Rec'd via Email on 7-28-21 from Provider. [illegible]

Division of Health Service Regulation

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-C 06/21/2021

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 and annual and follow-up survey, and a complaint investigation on June 16, 2021 to June 18, 2021 with an exit conference via telephone on June 21, 2021.	D 000		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure physician orders were implemented for 1 of 5 sampled residents (#5) with daily weights. The findings are: Review of Resident #5's current FL2 dated 05/06/2021 revealed: -Diagnoses included anasarca, arthritis, asthma, atrial fibrillation, cellulitis, chest pain, congestive heart failure, chronic atrial fibrillation, and chronic	D 276	See attached page form for POC HD	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] 7/28/21 | TITLE | (X6) DATE

STATE FORM 6899 53U511

Received and Acknowledged 8/2/21 [illegible]

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D 276	Continued From page 1 obstructive pulmonary disease. -There was an order for Bumex (used to treat fluid retention) 1mg twice a day. Review of Resident #5's patient summary with the Cardiologist on 05/17/21 revealed: -Diagnoses included chronic atrial fibrillation, left ventricular hypertrophy, morbid obesity, type 2 diabetes mellitus with hyperglycemia with chief complaint of atrial fibrillation. -Weight of 278 pounds upon discharge from the hospital was documented on 05/07/21. -Resident #5 was ordered daily weight and administer additional Bumex 1mg daily for weight gain of 3 pounds in 24 hours or 5 pounds in a week. -Resident #5 was to follow up with the Cardiologist in one month. Review of Resident #5's patient summary following an appointment with the Cardiologist on 06/14/21 revealed: -Fluid status had worsened. -Bumex was increased to 2mgs twice a day. -Weight during this visit was 290 pounds. -The resident had only one documented weight on his paperwork from the facility. -Resident #5 reported he had not been weighed at the facility. Review of Resident #5's electronic medication administration record (eMAR) for May 2021 revealed weights were obtained for Resident #5 for 4 of 31 opportunities; 05/20/21-285 pounds, 05/22/21-285 pounds, 05/23/21-285 pounds, 05/27/21-285 pounds. Review of Resident #5's eMAR for June 2021 revealed no weights had been documented on Resident #5.	D 276		

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D 276	Continued From page 2	D 276		

Interview with the medication aide (MA) on 06/18/21 at 9:06am revealed:
-Weights were obtained every morning and documented on the eMAR.
-If there was no place on the eMAR to document the weight, she wound document in the notes section of eMAR.
-She did not know why the weights she recorded on the eMAR were not showing up on computer, or being printed.
-She had not administered an extra dose of Bumex to Resident #5.

Interview with another MA on 06/18/21 at 9:08am revealed:
-She documented weights on the eMAR.
-She did not know why they could not be seen.
-She had not given an extra dose of Bumex to Resident #5.

Interview with the Resident Care Coordinator (RCC) on 06/17/21 at 9:00am revealed:
-All weights were documented on the eMAR.
-There were no scales in Resident #5's room.

Interview with the RCC on 06/18/21 at 9:28am revealed:
-There were scales in the facility.
-She was going to purchase scales for Resident #5's bathroom.

Interview with Resident #5 on 06/18/21 at 9:10am revealed:
-He had not been weighed by the staff.
-He had been weighted at the Cardiologist office on 06/14/21.
-His weight was 290 pounds on Monday, 06/14/21 when he was seen by the Cardiologist.
-He did not recall receiving any additional

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D 276	Continued From page 3 dosages of Bumex. Telephone interview with the triage nurse at the Cardiologist office on 06/18/21 at 3:30pm revealed: -Resident #5 was seen in the office on 05/17/21 and 06/14/21 for follow-up since the hospitalization on 05/01/21. -Resident #5 needed daily weights due to fluid overload. -He had an order for additional Bumex if needed related to daily weight. -If weight increased and he did not receive additional Bumex he could be hospitalized again or could die due to fluid overload. -He should return to the Cardiologist again in three weeks.	D 276		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to serve therapeutic diets as ordered by the physician for 1 of 2 sampled residents (Resident #6) who had a diet order for a mechanical soft (MS) consistency.	D 310	See Attached Plan of Correction	

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D 310	Continued From page 4	D 310		

The findings are:

Review of Resident #6's current FL2 dated 02/12/21 revealed:
-Diagnoses included dementia, altered mental status, laryngeal mass, dysphagia, pharyngeal dysphagia and right-side weakness.
-There was a diet order for consistent carbohydrate diet.

