarction, unspecified fracture of the lower end of the left femur, cognitive social or emotional deficit, dysphagia following cerebral vascular accident, and schizophrenia. Review of Resident #1's physician's order dated 01/23/19 revealed a physician's order for lorazepam (used to treat anxiety) 1mg every morning and noon. Review of Resident #1's subsequent physician's order dated 02/15/19 revealed a physician's order to change lorazepam 1mg to noon and 4:00pm. Review of Resident #1's subsequent physician's order dated 02/21/19 revealed a physician's order to change lorazepam 1mg to noon and 6:00pm. Review of Resident #1's subsequent physician's order dated 03/05/19 revealed a physician's order to change lorazepam 1mg three times a day. Review of Resident #1's subsequent physician's order dated 04/19/19 revealed a physician's order to change lorazepam 1mg twice a day. Review of Resident #1's subsequent physician's order dated 04/24/19 revealed a physician's order to change lorazepam 1mg three times a day. Review of Resident #1's February 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for lorazepam 1mg each morning and at noon scheduled at 9:00am and 12:00pm from 02/01/19 through 02/17/19. -Staff documented lorazepam 1mg was	D 358		

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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 R 05/16/2019
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 358	Continued From page 39 administered at 9:00am and 12:00pm from 02/01/19 through 02/17/19. -There was an entry for lorazepam 1mg each morning and at noon scheduled at 9:00am and 4:00pm from 02/18/19 through 02/22/19. -Staff documented lorazepam 1mg was administered at 9:00am and 4:00pm from 02/18/19 through 02/21/19 (9:00am). -Staff documented lorazepam 1mg was not administered at 9:00am and 4:00pm from 02/21/19 (4:00pm) through 02/22/19 because lorazepam was not available. -There was an entry for lorazepam 1mg twice a day scheduled at 12:00pm and 6:00pm from 02/23/19 through 02/28/19. -Staff documented lorazepam 1mg was not administered at 12:00pm and 6:00pm from 02/23/19 through 02/28/19 because lorazepam was not available. -Staff did not document lorazepam was administered due to lorazepam was not available for 15 of 56 opportunities. Review of Resident #1's March 2019 eMAR revealed: -There was an entry for lorazepam 1mg twice a day scheduled at 12:00pm and 6:00pm from 03/01/19 through 03/08/19 (12:00pm). -Staff documented lorazepam 1mg was not administered at 12:00pm and 6:00pm from 03/01/19 through 03/03/19 because lorazepam was not available. -Staff documented lorazepam 1mg was administered at 12:00pm and 6:00pm from 03/03/19 through 03/08/19 (12:00pm). -There was an entry for lorazepam 1mg three times a day scheduled at 7:00am, 1:00pm, and 6:00pm from 03/06/19 (6:00pm) through 03/20/19. -Staff documented lorazepam 1mg was	D 358			

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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 R 05/16/2019
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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
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(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 358	Continued From page 40 administered at 7:00am, 1:00pm, and 6:00pm from 03/06/19 (6:00pm) through 03/20/19. -There was an entry for lorazepam 1mg three times a day scheduled at 5:30am, 1:00pm, and 6:00pm from 03/21/19 through 03/31/19. -Staff documented lorazepam 1mg was administered at 5:30am, 1:00pm, and 6:00pm from 03/21/19 through 03/31/19; except on 03/28/19 at 6:00pm. -Staff did not document lorazepam was administered due to lorazepam was not available for 6 of 86 opportunities. Review of Resident #1's care noted revealed: -On 02/21/19, a medication aide (MA) informed the Resident Care Coordinator (RCC) Resident #1 had taken her last lorazepam. The RCC told the MA Resident #1 was scheduled to see the physician and would get a hard script. -On 03/04/19, the RCC called Resident #1's ordering physician regarding lorazepam refill. The physician did not return the call or provide a refill. -On 03/05/19, a MA called the pharmacy regarding the lorazepam hard script. The pharmacy told her they called three times with no response. The pharmacy was still waiting on the lorazepam hard script. The MA called the ordering physicians office and left a message requesting a lorazepam refill for Resident #1. The physician did not return the call. -On 03/05/19, the transportation coordinator traveled to the ordering physicians office to attempt to get a hard script for the lorazepam. A representative at the physicians office informed the transportation coordinator the physician was not in the office and she would need to return the following day. -On 03/05/19, the RCC noted a lorazepam hard script was called into the pharmacy for scheduled and as needed order.	D 358		

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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 R 05/16/2019
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 358	Continued From page 41 Interview with Resident #1 on 05/14/19 at 1:20 pm revealed: -She knew she was prescribed lorazepam. -Lorazepam was prescribed for her anxiety. Interview with the facility's contracted pharmacy on 05/17/19 at 10:35 am revealed: -Lorazepam 1mg three times a day was an active order. -The lorazepam had been changed several times over the past few months. -On 01/23/19, the pharmacy received an order for 1mg every morning and noon and 1mg every day as needed (prn) for anxiety. -There were 75 tablets of lorazepam 1mg dispensed on 01/23/19. -There were 15 tablets of lorazepam 1mg (prn dose) dispensed on 01/23/19. -The pharmacy faxed a refill request to the ordering physician on 02/15/19 and 02/18/19. -On 02/21/19, facility staff requested a dose increase due to increased anxiety and the physician responded with a new order for lorazepam 1mg at noon and 6:00pm and 0.5mg everyday prn for anxiety. -On 02/21/19, 02/26/19, and 03/01/19 the pharmacy faxed an order clarification and requested a written prescription to the ordering physician. -On 03/03/19, the pharmacy was finally able to reach the ordering physician and received a verbal order for lorazepam 1mg twice a day (noon and 6:00pm) and 1mg everyday prn for anxiety. -There were 6 tablets of lorazepam 1mg dispensed on 03/03/19 as an emergency fill. -On 03/05/19, the pharmacy received a verbal order for lorazepam 1mg three times a day and 0.5mg everyday prn for anxiety. -There were 90 tablets of lorazepam 1mg	D 358			

