STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034069	A. BUILDING: _____ B. WING _____	R 03/19/2021

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 000	Initial Comments The Adult Care Licensure Section conducted a Follow-Up Survey and a Complaint Investigation with an onsite visit on 03/16/21 through 03/17/21 and a desk review survey on 03/18/21 through 03/19/21 with an exit via telephone on 03/19/21.	D 000		
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: FOLLOW-UP TO TYPE A2 VIOLATION Based on these findings, the previous Type A2 Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 1 of 5 sampled residents (Resident #4) related to incorrectly administering a short acting insulin (Humulin R) and a rapid acting insulin (Novolog). The findings are: Review of Resident #4's current FL-2 from a local rehabilitation facility dated 01/05/21 revealed diagnoses included bipolar disorder, and type 2	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 1 diabetes without complications. a. Review of Resident #4's physician's orders dated 01/13/21 revealed an order for Humulin R concentrated U-500 (a short acting insulin used to lower blood sugar levels in a concentrated dose of 500 units per 1 milliliter) 125 units subcutaneously (SQ) twice a day. Review of Resident #4's previous physician's orders dated 11/19/20 revealed Humulin R U500/ml Kwikpen (Kwikpen is a medication delivery device used to dispense insulin for injection by dialing the indicated dosage on the Kwikpen instead of drawing up the dose in a calibrated syringe) inject 120 units SQ twice a day. Review of Resident #4's physician's progress note dated 02/03/21 revealed the primary care provider (PCP) clarified with the contracted pharmacy that Humulin R 125 units subcutaneously twice a day was the current order for Resident #4's Humulin R U500 dose. Observation of Resident #4's medication on hand for administration on 03/17/21 at 1:49pm revealed: -There was one opened box labeled with Resident #4's name, dispensed on 01/08/21 with instructions to inject 120 units SQ twice a day. The 20 milliliters vial inside the box was missing the security cap on the top and was approximately half empty. -There was one unopened box of Humulin R U500 labeled with Resident #4's name and a dispensing date of 03/11/21 with instructions to inject 125 units SQ twice a day. -There were no U500 calibrated insulin syringes on hand for Resident #4 in the facility.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 2	D 358		

(Administering Humulin R insulin 500 units per ml using insulin syringes calibrated for 100 units per ml results in receiving 5 times the prescribed amount of insulin.)
-There were 31 gauge 1 cc 5/16 of an inch in length syringes label for U100 insulin administration in the medication room for administering insulin to residents.

Review of the manufacturer's packages for Humulin R U500 20 milliliters vials removed from the facility's medication refrigerator on 03/17/21 at 1:49pm revealed:
-There was a red warning label with white letters prominently located on the front upper portion of the package that read "Warning Dose Can Be Dangerous".
-There was a red warning label with white letters prominently located on the front upper portion of the package that read "Warning- Highly Concentrated Important use only with a U500 syringe".

Review of Resident #4's January 2021 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Humulin R U500 units/ml vial listed with instructions to inject 120 units SQ twice a day scheduled for administration at 6:30am and 4:30pm. (Administering 120 units of U500 concentration with U100 insulin syringes would deliver 600 units of U500 insulin.)
-At 6:30am, Humulin R U500 insulin SQ injections were documented as refused for 21 of 25 doses, with administration documented on 01/26/21 (FSBS at 11:30am was 378), on 01/28/21 (FSBS at 11:30am was 351), on 01/29/21(FSBS at 11:30am was 367) on 01/30/21 (FSBS at 11:30am was 315).
-At 4:30pm, Humulin R U500 insulin SQ injections

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034069	A. BUILDING: _____ B. WING _____	R 03/19/2021

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THE BRADFORD VILLAGE OF KERNERSVILLE - WES	602 PINEY GROVE ROAD KERNERSVILLE, NC 27284

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D 358	Continued From page 3	D 358		

were documented as refused for 19 of 25 doses, with administration documented on 01/06/21 (FSBS at 8:00pm was 254), on 01/07/21 (FSBS at 8:00pm was 153), on 01/13/21 (FSBS at 8:00pm was 189), 01/27/21 (FSBS at 8:00pm was 401), on 01/28/21 (FSBS at 8:00pm was 361) and on 01/30/21 (FSBS at 8:00pm was 358).