Review of Resident #6's diet orders revealed:
-There was a diet order for MS diet and nectar thick liquids dated 05/07/21.
-There was a diet order for MS diet and nectar thick liquids dated 04/30/21.

Review of the "Resident Diet Chart" posted in the kitchen on 06/16/21 revealed Resident #6 was to be served a MS diet with nectar thick liquids.

Review of the therapeutic menu for residents with a MS diet revealed:
-The lunch meal served today (06/06/21), was to consist of ground baked ham, macaroni & cheese, green peas, wheat dinner roll or bread, berry crisp, milk and beverage of choice.

Observation of Resident #6's lunch meal served on 06/06/21 at 12:43pm revealed:
-Resident #6's meal served in the resident's room.
-Resident #6 ate his meal while sitting in the bed.
-Resident #6's meal consisted of chopped ham, that was cut in ¼ inch to 1-inch oblong and square pieces, macaroni & cheese, green peas, applesauce and nectar thick tea.
-Resident #6 did not receive feeding assistance but independently fed himself.
-Resident #6 consumed 100% of the meal without difficulty.

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D 310	Continued From page 5 Interview with Resident #6 on 06/16/21 at 1:10pm revealed: -He was always served meats that were chopped as they were today. -He did not know when or if he was ordered chopped meats or any other specialty diet. -He took his time chewing his food and did not have difficulty consuming the chopped meats. -In the past he had difficulty when consuming certain foods but recently he had no problems. -He was unable to recall how long it was when he had difficulty swallowing certain foods. Telephone interview with a representative from the Hospice agency on 06/17/21 at 4:16pm revealed: -Resident #6 became a Hospice patient in December 2020. -Staff reported that Resident #6 started declining and his intake of food was poor with difficulty swallowing. - Resident #6 was ordered a MS diet with nectar thick liquids. -On 04/20/21, it was reported to Hospice by facility staff that Resident #6 got choked and strangled when consuming a grilled cheese sandwich. -There was an order dated 04/30/21 to continue the MS diet with nectar thick liquids. -There was a current order dated 05/07/21 for a MS diet with nectar thick liquids. Interview with the cook on 06/16/21 at 12:43pm revealed: -She prepared Resident #6's meal. -She had never ground the meat for Resident #6's meal. -When she started working at the facility, she was told to chop Resident #6's "food up."	D 310		

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D 310	Continued From page 6 -The previous cook trained her how to prepare MS diets by chopping the meats. -She was aware the facility had menus, but she did not use the menu when preparing Resident #6's meal. Interview with Resident #6's Primary Care Provider (PCP) on 06/18/21 at 1:52pm revealed: -Resident #6 had a modified barium swallow study last year. -The results showed Resident #6 had difficulty swallowing on a regular diet. -The speech therapist recommended a MS diet due to swallowing difficulty. -Based on the results of the modified barium swallow study and the therapist recommendations she ordered Resident #6 a MS diet with nectar thick liquids. -She expected Resident #6 to be served the MS diet as ordered. Interview with the Administrator on 06/16/21 at 1:05pm revealed: -She was not aware Resident #6's diet was not being served as ordered. -She expected the cooks to serve meals as ordered. -Currently, the facility did not have a dietary manager to observe meals prepared by the cook to ensure they were served as ordered.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.	D 338		

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D 338	Continued From page 7	D 338		

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observation, record review and interviews, the facility failed to ensure residents were treated with respect, consideration, and dignity as related to vaccinated residents being required to wear face masks when not in their room and not being allowed to leave the facility.

The findings are:

Review of the facility's updated COVID-19 policy dated 05/14/21 revealed:
-Residents may dine and participate in activities without face coverings or social distancing.
-The facility should conduct a risk assessment taking into consideration the activity of the resident while visiting off campus. Elements to consider in this risk assessment include:
-COVID-19 transmission (i.e., county positivity rate) in the community that the resident will be visiting.
-The individual and community (known or perceived) adherence to infection control recommendation (3 W's/ wear, wait, wash).

Observation of staff and residents on 06/16/21 from 9:47am to 10:20am revealed:
-There was a resident walking in the hallway using her walker to ambulate, who did not have a face mask on.
-The resident approached the medication aide (MA) and asked for assistance with finding an item.
-The MA asked the resident where was her face mask and the resident did not respond.
-The MA walked away and returned with several face masks.