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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 R 05/16/2019
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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
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(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 358	Continued From page 42 dispensed on 03/05/19. -There were 30 tablets of lorazepam 0.5mg dispensed on 03/05/19. -There were 90 tablets of lorazepam 1mg dispensed on 04/01/19. -There were 30 tablets of lorazepam 0.5mg dispensed on 04/01/19. -On 04/19/19, the pharmacy received a written prescription for lorazepam 1mg twice a day and 1mg everyday prn for anxiety. -The pharmacy did not send an additional amount of lorazepam because it was too early and the facility had enough lorazepam. -On 04/24/19, the pharmacy received a written prescription for lorazepam 1mg three times a day and 0.5mg everyday prn for anxiety. -There were 90 tablets of lorazepam 1mg dispensed on 04/24/19. -There were 30 tablets of lorazepam 0.5mg dispensed on 04/24/19. Interview with a first shift MA on 05/14/19 at 11:35am revealed: -She knew Resident #1 ran out of lorazepam at the end of February and the issue continued into early March 2019. -The facility was not able to reach the physician to get a written prescription for lorazepam. -She notified the pharmacy when Resident #1 had 1 tablet left. -She knew an emergency supply was sent for Resident #1 but did not remember the date. Interview with the Resident Care Coordinator (RCC) on 05/15/19 at 4:07pm revealed: -Resident #1 was prescribed lorazepam for her constant anxiety. -She knew Resident #1 ran out of lorazepam in February and March 2019. -A MA documented she had ordered the	D 358		

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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 R 05/16/2019
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

THE BRADFORD VILLAGE OF KERNERSVILLE - WES 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 358	Continued From page 43 lorazepam and as a team they did not follow up and as a result Resident #1 did not get a refill. -Another MA noticed the lorazepam had not been delivered and called the pharmacy regarding the refill and an emergency refill was sent out. -The facility had a difficult time getting the physician to refill the lorazepam. -She and the MAs called and faxed the ordering physician on several occasions requesting a refill. -The transportation coordinator was sent to the physicians office to attempt to get a written prescription for lorazepam. -When the transportation coordinator got tot he physicians office he was not in the office and she was told to come back the next day. -The following day on 03/05/19 Resident #1's family member picked up a written prescription from the physicians office and delivered the prescription to the pharmacy. -She had implemented a count sheet and MAs were to count all medications for each resident during each shift change daily. -The MAs were to contact the pharmacy or physician regarding a refill when the medication gets down to 10 tablets. -Controlled substances were not on cycle fill. -The RCC, staffing coordinator, supervisor, or MA were responsible for conducting cart audits on all residents weekly. -They looked to make sure ordered medications were available, count medications, send back expired medications, order medications if needed. Interview with the Executive Director on 05/14/19 at 1:00pm revealed: -The staff did not make him aware Resident #1 ran out of lorazepam in February and March 2019. -Resident #1's family member informed him	D 358		

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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 R 05/16/2019
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 358	Continued From page 44 Resident #1's was out of lorazepam. Interview with Resident #1's family member on 05/16/19 at 2:30pm revealed: -Resident #1 was prescribed lorazepam for anxiety. -Resident #1 ran out of lorazepam for 9 days. -She did not feel the staff were capable of managing Resident #1's medications. -She felt the staff would call and get the lorazepam changed without discussing it with her. -She felt the staff did not clarify orders when needed. Attempted interview with the ordering physician on 05/15/19 at 4:00pm was unsuccessful. The facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 2 of 5 sampled residents related to lorazepam not administered as ordered due to the medication was not available (#1); missed administration of medications of lantus, mirtazapine, and spiriva due to medication not being available in the facility and errors with administration of novolog (#5). The facility's failure to assure medications were available and administered as ordered was detrimental to the health, and safety of the residents and constitutes a Type B Violation The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/16/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 30, 2019.	D 358			

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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 R 05/16/2019
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 367	Continued From page 45	D 367		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure the Medication Administration Records (MARs) were accurate and complete for 2 of 5 sampled residents (Resident #1 and #3), as related to eight medications not documented as administered on several occasions in March and	D 367	Rcc will Audit all mar's weekly to review med exception report and follow-up to assure medication is available. Rcc will Audit all Mar's monthly to review medication administration	6/30/19 6/30/19

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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 R 05/16/2019
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 367	Continued From page 46 April 2019 (#1) and eight medications not documented as administered on several occasions in March, April, and May 2019 (#3) . The findings are: 1. Review of Resident #1's current FL2 dated 01/02/19 revealed: -Diagnoses included presence of artificial hip joint, unspecified fall, muscle weakness, cerebral infarction, unspecified fracture of the lower end of the left femur, cognitive social or emotional deficit, dysphagia following cerebral vascular accident, and schizophrenia. a. Review of Resident #1's current FL2 dated 01/02/19 revealed a physician's order for atorvastatin (used to treat high cholesterol) 40 mg daily. Review of Resident #1's March 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for atorvastatin 40mg at bedtime scheduled at 9:00pm. -Staff did not document atorvastatin as administered for 4 of 31 opportunities. -There was no documentation atorvastatin was administered on 03/21/19, 03/22/19, 03/28/19 and on 03/31/19. -Staff did not document a reason the atorvastatin was not administered. Review of Resident #1's April 2019 eMAR revealed: -There was an entry for atorvastatin 40mg at bedtime scheduled at 9:00pm. -Staff did not document atorvastatin as administered for 3 of 30 opportunities. -There was no documentation atorvastatin was	D 367			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HA034069	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/16/2019
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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
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D 367	Continued From page 47 administered on 04/07/19, 04/11/19 and on 04/17/19. -Staff did not document a reason the atorvastatin was not administered. Observation of Resident #1's medication on hand on 05/16/19 at 10:00am revealed: -Atorvastatin 40mg was available to be administered. -There were 30 tablets of atorvastatin dispensed on 05/01/19. -There were 19 tablets left. Interview with the Resident Care Coordinator (RCC) on 05/15/19 at 5:07pm revealed: -She did not know Resident #1 had documentation missing for administration of atorvastatin in March and April 2019. -Without documentation she could not ensure if the atorvastatin was administered or not. Interview with the Administrator on 05/16/19 at 11:00am revealed he did not know atorvastatin was not documented as administered on several occasions in March and April 2019. Attempted interview with Resident #1's specialist provider on 05/15/19 at 4:00pm was unsuccessful. Refer to interview with Resident #1 on 05/14/19 at 1:20pm. Refer to interview with Resident #1's Primary Care Provider (PCP) on 05/15/19 at 3:50pm. Refer to interview with the Administrator on 05/16/19 at 11:00am. Refer to interview with a second shift medication	D 367		