Review of Resident #4's February 2021 eMAR revealed:
-There was an entry for Humulin R U500 units/ml vial listed with instructions to inject 120 units SQ twice a day scheduled for administration at 6:30am and 4:30pm from 02/01/21 to 02/03/21 discontinued on 02/03/21. [Administering insulin of U500 concentration (500 units per ml) with U100 insulin syringes (100units per ml) calibration would deliver 5 times the dose].
-At 6:30am, Humulin R U500 insulin 120 units SQ injections were documented as administered on 02/01/21 (FSBS at 11:30am was 345), on 02/02/21 (FSBS at 11:30am was 375), on 02/03/21 (FSBS at 11:30am was 391).
-At 4:30pm, Humulin R U500 insulin 120 units SQ injections were documented as administered on 02/01/21 (FSBS at 8:00pm was 359), on 02/02/21 (FSBS at 8:00pm was 389), and on 02/03/21 (FSBS at 8:00pm was 394).
-There was an entry for Humulin R U500 units/ml vial listed with instructions to inject 125 units SQ twice a day scheduled for administration at 8:00am and 8:00pm from 02/04/21 to 02/28/21. [Administering insulin of U500 concentration (500 units per ml) with U100 insulin syringes (100units per ml) calibration would deliver 5 times the dose].
-At 8:00am, Humulin R U500 insulin 125 units SQ injections were documented as refused for 17 of 25 doses from 02/04/21 to 02/28/21, with administration documented on 02/06/21 (FSBS at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034069	A. BUILDING: _____ B. WING _____	R 03/19/2021

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 4	D 358		

11:30am was 247), on 02/07/21 (FSBS at 11:30am was 354), on 02/08/21 (FSBS at 11:30am was 328), on 02/10/21 (FSBS at 11:30am was 344), on 02/13/21 (FSBS at 11:30am was 332), on 02/20/21 (FSBS at 11:30am was 145), on 02/24/21 (FSBS at 11:30am was 278) and on 02/28/21 (FSBS at 11:30am was 273).
-At 8:00pm, Humulin R U500 insulin 125 units SQ injections were documented as refused for 12 of 25 doses, with administration documented on 02/04/21 (FSBS on the next morning at 7:30am was 305), on 02/06/21(FSBS on the next morning at 7:30am was 372) , on 02/07/21 (FSBS on the next morning at 7:30am was 343), on 02/08/21 (FSBS on the next morning at 7:30am was 354), on 02/09/21 (FSBS on the next morning at 7:30am was 379), 02/11/21 (FSBS on the next morning at 7:30am was 298), on 02/13/21 (FSBS on the next morning at 7:30am was 291), on 02/17/21 (FSBS on the next morning at 7:30am was 341), on 02/19/21 (FSBS on the next morning at 7:30am was 72), on 02/21/21 (FSBS on the next morning at 7:30am was 287), on 02/24/21 (FSBS on the next morning at 7:30am was 234), on 02/26/21 (FSBS on the next morning at 7:30am was 228), and on 02/27/21 (FSBS on the next morning at 7:30am was 232).

Review of Resident #4's March 2021 eMAR revealed:
-There was an entry for Humulin R U500 units/ml vial listed with instructions to inject 125 units SQ twice a day scheduled for administration at 8:00am and 8:00pm from 03/01/21 to 03/15/21. [Administering insulin of U500 concentration (500 units per ml) with U100 insulin syringes (100units per ml) calibration would deliver 5 times the dose].
-At 8:00am, Humulin R U500 insulin 125 units SQ

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034069	A. BUILDING: _____ B. WING _____	R 03/19/2021

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 5	D 358		

injections were documented as refused for 10 of 15 doses with administration documented on 03/01/21 (FSBS at 11:30am was 60 and at 4:30pm FSBS was 78), on 03/04/21 (FSBS at 11:30am was 297), on 03/07/21 (FSBS at 11:30am was 280), on 03/12/21 (FSBS at 11:30am was 330), and on 03/14/21 (FSBS at 11:30am was 308).
-At 8:00pm, Humulin R U500 insulin 125 units SQ injections were documented as refused for 12 of 15 doses, with administration documented on 03/01/21 (FSBS on the next morning at 7:30am was 260), on 03/10/21 (FSBS on the next morning at 7:30am was 311), and on 03/15/21 (FSBS on the next morning at 7:30am was 356).
-Administering 120 units of U500 concentration with U100 insulin syringes would deliver 600 units of U500 insulin.
-Administering 125 units of U500 concentration with U100 insulin syringes would deliver 625 units of U500 insulin.

Review of Resident #4's laboratory values dated 02/24/21 revealed a hemoglobin A1C (HbA1C) value of 9.4. The hemoglobin A1C test tells you your average level of blood sugar over the past 2 to 3 months. (According to the American Diabetic a HbgA1C value less than 7.0 is a goal for diabetic residents with the normal range for HbA1C being 4 to 5.9).

Interview with the Resident Care Coordinator (RCC) on 03/17/21 at 12:32pm revealed:
-The RCC had been filling in on the medication cart a lot since January 2021 due to staff shortages.
-Resident #4 refused insulin administration a lot.
-Resident #4's Primary Care Provider (PCP) had been made aware of the multiple refusals of insulin over the last 3 months.