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-The MA handed the resident a face mask and told her to put the face mask on.
-There were two residents sitting in the common foyer living room area of the facility.
-One resident was sitting in a chair with her back to the wall.
-The second resident was on the opposite side of the foyer sitting on the seat of her rolling walker.
-Neither of the residents were wearing face masks.
-The MA approached each resident and handed them a face mask, saying they needed to wear a face mask when out of their room.
-The residents took the face masks and put them on.

Interview with the MA on 06/16/21 at 10:23am revealed:
-When she started working at the facility, the Administrator told all staff that residents were to wear face masks when out of their room.
-The Administrator told staff to remind residents to put a face mask on when in the hallway and common areas of the facility.
-Residents wore face masks to the dining room but took them off to eat.
-She thought most residents at the facility had received both COVID-19 vaccine injections.
-She did not know why residents still had to wear face masks.
-She did what she was instructed to do and that was remind residents to wear a face mask when out of their room.
-Some residents were not happy that they were required to wear face masks.
-Some residents were used to wearing the face mask and said nothing about being required to wear the face mask.
-The Administrator also told staff that residents were not allowed to leave the facility due to

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D 338	Continued From page 9 COVID-19. -Some residents complained about not being able to go out as they desired. -Residents could go out for extended periods of time only if they got prior approval from management. Confidential interview with an outside provider agency on 06/17/21 at 11:13am revealed: -She visited to the facility three to four times within the past couple of months. -The residents complained since they had received both COVID-19 vaccines and did not want to continue wearing face masks. -Some residents told her they were upset about still being required to wear a face mask. -One resident said they were told once they got vaccinated, they would not have to wear face mask anymore. -Residents reported they wanted to go out with family members and asked the Administrator about going out. -The Administrator told the residents "she was not changing until she received a phone call from the governor himself." -At least 10 different residents complained to her about not being able to go out of the facility and being continually made to wear face masks. Interview with a resident on 06/16/21 at 12:25pm revealed: -He had been vaccinated with both vaccines. -The resident wanted to go out of the facility because he liked being active. -He could not go out because the Administrator told him he could not go out because of COVID-19. -Not being allowed to go out made him feel angry and he was discussed when he was told that he could not go out.	D 338		

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Interview with a second resident on 06/16/21 at 12:26pm revealed:
-He had been vaccinated twice.
-He received the last vaccine two months ago.
-He asked to go out to eat on Sunday with a family member that came from out of town.
-The Administrator told him that he could not go out.
-He was "angry as [expletive] and depressed" that he was not allowed to go anywhere.

Interview with a third resident on 06/16/21 at 12:40pm revealed:
-Last week his family member got married and he was not allowed to go.
-The week prior to his family member's wedding another family member died, and he was not allowed to go out.
-The Administrator said he was not allowed to go out because the governor did not open assisted living homes back up yet.
-He also liked to walk and go to the store but was told he could not leave the facility.
-He had very bad anxiety and now his anxiety was "off the chain" because he was not allowed to go anywhere.

Interview with a fourth resident on 06/16/21 at 9:08am and 06/17/21 at 8:13am revealed:
-She received both vaccines, the last vaccine was administered two months ago.
-When she left her room, she always wore a face mask. She thought it was required by the Administrator.
-She knew that she had to wear her face mask, so she always put it on when she left the room.
-The Administrator told residents they were not allowed to leave the facility.
-She was unable to recall the exact date when the

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D 338	Continued From page 11 Administrator told the residents they were not allowed to leave the facility. Interview with a fifth resident on 06/16/21 at 9:18am revealed: -She had both COVID-19 vaccinations. -The Administrator told them they still had to wear face masks when not in their room. -She did not like wearing face masks when she was not in her room. -In March 2021, the Administrator said the residents could not visit anyone outside the facility. Interview with a sixth resident on 06/16/21 at 9:38am and 06/17/21 at 8:25am revealed: -She had both vaccines completed about two months ago. -Two weeks ago, in a meeting that was held in the common living area, the Administrator told all the residents that they had to continue to wear face masks when in the hallway and common areas. -The Administrator told the residents the only time they could take the face mask off was when they were in the backyard, in their room or when eating. -If she went out of her room without a face mask, the staff would tell her to put the face mask back on. -"We are not allowed to go out at all." -On the same date (two weeks ago) she asked to walk to the dollar store which was near the facility, and the Administrator told her it would be a long time before she could leave the facility. -The Administrator said assisted living facilities were still under restrictions by the governor, because he was afraid stray cases of COVID-19 would result due to some people not taking the vaccine.	D 338		