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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 R 05/16/2019
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D 367	Continued From page 48 aide (MA) on 05/16/19 at 12:40pm. Refer to interview with the facility's contracted pharmacy on 05/16/19 at 3:37pm. b. Review of Resident #1's current FL2 dated 01/02/19 revealed a physician's order for benztropine (used to treat Parkinson's disease or side effects from other drugs) 0.5mg at bedtime. Review of Resident #1's March 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for benztropine 0.5mg at bedtime scheduled at 9:00pm. -Staff did not document benztropine as administered for 4 of 31 opportunities. -There was no documentation benztropine was administered on 03/21/19, 03/22/19, 03/28/19 and on 03/31/19. -Staff did not document a reason benztropine was not administered. Review of Resident #1's April 2019 eMAR revealed: -There was an entry for benztropine 0.5mg at bedtime scheduled at 9:00pm. -Staff did not document benztropine as administered for 3 of 17 opportunities. -There was no documentation benztropine was administered on 04/07/19, 04/11/19 and on 04/17/19. -Staff did not document a reason benztropine was not administered. -The benztropine was discontinued on 04/18/19. Review of Resident #1's subsequent physician's order dated 04/18/19 revealed an order to discontinue benztropine.	D 367			

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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 R 05/16/2019
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 367	Continued From page 49 Interview with the Resident Care Coordinator (RCC) on 05/15/19 at 5:07pm revealed: -She did not know Resident #1 had documentation missing for administration of benztropine in March and April 2019. -Without documentation she could not ensure if the benztropine was administered or not. Interview with the Administrator on 05/16/19 at 11:00am revealed he did not know benztropine was not documented as administered on several occasions in March and April 2019. Attempted interview with Resident #1's specialist provider on 05/15/19 at 4:00pm was unsuccessful. Refer to interview with Resident #1 on 05/14/19 at 1:20pm. Refer to interview with Resident #1's Primary Care Provider (PCP) on 05/15/19 at 3:50pm. Refer to interview with the Administrator on 05/16/19 at 11:00am. Refer to interview with a second shift medication aide (MA) on 05/16/19 at 12:40pm. Refer to interview with the facility's contracted pharmacy on 05/16/19 at 3:37pm. c. Review of Resident #1's current FL2 dated 01/02/19 revealed a physician's order for diazepam (used to treat anxiety) 5mg at bedtime. Review of subsequent physician's order dated 01/03/19 revealed an order to change diazepam to 7mg at bedtime.	D 367			

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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 R 05/16/2019
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 367	Continued From page 50 Review of subsequent physician's order dated 01/23/19 revealed an order to change diazepam to 5mg at bedtime. Review of Resident #1's March 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for diazepam 5mg at bedtime scheduled at 8:00pm. -Staff did not document diazepam as administered for 4 of 31 opportunities. -There was no documentation diazepam was administered on 03/21/19, 03/22/19, 03/28/19 and on 03/31/19. -Staff did not document a reason diazepam was not administered. Review of Resident #1's April 2019 eMAR revealed: -There was an entry for diazepam at bedtime scheduled at 8:00pm. -Staff did not document diazepam as administered for 3 of 17 opportunities. -There was no documentation diazepam was administered on 04/07/19, 04/11/19 and on 04/17/19. -Staff did not document a reason diazepam was not administered. Review of subsequent physician's order dated 04/18/19 revealed an order to discontinue diazepam. Interview with the Resident Care Coordinator (RCC) on 05/15/19 at 5:07pm revealed: -She did not know Resident #1 had documentation missing for administration of diazepam in March and April 2019. -Without documentation she could not ensure if the diazepam was administered or not.	D 367			

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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 R 05/16/2019
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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
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(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 367	Continued From page 51 Interview with the Administrator on 05/16/19 at 11:00am revealed he did not know diazepam was not documented as administered on several occasions in March and April 2019. Attempted interview with Resident #1's specialist provider on 05/15/19 at 4:00pm was unsuccessful. Refer to interview with Resident #1 on 05/14/19 at 1:20pm. Refer to interview with Resident #1's Primary Care Provider (PCP) on 05/15/19 at 3:50pm. Refer to interview with the Administrator on 05/16/19 at 11:00am. Refer to interview with a second shift medication aide (MA) on 05/16/19 at 12:40pm. Refer to interview with the facility's contracted pharmacy on 05/16/19 at 3:37pm. d. Review of Resident #1's physician's order dated 01/04/19 revealed an order for haloperidol (used to treat schizophrenia) 10mg at bedtime. Review of Resident #1's March 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for haloperidol 10mg at bedtime scheduled at 9:00pm. -Staff did not document haloperidol as administered for 4 of 31 opportunities. -There was no documentation haloperidol was administered on 03/21/19, 03/22/19, 03/28/19 and on 03/31/19. -Staff did not document a reason haloperidol was	D 367		

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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 R 05/16/2019
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 367	Continued From page 52 not administered. Review of Resident #1's subsequent physician's order dated 04/18/19 revealed an order to decrease haloperidol to 5mg twice a day in 2 weeks. Review of Resident #1's April 2019 eMARs revealed: -There was an entry for haloperidol 10mg at bedtime scheduled at 9:00pm. -Staff did not document haloperidol as administered for 3 of 30 opportunities. -There was no documentation haloperidol was administered on 04/07/19, 04/11/19 and on 04/17/19. -Staff did not document a reason haloperidol was not administered. Observation of Resident #1's medication on hand on 05/16/19 at 10:00am revealed: -Haloperidol was available to be administered. -There were 60 tablets of haloperidol dispensed on 05/01/19. -There were 18 tablets of haloperidol remaining. Interview with the facility's contracted pharmacy on 05/17/19 rev at 10:35am revealed: -Haloperidol was dispensed on 04/18/19. -There were 30 tablets dispensed on 03/01/19 and 04/01/19. -The order changed on 05/01/19 and the pharmacy dispensed 60 tablets of haloperidol 5mg. Interview with the Resident Care Coordinator (RCC) on 05/15/19 at 5:07pm revealed: -She did not know Resident #1 had documentation missing for administration of haloperidol in March and April 2019.	D 367			

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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 R 05/16/2019
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 367	Continued From page 53 -Without documentation she could not ensure if the haloperidol was administered or not. Interview with the Administrator on 05/16/19 at 11:00am revealed he did not know benzotropine was not documented as administered on several occasions in March and April 2019. Attempted interview with Resident #1's specialist provider on 05/15/19 at 4:00pm was unsuccessful. Refer to interview with Resident #1 on 05/14/19 at 1:20pm. Refer to interview with Resident #1's Primary Care Provider (PCP) on 05/15/19 at 3:50pm. Refer to interview with the Administrator on 05/16/19 at 11:00am. Refer to interview with a second shift medication aide (MA) on 05/16/19 at 12:40pm. Refer to interview with the facility's contracted pharmacy on 05/16/19 at 3:37pm. e. Review of Resident #1's physician's order dated 01/23/19 revealed a physician's order for lorazepam (used to treat anxiety) 1mg every morning and noon. Review of Resident #1's subsequent physician's order dated 02/21/19 revealed a physician's order to change lorazepam 1mg to noon and 6:00pm. Review of Resident #1's subsequent physician's order dated 03/05/19 revealed a physician's order to change lorazepam 1mg three times a day.	D 367			