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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 6 -The facility changed contracted pharmacy providers while the resident was out of the facility. -Prior to the pharmacy change, Humulin R U500 was administered to Resident #4 using an "insulin pen" allowing the medication aides (MAs) to dial the prescribed dose on the device that measured the insulin dose instead of drawing the dose into a syringe from a multidose insulin vial using a syringe. -The resident received a Humulin R U500/ml vial from the current contracted pharmacy on 01/08/21. -She had administered Humulin R U500 to Resident #4 on a few occasions since the medication came from the pharmacy. -The pharmacy did not send any special insulin syringes when the Humulin R U500 insulin was sent to the facility. -She did not know of an insulin syringe specifically calibrated for use with U500 insulin. -She used the same type insulin syringe that was used to administer standard U 100 insulin to draw up 100 units on the scale (one full milliliter) and a second syringe to draw up an additional 20 units on the U 100 syringe. She did not know the U500 strength was 5 times as strong as the U 100 and that would equal 600 units of insulin. -There had not been an inservice to alert the MAs of the need to ensure the proper calibrated syringe was used to prepare and administer Resident #4's Humulin R U500 insulin. Interview with Resident #4's PCP on 03/17/21 at 12:45pm revealed: -She did not know Resident #4 was receiving Humulin R U500 incorrectly due to improper measuring of the insulin during preparation. -She thought Resident #4 had the Kwikpen used to dial up the correct amount of insulin when administering.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034069	A. BUILDING: _____ B. WING _____	R 03/19/2021

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 7	D 358		

-She did not order Resident #4's U500 strength originally, but took over continuing her medications after she came from the rehabilitation facility and the restrictions of coronavirus interfered with the resident seeing her diabetic specialist.
-When the pharmacy sent Resident #4's Humulin R U500 insulin in January 2021, they sent the insulin in a vial.
-She was not familiar with the U500 strength in a vial; therefore she did not ask staff how they were administering the medication.
-She called the pharmacy on 03/17/21 to switch the resident back to Humulin R U500 Kwikpen for accurate measurement of the dose.

Telephone interview with a representative from the facility's contracted pharmacy on 03/17/21 at 3:00pm revealed:
-The pharmacy began providing medication services in early December 2020.
-The pharmacy did not routinely stock insulin in the U500 concentration, but ordered it for Resident #4 when the pharmacy took over providing medications for the facility's residents. They had not dispensed vials of U500 vial strength before.
-The pharmacy sent the first vial of Humulin R U500 insulin on 01/08/21.
-The pharmacy did not send special U500 strength insulin syringes with the insulin because the facility did not request the syringes.
-The facility did not request any kind of in-service for the Humulin R U500 strength insulin in a vial.
-There was no documentation the facility contacted the pharmacy for information or administration instructions when the insulin switched from the Kwikpen to the vial.

Interview with Resident #4 on 03/17/21 at 3:34pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034069	A. BUILDING: _____ B. WING _____	R 03/19/2021

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 8	D 358		

revealed:
-She refused Humulin R U500 "most of the time" because she was afraid her blood sugar would go too low and she would get shaky and clammy.
-She was given some orange juice when her sugar got too low.
-She could not recall the last time her sugar was low enough to need orange juice but did recall she did not like "that feeling".
-She had another type of insulin she was supposed to be administered at lunch if her FSBS was high.
-She did not "usually refuse that insulin shot".
-She could not recall if the insulin was in a dose pen or in a regular syringe.

Interviews with the Executive Director (ED) on 03/17/21 at 1:15pm and 4:15pm revealed:
-She filled in on the medication cart a lot due to staff shortage.
-All residents had pre-filled insulin pens for measuring and administering insulin except Resident #4 had received an insulin vial in January 2021 after the resident had been in the hospital and then in a rehabilitation facility and returned to the facility.
-The facility had changed pharmacy providers in December 2020 just prior to Resident #4's hospitalization and she was certain Resident #4 had a Humulin R U500 Kwikpen for administering her Humulin R insulin.
-She used the same type of insulin syringe as she used with U 100 insulin and measured the units the same by drawing up 100 units in one syringe and 25 units in a second syringe.
-Resident #4 routinely refused her Humulin R U500 insulin as was documented on the eMARs.
-Sometimes Resident #4 allowed the ED to give her a partial dose of Humulin R U500 which she documented in the eMAR care notes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034069	A. BUILDING: _____ B. WING _____	R 03/19/2021

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 9	D 358		

-She had administered the entire dose drawn in the 2 syringes at least one time.
-She did not know why the contracted pharmacy did not alert the facility for the U500 insulin syringes required to be used to administer the correct dose.
-She consulted with Resident #4's PCP (who was at the facility this day) and sent an order to the contracted pharmacy for Humulin R U500 Kwikpen.
-Resident #4's vials of Humulin R U500 were removed from access by MAs for administration while awaiting return to the contracted pharmacy.

Telephone interview with a representative from the previous contracted pharmacy on 03/18/21 at 9:26am revealed:
-Resident #4 had an order for Humulin R U500 Kwikpen dated 10/15/20.
-The pharmacy dispensed 2 Humulin R U500 Kwikpens on 10/15/20 each containing 3 milliters (mls).
-The pharmacy dispensed 2 Humulin R U500 Kwikpens with directions of 120 units SQ twice a day on 11/08/20 with 3 mls in each Kwikpen.
-The pharmacy stopped providing medications to the facility at the end of November 2020.