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Interview with a seventh resident on 06/17/21 at 8:41am revealed:
-Since COVID-19 started residents were told they had to wear face masks when not in their room.
-She had received both COVID-19 vaccines.
-The Administrator told the residents they had to wear face masks when not in their room.
-Some staff reminded residents they had to wear a face mask when out of their room.
-She knew the protocol, so she made sure to wear her face mask when she left her room.
-The Administrator told residents they were not allowed to leave the facility, so she did not ask to go out, and only went out to medical appointments.

Interview with an eighth resident on 06/16/21 at 4:25pm revealed:
-Since his admission in May 2021, residents were told they had to wear face masks when not in their room.
-He had received both COVID-19 vaccines.
-The Administrator told residents they had to wear face masks when not in their room.
-He made sure to wear his face mask when he left his room.
-He had asked to leave the facility to go to a restaurant for lunch with family and a friend at different times but was told by the Administrator that they must go through a drive-thru and bring the meal back and eat on the facility porch.

Interview with a ninth resident on 06/18/21 at 2:35pm revealed:
-Since the pandemic residents were told they had to wear face masks when in the hall.
-She had received both COVID-19 vaccines.
-The Administrator told residents they had to wear face masks when not in their room.

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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 338	Continued From page 13 -She had asked to leave the facility to go to the store, but the Administrator said she had to have a personal care aide (PCA) with her and there was no staff to accompany her. Interview with a tenth resident on 06/18/21 at 4:10pm revealed: -Since the pandemic started the residents were told they had to wear face masks when in the hall. -He had received both COVID-19 vaccines. -The Administrator told the residents they had to wear face masks when not in their room. -He had not asked to leave the facility because it was "understood" by residents that they could not leave the facility. -The Administrator recently, in the last 2 or 3 weeks, gave residents permission to go out to the facility porch. -He would like to go out to family cook outs and visit. Interview with a personal care aide (PCA) on 06/17/21 at 9:24am revealed: -When she started working at the facility she was told when residents were not in their room, they had to wear a face mask. -If she saw a resident in the hallway without a face mask, she reminded them to put their face mask on. -Some residents got upset and questioned why they still had to wear face masks when they had received both COVID-19 vaccines. -The Administrator also informed staff the residents were not allowed to leave the facility due to COVID-19. -Residents complained about not being able to come and go as they pleased. -She had not shared the residents' complaints with her supervisor or with the Administrator.	D 338		

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D 338	Continued From page 14 Interview with the Administrator on 06/16/21 at 3:59pm revealed: -The owner said residents should be asked to continue to wear a face mask. -Therefore, the facility's policy was to encourage residents to wear face masks continually because not 100% of all residents and staff had been vaccinated. -Several residents wanted to know when they could go out and about. -She did not say residents could not go out into the community, but they had to ask. -She did not know why residents believed they could not leave the facility. -If staff were telling the residents they could not leave she was not aware. The facility failed to ensure residents were treated with respect, consideration, and dignity by requiring residents to wear face masks and not allowing residents to leave the facility after residents had received both COVID-19 injections which resulted in the residents feeling depressed, anxious and angry. The facility's failure was detrimental to the health and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S.131D-34 on 06/16/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 6, 2021.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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D 358	Continued From page 15 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 A CONTINUING TYPE A2 VIOLATION Based on these findings, the Previously Unabated Type A2 Violation was abated. Non-compliance continues. TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 1 of 2 residents (#3) observed during the medication passes including errors with nebules for inhalation, an anxiety medication, a diuretic for fluid retention, and a medication for high blood pressure/rapid heat beat; and for 1 of 5 residents (#3) sampled for record review including errors in administration of insulin for fingerstick blood sugar within specified parameters. The findings are: 1. The medication error rate was 14% as evidenced by the observation of 4 errors out of 27 opportunities during the 8:00am medication pass on 06/17/21.	D 358	See Attached typewritten sheet for POC. HNS	

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D 358	Continued From page 16	D 358		

Review of Resident #3's current hospital discharge FL2 dated 05/14/21 revealed diagnoses included diabetes mellitus type 2, hypertension, tachycardia, and unspecified nonpsychotic mental disorder.

a. Review of Resident #3's hospital discharge summary dated 06/15/21 revealed a physician's order for Duoneb 0.5-3(2.5)mg/3ml (a combination of short and long acting bronchodilator used treat difficult breathing) contents of one nebule in nebulizer 3 times a day.