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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 R 05/16/2019
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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
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(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 367	Continued From page 54 Review of Resident #1's subsequent physician's order dated 04/19/19 revealed a physician's order to change lorazepam 1mg twice a day. Review of Resident #1's subsequent physician's order dated 04/24/19 revealed a physician's order to change lorazepam 1mg three times a day. Review of Resident #1's March 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for lorazepam 1mg twice a day scheduled at 12:00pm and 6:00pm from 03/01/19 through 03/08/19. -There was an entry for lorazepam 1mg three times a day at 7:00am, 1:00pm, and 6:00pm from 03/06/19 through 03/20/19. -There was an entry for lorazepam 1mg three times a day at 5:30am, 1:00pm, and 6:00pm from 03/20/19 through 03/31/19. -Staff did not document lorazepam 1mg as administered for 1 of 86 opportunities. -Staff double (twice) documented lorazepam 1mg for 4 of 86 opportunities. -On 03/06/19 at 6:00pm, staff documented lorazepam 1mg was administered on the twice a day entry (12:00pm and 6:00pm) and three times a day entry (7:00am, 1:00pm, and 6:00pm). -On 03/07/19, staff documented lorazepam 1mg was administered on the twice a day entry (12:00pm and 6:00pm) and three times a day entry (7:00am, 1:00pm, and 6:00pm). -On 03/08/19, staff documented lorazepam 1mg was administered on the twice a day entry (12:00pm) and three times a day entry (7:00am, 1:00pm, and 6:00pm). -On 03/28/19 at 6:00pm, there was no documentation lorazepam 1mg was administered. -Staff did not document a reason lorazepam was	D 367		

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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 R 05/16/2019
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 367	Continued From page 55 not administered. Review of Resident #1's controlled substance log sheet (CSCS) on 05/16/19 at 10:00am revealed: -There were 27 tablets of lorazepam 1mg remaining. -The count was correct with the current amount of lorazepam available. Observation of Resident #1's medication on hand on 05/16/19 at 10:00am revealed: -Lorazepam 1 mg was available to be administered. -There were 90 tablets of lorazepam 1mg dispensed on 04/24/19. -There were 27 tablets of lorazepam 1mg left. Interview with Resident #1 on 05/14/19 at 1:20pm revealed: -She knew she was prescribed lorazepam. -Lorazepam was prescribed for her anxiety. Interview with the facility's contracted pharmacy on 05/17/19 at 10:35am revealed: -Lorazepam 1mg three times a day was an active order. -The lorazepam had been changed several times over the past few months. -There were 75 tablets dispensed on 01/23/19. -There were 6 tablets dispensed on 03/03/19. -There were 90 tablets dispensed on 03/05/19. -There were 90 tablets dispensed on 04/01/19. -There were 90 tablets dispensed on 04/24/19. Interview with the Resident Care Coordinator (RCC) on 05/15/19 at 5:07pm revealed: -She did not know Resident #1 had documentation missing for administration of lorazepam in March 2019. -Without documentation she could not ensure if	D 367			

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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 R 05/16/2019
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 367	Continued From page 56 the lorazepam was administered or not. Interview with the Administrator on 05/16/19 at 11:00am revealed he did not know lorazepam was not documented as administered on several occasions in March 2019. Attempted interview with Resident #1's specialist provider on 05/15/19 at 4:00pm was unsuccessful. Refer to interview with Resident #1 on 05/14/19 at 1:20pm. Refer to interview with Resident #1's Primary Care Provider (PCP) on 05/15/19 at 3:50pm. Refer to interview with the Administrator on 05/16/19 at 11:00am. Refer to interview with a second shift medication aide (MA) on 05/16/19 at 12:40pm. Refer to interview with the facility's contracted pharmacy on 05/16/19 at 3:37pm. f. Review of Resident #1's current FL2 dated 01/02/19 revealed a physician's order for metoprolol tartrate (used to treat high blood pressure) 12.5mg twice a day. Review of Resident #1's March 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for metoprolol tartrate 25mg, take 12.5mg twice a day scheduled at 9:00am and 9:00pm. -Staff did not document for metoprolol tartrate as administered for 4 of 62 opportunities. -There was no documentation metoprolol tartrate	D 367			

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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 R 05/16/2019
NAME OF PROVIDER OR SUPPLIER THE BRADFORD VILLAGE OF KERNERSVILLE - WES			STREET ADDRESS, CITY, STATE, ZIP CODE 602 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
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D 367	Continued From page 57 was administered at 9:00pm on 03/21/19, 03/22/19, 03/28/19 and on 03/31/19. -Staff did not document a reason metoprolol tartrate was not administered. Review of Resident #1's April 2019 eMAR revealed: -There was an entry for metoprolol tartrate 25mg, take 12.5mg twice a day scheduled at 9:00am and 9:00pm. -Staff did not document metoprolol tartrate as administered for 3 of 30 opportunities. -There was no documentation metoprolol tartrate was administered at 9:00pm on 04/07/19, 04/11/19 and on 04/17/19. -Staff did not document a reason metoprolol tartrate was not administered. Observation of Resident #1's medication on hand on 05/16/19 at 10:00am revealed: -Metoprolol tartrate was available to be administered. -There were 60 tablets dispensed on 05/01/19. -There were 18 tablets remaining of the bedtime dose. Interview with the facility's contracted pharmacy on 05/17/19 rev at 10:35am revealed: -Metoprolol tartrate was an active order. -There were 60 tablets dispensed on 02/03/19, 03/01/19, 04/01/19, and 05/01/19. Interview with the Resident Care Coordinator (RCC) on 05/15/19 at 5:07pm revealed: -She did not know Resident #1 had documentation missing for administration of metoprolol tartrate in March and April 2019. -Without documentation she could not ensure if the metoprolol tartrate was administered or not.	D 367			