Telephone interview with a MA on 03/18/21 at 1:39pm revealed:
-She used the syringes stored in the medication cabinet to administer Humulin R U500 to Resident #4.
-Resident #4 was the only resident in the facility who used syringes to administer insulin.
-The syringe used to administer Humulin R U500 was a regular syringe with an orange cap and the syringe held 100 units of insulin.
-When she administered Humulin R U500 to Resident #4, she filled 1 syringe with 100 units

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034069	A. BUILDING: _____ B. WING _____	R 03/19/2021

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 10	D 358		

and a filled a second syringe with 25 units.
-No one provided training or instructions on how to draw up insulin for Humulin R U500 because she had already received diabetic training.
-She received diabetic care training in November 2020 which consisted of watching a video and completed return demonstration with a Registered Nurse (RN).

Telephone interview with a second MA on 03/18/21 at 1:56pm revealed:
-She had not been given any instructions on how to administer Humulin R U500 to Resident #4.
-She had not seen any special syringes.
-She asked Resident #4 if she wanted to take Humulin R prior to administration and Resident #4 refused Humulin R each time she asked her.
-She remembered having training on diabetic care, but she did not remember when.

Telephone interview with the RCC on 03/18/21 at 2:17pm revealed:
-She used the syringes that were in the cabinet in the medication room.
-The syringes would hold 100 units so she measured 100 units of insulin and would use a second syringe for 25 more units to total 125 units.
-She never saw any special syringes. At one time the pharmacy was sending a pen for Resident #4.
-She did not know there should have been a special syringe for the Humulin R U500.
-There had been no training provided to her or the MAs regarding administration of Humulin R U500.
-She did not know initially Humulin R had been changed from the pen to the vial.
-She became aware of the change from the pen to the vial of insulin after the facility ran out of pens, but she did not remember when.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034069	A. BUILDING: _____ B. WING _____	R 03/19/2021

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 11	D 358		

-She did not contact the pharmacy to ask why the pen changed to vial.
-She had received diabetic care training at another facility 2 to 3 years ago.

Telephone interview with Resident #4's PCP on 03/19/21 at 11:00am revealed:
-She was concerned if Resident #4 received 5 times the dose of Humulin R U500, the resident could suffer from hypoglycemia, including diabetic coma.
-She did not know of any instance when a low blood sugar episode was reported to her for Resident #4.
-She usually requested Resident #4's eMARs to review when she saw the resident on her routine visits.
-She had not seen alarming low FSBS on the eMARs.

b. Review of Resident #4's hospital discharge summary dated 12/17/20 revealed there was an order for Humalog 100unit/ML inject 5 units into the skin 3 times daily as needed for fingerstick blood sugars (FSBS) greater than 450.

Review of Resident #4's physician's orders dated 01/05/21 revealed check FSBS before meals and at bedtime.

Review of Resident #4's physician's orders dated 01/13/21 revealed an order for Novolog (a rapid acting insulin used to lower blood sugar levels) 100 units/ML inject 5 units 3 times daily as needed for FSBS greater than 450.

Review of Resident #4's January 2021 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for FSBS three times daily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034069	A. BUILDING: _____ B. WING _____	R 03/19/2021

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 12	D 358		

and at bedtime scheduled for 7:30am, 11:30am, 4:30pm, and 8:00pm.
-There was an entry for Humalog 100 units/ML pen inject 5 units 3 times a day as needed for FSBS over 450 with administration times of 7:00am, 11:30am, and 5:00pm.
-There was documentation Resident #4 refused Humalog 33 times between 01/06/21 and 01/31/21 when her FSBS was less than 450, but Humalog should not have been offered per Resident #4's physician's order to administer Humalog as needed for FSBS over 450.
-There was documentation Resident #4 was administered Humalog 24 times between 01/06/21 and 01/31/21 when her FSBS was less than 450 and ranged from 152 to 381.

Review of Resident #4's February 2021 eMAR revealed:
-There was an entry for FSBS three times daily and at bedtime scheduled for 7:30am, 11:30am, 4:30pm, and 8:00pm.
-There was an entry for Humalog 100 units/ML pen inject 5 units 3 times a day as needed for FSBS over 450 with as needed administration times of 7:00am, 11:30am, and 5:00pm from 02/01/21 through 02/21/21 and administration times of 6:30am, 11:30am, and 5:00pm from 02/22/21 through 02/28/21.
-There was documentation Resident #4 refused Humalog 14 times between 02/01/21 and 02/28/21 when her FSBS was less than 450, but Humalog should not have been offered per Resident #4's physician's order to administer Humalog as needed for FSBS over 450.
-There was documentation Resident #4 was administered Humalog 62 times between 02/01/21 and 02/28/21 when her FSBS was less 450 and ranged from 59 to 445.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034069	A. BUILDING: _____ B. WING _____	R 03/19/2021