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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 R 05/16/2019
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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
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(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 367	Continued From page 58 Interview with the Administrator on 05/16/19 at 11:00am revealed he did not know metoprolol tartrate was not documented as administered on several occasions in March and April 2019. Attempted interview with Resident #1's specialist provider on 05/15/19 at 4:00pm was unsuccessful. Refer to interview with Resident #1 on 05/14/19 at 1:20pm. Refer to interview with Resident #1's Primary Care Provider (PCP) on 05/15/19 at 3:50pm. Refer to interview with the Administrator on 05/16/19 at 11:00am. Refer to interview with a second shift medication aide (MA) on 05/16/19 at 12:40pm. Refer to interview with the facility's contracted pharmacy on 05/16/19 at 3:37pm. g. Review of Resident #1's current FL2 dated 01/02/19 revealed a physician's order for nortriptyline hcl (used to treat depression) 25mg twice a day. Review of Resident #1's March 2019 electronic Medication Administration Records (eMAR) revealed: -There was an entry for nortriptyline hcl twice a day scheduled at 9:00am and 9:00pm. -Staff did not document nortriptyline hcl as administered for 4 of 62 opportunities. -There was no documentation nortriptyline hcl was administered at 9:00pm on 03/21/19, 03/22/19, 03/28/19 and on 03/31/19. -Staff did not document a reason the nortriptyline	D 367		

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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
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(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 367	Continued From page 59 hcl was not administered. Review of Resident #1's April 2019 eMAR revealed: -There was an entry for nortriptyline hcl twice a day scheduled at 9:00am and 9:00pm. -Staff did not document nortriptyline hcl as administered for 3 of 30 days. -There was no documentation nortriptyline hcl was administered at 9:00pm on 04/07/19, 04/11/19 and on 04/17/19. -Staff did not document a reason the nortriptyline hcl was not administered. Observation of Resident #1's medication on hand on 05/16/19 at 10:00am revealed: -Nortriptyline hcl was available to be administered. -There were 60 tablets of nortriptyline hcl dispensed on 05/01/19. -There were 18 tablets remaining of the bedtime dose. Interview with the facility's contracted pharmacy on 05/17/19 rev at 10:35am revealed: - Nortriptyline hcl was an active order. -There were 60 tablets dispensed on 02/03/19, 03/01/19, 04/01/19, and 05/01/19. Interview with the Resident Care Coordinator (RCC) on 05/15/19 at 5:07pm revealed: -She did not know Resident #1 had documentation missing for nortriptyline hcl in March and April 2019. -Without documentation she could not ensure if the nortriptyline hcl was administered or not. Interview with the Administrator on 05/16/19 at 11:00am revealed he did not know nortriptyline hcl was not documented as administered on	D 367		

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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 R 05/16/2019
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 367	Continued From page 60 several occasions in March and April 2019. Attempted interview with Resident #1's specialist provider on 05/15/19 at 4:00pm was unsuccessful. Refer to interview with Resident #1 on 05/14/19 at 1:20pm. Refer to interview with Resident #1's Primary Care Provider (PCP) on 05/15/19 at 3:50pm. Refer to interview with the Administrator on 05/16/19 at 11:00am. Refer to interview with a second shift medication aide (MA) on 05/16/19 at 12:40pm. Refer to interview with the facility's contracted pharmacy on 05/16/19 at 3:37pm. h. Review of Resident #1's physician's order dated 02/21/19 revealed a physician's order for temazepam (used to treat insomnia) 30 mg at bedtime. Review of Resident #1's March 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for temazepam every evening scheduled at 9:00pm. -Staff did not document temazepam as administered for 4 of 31 opportunities. -There was no documentation temazepam was administered on 03/21/19, 03/22/19, 03/28/19 and on 03/31/19. -Staff did not document a reason the temazepam was not administered. Review of Resident #1's April 2019 eMAR	D 367			

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D 367	Continued From page 61 revealed: -There was an entry for temazepam every evening scheduled at 9:00pm. -Staff did not document temazepam as administered for 3 of 30 opportunities. -There was no documentation temazepam was administered on 04/07/19, 04/11/19 and on 04/17/19. -Staff did not document a reason the temazepam was not administered. Observation of Resident #1's medication on hand on 05/16/19 at 10:00am revealed: -Temazepam was available to be administered. -There were 30 tablets of temazepam dispensed on 04/08/19. -There were 8 tablets remaining. -There were 30 tablets of temazepam dispensed on 05/01/19. -There were 30 tablets remaining. Interview with the facility's contracted pharmacy on 05/17/19 rev at 10:35am revealed: -Temazepam was an active order. -There were 30 tablets dispensed on 02/21/19, 03/16/19, 04/08/19, and 05/01/19. Interview with the Resident Care Coordinator (RCC) on 05/15/19 at 5:07pm revealed: -She did not know Resident #1 had documentation missing for administration of temazepam in March and April 2019. -Without documentation she could not ensure if the temazepam was administered or not. Interview with the Administrator on 05/16/19 at 11:00am revealed he did not know temazepam was not documented as administered on several occasions in March and April 2019.	D 367			

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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 R 05/16/2019
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 367	Continued From page 62 Attempted interview with Resident #1's specialist provider on 05/15/19 at 4:00pm was unsuccessful. Refer to interview with Resident #1 on 05/14/19 at 1:20pm. Refer to interview with Resident #1's Primary Care Provider (PCP) on 05/15/19 at 3:50pm. Refer to interview with the Administrator on 05/16/19 at 11:00am. Refer to interview with a second shift medication aide (MA) on 05/16/19 at 12:40pm. Refer to interview with the facility's contracted pharmacy on 05/16/19 at 3:37pm. Interview with Resident #1 on 05/14/19 at 1:20pm revealed: -Staff administer all of her medications. -She did not remember all the medications she was prescribed. Interview with Resident #1's Primary Care Provider (PCP) on 05/15/19 at 3:50pm revealed: -She expected staff to administer medications as ordered. -She expected staff to make her aware if medications were missed. -She was not notified of the missed documentation in March or April 2019 for Resident #1. Interview with the Administrator on 05/16/19 at 11:00am revealed: -He expected all MAs to document all medications administered. -He expected all MAs to check their	D 367			

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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 R 05/16/2019
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 367	Continued From page 63 documentation prior to leaving their shift to ensure they had documented all medications administered during their shift. -The oncoming MAs should also be checking behind the previous shift and make the MA aware if they missed documentation. -The RCC was suppose to be completing record audits monthly on all residents and monthly when any issues were found. -He did not know Resident #1 was missing documentation of administration of several medications during March and April 2019. -He expected his staff to make him aware when their were documentation issues. Interview with a second shift medication aide (MA) on 05/16/19 at 12:40pm revealed: -She did not know she had not documented medications in March and April 2019. -She thought she gave the medication on 03/21/19, 04/07/19, 04/11/19, 04/17/19 but forgot to document. -She was taught to document all medications administered on her shift. -She was taught to check behind her documentation prior to leaving her shift. -She must have forgotten to check her documentation prior to leaving the facility. Interview with the facility's contracted pharmacy on 05/16/19 at 3:37pm revealed: -The pharmacy manages the electronic medication administration record (eMAR) for the facility. -The RCC was the only staff that could make changes in the eMAR system. -MAs had to approve new medications in the eMAR system. -The physician and the facility faxed orders to the pharmacy.	D 367			

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D 367	Continued From page 64 -Resident #1's family member was very active and at times was dependent on the family member to get the orders. -The pharmacy conducted quarterly medication reviews. -The facility was on cycle fill except for controlled substances, creams, and as needed medications. -Resident #1 was the only resident with a multi-dose pack because the family member requested it. 2. Review of Resident #3's current FL2 dated 02/06/19 revealed a physician's order for baclofen 10mg 1 tablet daily (used to treat muscle spasms, pain, and stiffness). a. Review of Resident #3's physician's orders revealed a subsequent order dated 04/10/19 for baclofen 10mg take ½ tablet daily. Review of Resident #3' electronic Medication Administration Record (eMAR)for March 2019 revealed: -There was an entry for baclofen 10mg 1 tablet daily and scheduled for administration at 9:00pm. -There was no documentation baclofen 10mg was administered at 9:00pm on 03/14/19, 03/22/19, 03/25/19, and 03/30/19. -There was no documentation why baclofen was not administered on 03/14/19 or 03/22/19, 03/25/19, and 03/30/19. Review of Resident #3' eMAR for April 2019 revealed: -There was an entry for baclofen 10mg 1 tablet daily and scheduled for administration at 9:00pm. -There was no documentation baclofen 10mg was administered on 04/07/19. -There was an entry for baclofen 10mg take ½ tablet (5mg) daily at 9:00am. -There was no documentation baclofen ½ tablet	D 367		

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D 367	Continued From page 65 (5mg) was administered on 04/10/19 at 9:00am. -There was no documentation why baclofen was not administered on 04/07/19 or 04/10/19. Refer to interview with the Resident Care Coordinator (RCC) on 05/15/19 at 5:07pm. Refer to interview with a medical assistant with Resident #3's Primary Care Provider's (PCP) office on 05/16/19 at 3:07pm. Refer to interview with a second shift medication aide (MA) on 05/16/18 at 12:40pm. Refer to interview with the facility's contracted pharmacy on 05/16/19 at 3:37pm. Refer to interview with Resident #3 on 05/16/19 at 5:25pm. Refer to interview with the Administrator on 05/16/19 at 7:21pm. b. Review of Resident #3's current FL2 dated 02/06/19 revealed a physician's order for clonazepam 0.5mg ½ tablet twice daily (used to treat and prevent seizures). Review of Resident #3's electronic Medication Administration Record (eMAR) for March 2019 revealed: -There was an entry for clonazepam 0.5mg ½ tablet twice daily and scheduled for administration at 9:00am and 9:00pm. -There was no documentation clonazepam 0.5mg was at 9:00pm on 03/14/19, 03/22/19, 03/25/19, and 03/30/19. -There was no documentation why clonazepam was not administered on 03/14/19 or 03/22/19, 03/25/19, and 03/30/19.	D 367			

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D 367	Continued From page 66 Review of Resident #3's eMAR for April 2019 revealed: -There was an entry for clonazepam 0.5mg ½ tablet twice daily and scheduled for administration at 9:00am and 9:00pm. -There was no documentation clonazepam 0.5mg was administered at 9:00pm on 04/07/19, 04/11/19, 04/17/19, and 04/26/19. -There was no documentation why clonazepam was not administered on 04/07/19 or 04/11/19, 04/17/19, and 04/26/19. Review of Resident #3' eMAR for May 2019 revealed: -There was an entry for clonazepam 0.5mg take ½ tablet twice daily and scheduled for administration at 9:00am and 9:00pm. -There was no documentation clonazepam was administered at 9:00pm on 05/10/19 and 05/13/19. -There was no documentation why clonazepam was not administered on 05/10/19 and 05/13/19. Refer to interview with the Resident Care Coordinator (RCC) on 05/15/19 at 5:07pm. Refer to interview with a medical assistant with Resident #3's Primary Care Provider's (PCP) office on 05/16/19 at 3:07pm. Refer to interview with a second shift medication aide (MA) on 05/16/18 at 12:40pm. Refer to interview with the facility's contracted pharmacy on 05/16/19 at 3:37pm. Refer to interview with Resident #3 on 05/16/19 at 5:25pm.	D 367		

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D 367	Continued From page 67 Refer to interview with the Administrator on 05/16/19 at 7:21pm. c. Review of Resident #3's current FL2 dated 02/06/19 revealed a physician's order for Depakote (divalproex sodium) ER 250mg 1 tablet daily (used to treat seizure disorders and psychiatric conditions). Review of Resident #3's physician's orders revealed a subsequent physician's order dated 2/15/19 to discontinue Depakote 250mg 1 tablet daily and start Depakote 250mg 1 tablet twice daily. Review of Resident #3's electronic Medication Administration Record (eMAR) for March 2019 revealed: -There was an entry for divalproex sodium ER 250mg take 1 tablet twice daily and scheduled for administration at 9:00am and 9:00pm. -There was no documentation divalproex sodium was administered at 9:00pm on 03/14/19, 03/22/19, 03/25/19, and 03/30/19. -There was no documentation why divalproex sodium was not administered on 03/14/19 or 03/22/19, 03/25/19, and 03/30/19. Review of Resident #3's eMAR for April 2019 revealed: -There was an entry for divalproex sodium ER 250mg take 1 tablet twice daily and scheduled for administration at 9:00am and 9:00pm. -There was no documentation divalproex sodium was administered at 9:00pm on 04/07/19, 04/11/19, 04/17/19, and 04/26/19. -There was no documentation why divalproex sodium was not administered on 04/07/19 or 04/11/19, 04/17/19, and 04/26/19.	D 367		

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D 367	Continued From page 68 Review of Resident #3's eMAR for May 2019 revealed: -There was an entry for divalproex sodium ER 250mg take 1 tablet twice daily and scheduled for administration at 9:00am and 9:00pm. -There was no documentation divalproex sodium was administered at 9:00pm on 05/10/19 and 05/13/19. -There was no documentation why divalproex sodium was not administered on 05/10/19 and 05/13/19. Refer to interview with the Resident Care Coordinator (RCC) on 05/15/19 at 5:07pm. Refer to interview with a medical assistant with Resident #3's Primary Care Provider's (PCP) office on 05/16/19 at 3:07pm. Refer to interview with a second shift medication aide (MA) on 05/16/18 at 12:40pm. Refer to interview with the facility's contracted pharmacy on 05/16/19 at 3:37pm. Refer to interview with Resident #3 on 05/16/19 at 5:25pm. Refer to interview with the Administrator on 05/16/19 at 7:21pm. d. Review of Resident #3's current FL2 dated 02/06/19 revealed a physician's order for Depakote (divalproex sodium) ER 500mg 1 at bedtime (used to treat seizure disorders and psychiatric conditions). Review of Resident #3's electronic Medication Administration Record (eMAR) for March 2019 revealed:	D 367			