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D 358	Continued From page 13 Review of Resident #4's March 2021 eMAR revealed: -There was an entry for FSBS three times daily and at bedtime scheduled for 7:30am, 11:30am, 4:30pm, and 8:00pm. -There was an entry for Humalog 100 units/ML pen inject 5 units 3 times a day as needed for FSBS over 450 with as needed administration times of 6:30am, 11:30am, and 5:00pm. -There was documentation Resident #4 refused Humalog 13 times between 03/01/21 and 03/16/21 when her FSBS was less than 450, but Humalog should not have been offered per Resident #4's physician's order to administer Humalog as needed for FSBS over 450. -There was documentation Resident #4 was administered Humalog 31 times between 03/01/21 and 03/16/21 when her FSBS was less than 450 and ranged from 118 to 411. Observation of the medication available for administration for Resident #4 on 03/17/21 at 6:00pm revealed: -There was 1 pen of Humalog on the medication cart for Resident #4. -There was a medication box containing 1 pen of Humalog for Resident #4 in the refrigerator in the medication room. -The box was labeled Humalog 100 units/ML inject 5 units 3 times daily as needed for FSBS over 450. -There were 5 prefilled pens of Humalog dispensed to the facility on 01/08/21. Interview with a representative from the facility's contracted pharmacy on 03/19/21 at 9:11am revealed: -There was an active order for Humalog 100 units/ML 5 units 3 times daily as needed FSBS greater than 450.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034069	A. BUILDING: _____ B. WING _____	R 03/19/2021

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D 358	Continued From page 14 -Humalog was dispensed to the facility on 01/08/21 in the quantity of 5 pens with 3 mL each. Interview with Resident #4 on 03/17/21 at 3:32pm revealed: -Staff was supposed to administer 5 units of Humalog when her FSBS was over 450. -Staff told her what her FSBS was when they checked it and it was not regularly over 450. -Staff offered her Humalog, but she did not know how many times a day. -She refused Humalog "sometimes," but she "usually" took it when it was offered to her even when her FSBS was less than 450. -There were times, after she was administered Humalog and her other insulin, where she felt like her blood sugar was dropping low. -She felt shaky when her blood sugar dropped low. Interview with the Resident Care Coordinator (RCC) on 03/17/21 at 12:29pm revealed: -She did not know medication aides (MA) were administering Humalog when Resident #4's FSBS was below 450. -New MAs were trained by a more experienced MA and if the MA needed additional training, the MA would go to the Executive Director (ED). -She was responsible for reviewing eMARs for accuracy of medication administration. -She had not completed an eMAR audit since she started working as RCC in November 2020. Telephone interview with a MA on 03/18/21 at 1:39pm revealed: -If Resident #4's FSBS was over 350, sometimes the resident would ask for Humalog. -She administered Humalog to Resident #4 when her FSBS was less than 450, but over 350 because she refused to take her short acting	D 358		

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	HAL034069	A. BUILDING: _____ B. WING _____	R 03/19/2021

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D 358	Continued From page 15	D 358		

insulin (Humulin R).
-No one instructed her to administer Humalog to Resident #4 when her FSBS was less than 450.
-She had not followed up with Resident #4's Primary Care Provider (PCP) to let her know Resident #4 requested Humalog when her FSBS was less than 450 and the Humalog was administered to Resident #4 when her FSBS was less than 450.
-She did not tell the RCC, but the RCC knew Humalog was being administered to Resident #4 when her FSBS was less than 450.

Telephone interview with a second MA on 03/18/21 at 1:56pm revealed:
-Resident #4 had an order for Humalog 5 units 3 times daily as needed for FSBS greater than 450.
-She administered Humalog to Resident #4 when her FSBS was greater than 450.
-She asked Resident #4 if she wanted to take the Humalog when her FSBS was "high," greater than 300 just to see what her preference was.
-She knew that Humalog lowered FSBS, so she did not want Resident #4's FSBS to get too high after eating lunch or dinner.
-No one had instructed her to administer Humalog to Resident #4 when her FSBS was less than 450.
-She had not contacted Resident #4's PCP to let her know Humalog was being administered to Resident #4 when her FSBS was less than 450 because she did not know she needed to.

Interview with the RCC on 03/18/21 at 2:17pm revealed:
-Humalog was dispensed to the facility in the pen form.
-She double checked the amount that was supposed to be given, then dialed up the proper amount.

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	HAL034069	A. BUILDING: _____ B. WING _____	R 03/19/2021

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D 358	Continued From page 16 -Humalog was supposed to be administered when the Resident #4's FSBS was over 450. -She had administered Humalog to Resident #4 when she asked for it even if her blood sugar was under 450. -She did not know to tell Resident #4's PCP about Resident #4 asking for Humalog when her FSBS was below 450. -She did not know she should have followed up with Resident #4's PCP about administering medication to Resident #4 when it was below the parameter of 450. -She was responsible for following up with Resident #4's PCP. -She did not tell medication aides to administer Humalog when Resident #4's FSBS was below 450. -She did not know MAs were administering Humalog when Resident #4's FSBS was below 450. Interview with Resident #4's PCP on 03/17/21 at 12:33pm revealed: -She did not know Resident #4 was being administered Humalog when her FSBS was less than 450, although staff did make her aware Resident #4 refused Humalog at times. -She had concerns with the Humalog being administered when it should not have been and expected staff to only administer Humalog when Resident #4's FSBS was less than 450. -Administering Humalog to Resident #4 when her FSBS was less than 450 could cause hypoglycemia. -Staff had not made any reports to her regarding Resident #4 having signs or symptoms of hypoglycemia. Interview with the ED on 03/17/21 at 3:46pm revealed:	D 358		

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	HAL034069	A. BUILDING: _____ B. WING _____	R 03/19/2021

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D 358	Continued From page 17 -She did not know Resident #4 was administered Humalog when her FSBS was less than 450. -The RCC was responsible for reviewing the eMARs for accuracy of medication administration. -The RCC was responsible for training MAs prior to the MAs working independently. Interview with the ED on 03/19/21 at 11:05am revealed: -She did not know MAs were administering Humalog to Resident #4 when she asked for Humalog even when her FSBS was below the parameter of 450, until a MA told her on 03/18/21. -The MA told the ED she administered Humalog to Resident #4 when her FSBS were below 450 on days when she refused her short acting insulin (Humulin R). -She expected the RCC to follow-up with Resident #4's PCP regarding administration of Humalog outside of the parameters. _____ The facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (Resident #4) who has a diagnosis of diabetes type II and was administered the incorrect dose of Humulin R due to the facility not using the appropriate syringe (Administering Humulin R insulin 500 units per ml using insulin syringes calibrated for 100 units per ml resulting in receiving 5 times the prescribed amount of insulin for 10 doses documented as administered in January 2021, 27 doses documented as administered in February 2021, and 8 doses documented as administered in March 2021). The resident also had a physician's order for Humalog to be administered 3 times daily as needed when her FSBS was greater than 450, but staff administered Humalog to Resident #4 when her FSBS was less than 450. Failure to administer Resident #4's Humalog as ordered	D 358		

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D 358	Continued From page 18 and not using the correct syringe to administer Humulin R placed the resident at increased risk of hypoglycemia. The facility's failure placed the resident at substantial risk of physical harm and constitutes an Unabated Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/24/21 for this violation.	D 358		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure 1 of 5 residents sampled (#3) had an order to self-administer an emergency inhaler medication. The findings are: Review of Resident #3's current FL-2 dated	D 375		

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D 375	Continued From page 19 12/17/20 revealed diagnoses included chronic obstructive pulmonary disease (COPD), dementia, hypertension, gastroesophageal reflux, osteoporosis, congestive heart failure, seasonal allergies, rhinitis, and hiatal hernia. Review of Resident #3's signed physicians' orders dated 03/10/21 revealed there was an order for Advair (used to treat COPD) 250/50 Diskus inhale 1 puff twice daily. Review of Resident #3's electronic Medication Administration Records (eMARs) for January 2021, February 2021 and March 2021 revealed there was not an entry for Advair HFA 115/21. Observation of Resident #3's room on 03/16/21 at 9:35am revealed: -There was an Advair HFA 119/25 inhaler (used to treat asthma) on Resident #3's night stand. -The counter on the Advair-HFA inhaler indicated 39 doses remained available for administration. Interview with Resident #3 on 03/16/21 at 9:35am revealed: -She had COPD and used an emergency inhaler to aide her breathing when she experienced shortness of breath. -She kept the inhaler on her nightstand in her room. Second interview with Resident #3 on 03/16/21 at 2:57pm revealed: -She used the Advair inhaler she kept on her nightstand at least once a day. -She inhaled 2 puffs when she used the inhaler. -She only used the inhaler when she had shortness of breath. -She did not know how long she had the inhaler.	D 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 375	Continued From page 20	D 375		

Telephone interview with Resident #3's family member on 03/18/21 revealed:
-Resident #3 had a small purple inhaler she used when she felt out of breath; she did not know what the name of the inhaler was.
-She thought Resident #3 kept the inhaler with her when she was admitted into the facility in August 2020.

Telephone interview with the Pharmacist from the facility's contracted pharmacy on 03/17/21 at 3:40pm revealed:
-Resident #3 did not have an active order for an Advair HFA 115/21 inhaler.
-The pharmacy had not dispensed an Advair HFA inhaler for Resident #3.

Interview with the Resident Care Coordinator (RCC) on 03/17/21 at 11:58am revealed:
-She worked as a medication aide (MA) and was familiar with Resident #3 and her medications.
-Resident #3 had a ProAir inhaler that was kept on the medication cart and was PRN (as needed) for shortness of breath.
-She did not know of another inhaler in Resident #3's room on the nightstand; she was not aware of any self-administration orders for Resident #3.
-She was concerned Resident #3 would use the inhaler and then forget she had used it and reuse it again in less than an hour.