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D 367	Continued From page 69 -There was an entry for divalproex sodium ER 500mg take 1 tablet at bedtime and scheduled for administration at 9:00pm. -There was no documentation divalproex sodium was administered at 9:00pm on 03/14/19, 03/22/19, 03/25/19, and 03/30/19. -There was no documentation why divalproex sodium was not administered on 03/14/19 or 03/22/19, 03/25/19, and 03/30/19. Review of Resident #3's eMAR for April 2019 revealed: -There was an entry for divalproex sodium ER 500mg take 1 tablet at bedtime and scheduled for administration at 9:00pm. -There was no documentation divalproex sodium was administered at 9:00pm on 04/07/19, 04/11/19, 04/17/19, and 04/26/19. -There was no documentation why divalproex sodium was not administered on 04/07/19 or 04/11/19, 04/17/19, and 04/26/19. Review of Resident #3's eMAR for May 2019 revealed: -There was an entry for divalproex sodium ER 500mg take 1 tablet at bedtime and scheduled for administration at 9:00pm. -There was no documentation divalproex sodium was administered at 9:00pm on 05/10/19 and 05/13/19. -There was no documentation why divalproex sodium was not administered on 05/10/19 and 05/13/19. Refer to interview with the Resident Care Coordinator (RCC) on 05/15/19 at 5:07pm. Refer to interview with a medical assistant with Resident #3's Primary Care Provider's (PCP) office on 05/16/19 at 3:07pm.	D 367			

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D 367	Continued From page 70 Refer to interview with a second shift medication aide (MA) on 05/16/18 at 12:40pm. Refer to interview with the facility's contracted pharmacy on 05/16/19 at 3:37pm. Refer to interview with Resident #3 on 05/16/19 at 5:25pm. Refer to interview with the Administrator on 05/16/19 at 7:21pm. e. Review of Resident #3's current FL2 dated 02/06/19 revealed a physician's order for fexofenadine 180mg 1 tablet daily (used to treat allergies). Review of Resident #3's electronic Medication Administration Record (eMAR) for March 2019 revealed: -There was an entry for fexofenadine 180mg take 1 tablet once daily and scheduled for administration at 9:00am. -There was no documentation fexofenadine was administered at 9:00pm on 03/14/19, 03/22/19, 03/25/19, and 03/30/19. -There was no documentation why fexofenadine was not administered on 03/14/19 or 03/22/19, 03/25/19, and 03/30/19. Refer to interview with the Resident Care Coordinator (RCC) on 05/15/19 at 5:07pm. Refer to interview with a medical assistant with Resident #3's Primary Care Provider's (PCP) office on 05/16/19 at 3:07pm. Refer to interview with a second shift medication aide (MA) on 05/16/18 at 12:40pm.	D 367		

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D 367	Continued From page 71 Refer to interview with the facility's contracted pharmacy on 05/16/19 at 3:37pm. Refer to interview with Resident #3 on 05/16/19 at 5:25pm. Refer to interview with the Administrator on 05/16/19 at 7:21pm. f. Review of Resident #3's current FL2 dated 02/06/19 revealed a physician's order for Remeron (mirtazapine) 15mg 1 tablet at bedtime (used to treat depression). Review of Resident #3's electronic Medication Administration Record (eMAR) for March 2019 revealed: -There was an entry for mirtazapine 15mg take 1 tablet at bedtime and scheduled for administration at 9:00pm. -There was no documentation mirtazapine was administered at 9:00pm on 03/14/19, 03/22/19, 03/25/19, and 03/30/19. -There was no documentation why mirtazapine was not administered on 03/14/19 or 03/22/19, 03/25/19, and 03/30/19. Review of Resident #3's eMAR for April 2019 revealed: -There was an entry for mirtazapine 15mg take 1 tablet at bedtime and scheduled for administration at 9:00pm. -There was no documentation mirtazapine was administered at 9:00pm on 04/07/19, 04/11/19, 04/17/19, and 04/26/19. -There was no documentation why mirtazapine was not administered on 04/07/19 or 04/11/19, 04/17/19, and 04/26/19.	D 367			

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D 367	Continued From page 72 Review of Resident #3's eMAR for May 2019 revealed: -There was an entry for mirtazapine 15mg take 1 tablet at bedtime and scheduled for administration at 9:00pm. -There was no documentation mirtazapine was not administered at 9:00pm on 05/10/19 and 05/13/19. -There was no documentation why mirtazapine was not administered on 05/10/19 and 05/13/19. Refer to interview with the Resident Care Coordinator (RCC) on 05/15/19 at 5:07pm. Refer to interview with a medical assistant with Resident #3's Primary Care Provider's (PCP) office on 05/16/19 at 3:07pm. Refer to interview with a second shift medication aide (MA) on 05/16/18 at 12:40pm. Refer to interview with the facility's contracted pharmacy on 05/16/19 at 3:37pm. Refer to interview with Resident #3 on 05/16/19 at 5:25pm. Refer to interview with the Administrator on 05/16/19 at 7:21pm. g. Review of Resident #3's current FL2 dated 02/06/19 revealed a physician's order for trazadone 150mg 1 tablet at bedtime (used to treat depression). Review of Resident #3's electronic Medication Administration Record (eMAR) for March 2019 revealed: -There was an entry for trazadone 150mg take 1 tablet at bedtime and scheduled for	D 367			

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D 367	Continued From page 73 administration at 9:00pm. -There was no documentation trazadone was administered at 9:00pm on 03/14/19, 03/22/19, 03/25/19, and 03/30/19. -There was no documentation why trazadone was not administered on 03/14/19, 03/22/19, 03/25/19, and 03/30/19. Review of Resident #3's eMAR for April 2019 revealed: -There was an entry for trazadone 150mg take 1 tablet at bedtime and scheduled for administration at 9:00pm. -There was no documentation trazadone was administered at 9:00pm on 04/07/19, 04/11/19, 04/17/19, and 04/26/19. -There was no documentation why trazadone was not administered on 04/07/19 or 04/11/19, 04/17/19, and 04/26/19. Review of Resident #3's eMAR for May 2019 revealed: -There was an entry for trazadone 150mg take 1 tablet at bedtime and scheduled for administration at 9:00pm. -There was no documentation trazadone was administered at 9:00pm on 05/10/19 and 05/13/19. -There was no documentation why trazadone was not administered on 05/10/19 and 05/13/19. Refer to interview with the Resident Care Coordinator (RCC) on 05/15/19 at 5:07pm. Refer to interview with a medical assistant with Resident #3's Primary Care Provider's (PCP) office on 05/16/19 at 3:07pm. Refer to interview with a second shift medication aide (MA) on 05/16/18 at 12:40pm.	D 367			