Interview with Resident #3's primary care provider (PCP) on 03/17/21 at 11:39pm revealed:
-She had seen the Advair HFA 115/21 inhaler on Resident #3's nightstand the week before on 03/10/21.
-Resident #3 told her it was only for her to use when she could not breath and she only used it once a day.
-She did not know Resident #3 had an Advair

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D 375	Continued From page 21 HFA 115/21 inhaler because she did not order it. -Resident #3 must have had the inhaler before she became her patient; the resident did not tell her where it came from. -She told Resident #3 she could keep the inhaler until it was empty. -She would not give Resident #3 an order to self-administer the inhaler because she did not write the order for the inhaler and she would not answer whether Resident #3 could self-administer the inhaler on her own. -She ordered Resident #3 an Advair Diskus 225/50 on 03/10/21; she wanted the MA to administer the Advair Diskus to Resident #3. -The Executive Director (ED) was aware Resident #3 had the inhaler in her room because the ED was with her when she discovered it. Telephone interview with the ED on 03/19/21 at 11:10am revealed: -The facility had a policy for self-administration of medications. -She knew the resident had to have the PCP agree to a self-administration order because the resident would have to demonstrate the ability to self-administer the medication. -She was aware Resident #3 had an inhaler; she had found out just the week before when she overheard Resident #3 and the PCP discussing the inhaler. -Resident #3 must have had the inhaler when she was admitted into the facility and no one knew about it. -The PCP was going to allow Resident #3 to continue to use the inhaler. -She was aware Resident #3 needed a self-administration order for the inhaler. -She would remove the inhaler from Resident #3's room.	D 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 392	Continued From page 22	D 392		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure records of the receipt and administration of controlled substances were maintained, accurate and reconciled for 1 of 3 sampled residents (Resident #4) which orders for controlled substances. The findings are: Review of Resident #4's current FL-2 dated 01/05/21 revealed diagnoses included bipolar disorder, and type 2 diabetes without complications. a. Review of Resident #4's medication orders revealed an order dated 01/07/21 for clonazepam (used to treat anxiety) 0.5mg one tablet 2 times a day as needed for anxiety. Telephone interview with a pharmacist at the contracted pharmacy on 03/17/21 at 4:10 pm revealed: -On 01/07/21, the pharmacy dispensed 60 tablets of Resident #4's clonazepam 0.5mg with directions to take one tablet 2 times a day as needed for anxiety.	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 392	Continued From page 23 -The pharmacy routinely sent controlled substance count sheets (CSCS) to be used by the facility to track administration of the medication. Review of Resident #4's CSCS for clonazepam 0.5mg dispensed on 01/07/21 compared to the January 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for clonazepam 0.5mg with instructions to take one tablet 2 times a day, as needed for anxiety on the eMAR. -On 01/20/21 at 9:00 (no am or pm documented), one clonazepam 0.5mg tablet was signed out on the CSCS with no documentation for administration of clonazepam 0.5mg on 01/20/21 on the eMAR. -On 01/24/21 at 12:00pm, one clonazepam 0.5mg tablet was signed out on the CSCS with no documentation for administration of clonazepam 0.5mg on 01/24/21 at 12:00pm on the eMAR. -On 01/25/21 at 12:00pm, one clonazepam 0.5mg tablet was signed out on the CSCS with no documentation of administration of clonazepam 0.5mg on 01/25/21 at 10:00pm on the eMAR. -On 01/28/21 at 9:00am and at 9:00pm, there was a dose of clonazepam 0.5mg signed out on the CSCS with no documentation for administration of clonazepam 0.5mg on 01/28/21 at 9:00am or 9:00pm on the eMAR. -The remaining count on the CSCS of 19 tablets matched the quantitiy on hand. Interview with Resident #4 on 03/17/21 at 3:34pm revealed she did not know all her medications by name, but thought staff gave her medications as ordered. Refer to the telephone interview with the Resident Care Coordinator (RCC) on 03/19/21 at 3:53pm.	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 392	Continued From page 24 Refer to the telephone interview with the Executive Director on 03/19/21 at 4:15pm. b. Review of Resident #4's electronic physician order dated 01/13/21 revealed an order for hydrocodone-acetaminophen 5/325mg (used to treat mild to moderate pain) one-half tablet 3 times a day. Telephone interview with a pharmacist at the contracted pharmacy on 03/17/21 at 4:10 pm revealed: -The pharmacy routinely sent controlled substance count sheets (CSCS) to be used by the facility to track administration of the medication. -On 01/16/21, the pharmacy dispensed 60 doses of Resident #4's hydrocodone-acetaminophen 5/325mg with directions to take one-half tablet 3 times a day for pain. (All tables were accouted for from 01/18/21 to 02/08/21.) -On 02/11/21, the pharmacy dispensed 30 doses of Resident #4's hydrocodone-acetaminophen 5/325mg with directions to take one-half tablet 3 times a day for pain. (All tablets were accounted for from 02/11/21 to 02/22/21). -On 02/22/21, the pharmacy dispensed 90 doses of Resident #4's hydrocodone-acetaminophen 5/325mg with directions to take one-half tablet 3 times a day for pain. (All tablets were accounted for from 02/23/21 to 03/17/21 with 26 of one-tablets remaining on hand and on the CSCS sheet.) Review of Resident #4's CSCS for hydrocodone-acetaminophen 5/325mg dispensed on 01/16/21 compared to the January 2021 and February 2021 electronic Medication Administration Record (eMAR) revealed:	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034069	A. BUILDING: _____ B. WING _____	R 03/19/2021

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 392	Continued From page 25 -There was an entry for Resident #4's hydrocodone-acetaminophen 5/325mg with directions to take one-half tablet 3 times a day for pain scheduled for administration at 9:00am, 12:00pm, and 4:00pm on the eMAR. -On 01/25/21 at 8:00am, one-half hydrocodone-acetaminophen 5/325mg tablet was not signed out on the CSCS but was documented as administered on the eMAR on 01/25/21 at 8:00am. -On 01/28/21 at 4:00pm, there was a dose of one-half hydrocodone-acetaminophen 5/325mg tablet documented as refused on the eMAR, but there was a dose of one-half hydrocodone-acetaminophen 5/325mg tablet on 01/28/21 at 4:00pm on the eMAR. -On 02/01/21 at 4:00pm, one-half hydrocodone-acetaminophen 5/325mg tablet was documented as administered on the eMAR but was not signed out on the CSCS on 02/01/21 at 4:00pm. Review of Resident #4's CSCS for hydrocodone-acetaminophen 5/325mg dispensed on 02/11/21 and 02/22/21 compared to the February 2021 eMAR revealed: -There was an entry for Resident #4's hydrocodone-acetaminophen 5/325mg with directions to take one-half tablet 3 times a day for pain scheduled for administration at 9:00am, 12:00pm, and 4:00pm on the eMAR. -On 02/14/21 at 4:00pm, one-half hydrocodone-acetaminophen 5/325mg tablet was documented as administered on the eMAR but was not signed out on the CSCS on 02/14/21 at 4:00pm. -On 02/24/21 at 4:00pm, one-half hydrocodone-acetaminophen 5/325mg tablet was documented as administered on the eMAR but was not signed out on the CSCS on 02/24/21 at	D 392		

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D 392	Continued From page 26 4:00pm. -On 02/26/21 at 4:00pm, one-half hydrocodone-acetaminophen 5/325mg tablet was documented as administered on the eMAR but was not signed out on the CSCS on 02/26/21 at 4:00pm. Interview with Resident #4 on 03/17/21 at 3:34pm revealed she did not know all her medications by name, but thought staff gave her medications as ordered. Refer to the telephone interview with the Resident Care Coordinator (RCC) on 03/19/21 at 3:53pm. Refer to the telephone interview with the Executive Director on 03/19/21 at 4:15pm. _____ Telephone interview with the Resident Care Coordinator (RCC) on 03/19/21 at 3:53pm revealed: -She was responsible for ensuring medications were administered as ordered including accurate accounting for controlled medications. -Medication Aides (MAs) were reconciling controlled medications on hand compared to the CSCS between each shift change. -There was not currently a system in place for her to routinely audit residents' eMAR documentation compared to the CSCS documentation for each controlled medication. -She was careful to ensure all controlled medications removed from the narcotic lock drawer were documented on the corresponding CSCS log to make sure there was an accurate inventory tracking; however she may have been distracted or interrupted in the process of documenting into the eMAR system on at least one occasion. -There were times when she may have been	D 392		

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D 392	Continued From page 27 interrupted during medication passes having given routine medications but not prepared the controlled medication from the locked drawer. -She documented the resident received all their medications on the eMAR. -She did not know of a specific time this occurred, but there could have been an instance. Telephone interview with the Executive Director (ED) on 03/19/21 at 4:15pm revealed: -The RCC was responsible for ensuring medications were administered as ordered, and available for administration, including accurate accounting for controlled medications. -The MAs were responsible for completely documenting controlled substances on the CSCS. -When a MA signed out a controlled substance, they were to write the date, time, amount given, amount left and sign the entry on the CSCS. -If the entry on the CSCS was lacking any information it was not complete accounting of the controlled substance.	D 392		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure residents received care and services necessary to maintain the residents health, safety, and welfare as related to medication administration.	D912		

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D912	Continued From page 28 The findings are: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 1 of 5 sampled residents (Resident #4) related to incorrectly administering a short acting insulin (Humulin R) and a rapid acting insulin (Novolog). [Refer to Tag 0358, 10A NCAC 13F .1004(a) Medication Administration (Uabated Type A2 Violation)].	D912		