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D 367	Continued From page 74 Refer to interview with the facility's contracted pharmacy on 05/16/19 at 3:37pm. Refer to interview with Resident #3 on 05/16/19 at 5:25pm. Refer to interview with the Administrator on 05/16/19 at 7:21pm. h.. Review of Resident #3's current FL2 dated 02/06/19 revealed a physician's order for duonebs (ipratropium-albuterol)0.5-3(2.5) 90ml in hale 1 vial at bedtime and 1 vial every 4 hours as needed (used to treat shortness of breath and wheezing). Review of Resident #3's electronic Medication Administration Record (eMAR) for March 2019 revealed: -There was an entry for ipratropium-albuterol 0.5-3(2.5) 90ml inhale 1 vial via nebulizer at bedtime and scheduled for administration at 9:00pm. -There was no documentation ipratropium-albuterol was administered at 9:00pm on 03/14/19, 03/22/19, 03/25/19, and 03/30/19. -There was no documentation why ipratropium-albuterol was not administered on 03/14/19, 03/22/19, 03/25/19, and 03/30/19. -There was an entry for ipratropium-albuterol 0.5-3(2.5) 90ml inhale 1 vial via nebulizer every 4 hours as needed. Review of Resident #3's eMAR for April 2019 revealed: -There was an entry for ipratropium-albuterol 0.5-3(2.5) 90ml inhale 1 vial via nebulizer at bedtime and scheduled for administration at 9:00pm.	D 367		

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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		
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D 367	Continued From page 75 -There was no documentation ipratropium-albuterol was administered at 9:00pm on 04/07/19, 04/11/19, 04/17/19, and 04/26/19. -There was no documentation why ipratropium-albuterol was not administered on 04/07/19 or 04/11/19, 04/17/19, and 04/26/19. -There was an entry for ipratropium-albuterol 0.5-3(2.5) 90ml inhale 1 vial via nebulizer every 4 hours as needed. Review of Resident #3's eMAR for May 2019 revealed: -There was an entry for ipratropium-albuterol 0.5-3(2.5) 90ml inhale 1 vial via nebulizer at bedtime and scheduled for administration at 9:00pm. -There was no documentation ipratropium-albuterol was administered at 9:00pm on 05/10/19 and 05/13/19. -There was no documentation why ipratropium-albuterol was not administered on 05/10/19 and 05/13/19. Refer to interview with the Resident Care Coordinator (RCC) on 05/15/19 at 5:07pm. Refer to interview with a medical assistant with Resident #3's Primary Care Provider's (PCP) office on 05/16/19 at 3:07pm. Refer to interview with the facility's contracted pharmacy on 05/16/19 at 3:37pm. Refer to interview with a second shift medication aide (MA) on 05/16/18 at 12:40pm. Refer to interview with Resident #3 on 05/16/19 at 5:25pm. Refer to interview with the Administrator on	D 367			

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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 R 05/16/2019
NAME OF PROVIDER OR SUPPLIER THE BRADFORD VILLAGE OF KERNERSVILLE - WES			STREET ADDRESS, CITY, STATE, ZIP CODE 602 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
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D 367	Continued From page 76 05/16/19 at 7:21pm. Interview with the Resident Care Coordinator (RCC) on 05/15/19 at 5:07pm revealed: -She did not know Resident #3 had documentation missing for administration of medication in March, April and May 2019. -Without documentation she could not ensure if the medications were administered or not for Resident #3. Interview with a second shift medication aide (MA) on 05/16/18 at 12:40pm revealed: -She did not know she had not documented medications in April and May 2019. -She thought she gave the medication on 04/07/19, 04/11/19, 04/17/19, 04/26/19, 05/10/19, and 05/13/19 but forgot to document. -She was taught to document all medications administered on her shift. -She was taught to check behind her documentation prior to leaving her shift. -She must have forgotten to check her documentation prior to leaving the facility. -Interview with a medical assistant with Resident #3's Primary Care Provider's (PCP) office on 05/16/19 at 3:07pm revealed: -The PCP did not know medication were not documented as being administered in March, April, and May 2019 for Resident #3. -The PCP would expect for medication to be administered as ordered and to be notified of missed doses of medications. -The PCP would expect for staff to let her know if medication was not being administered as ordered. Interview with the facility's contracted pharmacy on 05/16/19 at 3:37pm revealed:	D 367			

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D 367	Continued From page 77 -The pharmacy manages the electronic medication administration record (eMAR) for the facility. -The RCC was the only staff that could make changes in the eMAR system. -MAs had to approve new medications in the eMAR system. -The physician and the facility faxed orders to the pharmacy. -The pharmacy conducted quarterly medication reviews. -The facility was on cycle fill except for controlled substances, creams, and as needed medications. Interview with Resident #3 on 05/16/19 at 5:25pm revealed: -Staff administered all of her medications. -She did not know what medications she was administered and did not remember if she had missed any doses. Interview with the Administrator on 05/16/19 at 7:21pm revealed: -He expected MAs to document all medication administered. -He expected for each shift to sign off on medication prior to leaving the facility. -If there was no documentation whether a medication was administered or not, he expected for the oncoming shift to find out whether the medication had been administered or not. -He did not know Resident #3 had missing documentation of medications in March, April, and May 2019. -He expected the staff to make him aware when there were documentation issues.	D 367		
D912	G.S. 131D-21(2) Declaration of Residents' Rights	D912	D 912 Resident rights will be implemented. cont.	6-30 -19

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D912	Continued From page 78 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, interviews and record reviews, the facility failed to assure each resident received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations as related to personal care and supervision and medication administration. The findings are: 1. Based on observations, interviews, and record reviews the facility failed to provide supervision for 1 of 5 sampled residents (Resident #1) with diagnoses of dementia, a history of repeated falls, and a history of a femur fracture. [Tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (B Violation)]. 2. Based on interviews and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 2 of 5 sampled residents (Residents #1 and #5) with orders for an anxiety medication (#1), a long-acting insulin, an appetite stimulant, tiotropium bromide inhalation powder, and a rapid acting insulin (#5). [Tag 0358, 10A NCAC 13F .1004(a) Medication Administration (B Violation)].	D912	D912 cont All staff have been re-trained and made aware of Resident Rights		6-30 -19

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