Observation of the 8:00am medication pass on 06/17/21 at 8:07am revealed:
-The medication aide (MA) prepared 13 oral medications, including a liquid for constipation, and an insulin injection.
-Duoneb was not included in the medications administered to Resident #3 at 8:00am.

Observation of medication on hand for administration for Resident #3 on 06/17/21 revealed a partial container of Duoneb 0.5-3(2.5)mg/3ml in the bottom drawer of the medication cart available for administration.

Review of Resident #3's June 2021 electronic medication administration record (eMAR) on 06/17/21 at 10:30am revealed:
-There was an entry for Duoneb 0.5-3(2.5)mg/3ml, nebulize one vial 3 times a day.
-Duoneb was scheduled for administration at 8:00am, 4:00pm and 8:00pm daily.
-The space for documenting administration of Duonebs was blank for 06/17/21 at 8:00am.

Interview with the MA (who administered Resident

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D 358	Continued From page 17 #3's during the 8:00am medication pass on 06/17/21) on 06/18/21 at 9:00am revealed: -She worked as a MA and a personal care aide (PCA). -She had only administered medications about one week. -She recalled Resident #3 had several medications to be administered on 06/17/21. -She thought she went through the eMAR slowly and administered all the medications listed on the eMAR. -She overlooked administering Resident #3's Duoneb 0.5-3(2.5)mg/3ml but was not sure why she did not see the nebules. Interview with the Administrator on 06/18/21 at 2:50pm revealed: -The MAs were responsible to administer medications as ordered on the eMAR. -The Resident Care Coordinator (RCC) was responsible for checking the eMARs to ensure medications were administered as ordered. Interview with the RCC on 07/17/21 at 4:45pm revealed the MAs should administered medications according to the eMAR. b. Review of Resident #3's hospital discharge summary dated 06/15/21 revealed a physician's order for escitalopram 10mg (used to treat depression), one tablet by mouth daily. Observation of the 8:00am medication pass on 06/17/21 at 8:07am revealed: -The medication aide (MA) prepared 13 oral medications, and an insulin injection. -Escitalopram 10mg was not included in the medications passed at 8:00am. Observation of medication on hand for	D 358		

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D 358	Continued From page 18 administration for Resident #3 on 06/17/21 revealed a partial bubble card of escitalopram 10mg labeled one tablet by mouth daily dispensed on 06/16/21 on the medication cart available for administration. Review of Resident #3's June 2021 electronic medication administration record (eMAR) on 06/17/21 at 10:30am revealed: -There was an entry for escitalopram 10mg one daily scheduled for administration at 8:00am. -The space for documenting administration of escitalopram 10mg was blank for administration on 06/17/21 at 8:00am. Interview with the MA (who administered Resident #3's during the 8:00am medication pass on 06/17/21) on 06/18/21 at 9:00am revealed: -She worked as a MA and a personal care aide (PCA). -She had only administered medications about one week. -She recalled Resident #3 had several medications to be administered on 06/17/21. -She thought she went through the eMAR slowly and administered all the medications listed on the eMAR. -She overlooked administering Resident #3's escitalopram 10mg but was not sure why she did not see the medication. Interview with the Administrator on 06/18/21 at 2:50pm revealed: -The MAs were responsible to administer medications as ordered on the eMAR. -The Resident Care Coordinator (RCC) was responsible for checking the eMARs to ensure medications were administered as ordered. Interview with the RCC on 07/17/21 at 4:45pm	D 358		

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D 358	Continued From page 19 revealed the MAs should administered medications according to the eMAR. c. Review of Resident #3's hospital discharge summary dated 06/15/21 revealed a physician's order for metoprolol 25mg (used to treat blood pressure and tachycardia), one-half (12.5mg) tablet daily. Review of Resident #3's previous medication orders dated 03/21/21 revealed there was an order for metoprolol 25mg one tablet daily. Observation of the 8:00am medication pass on 06/17/21 at 8:07am revealed: -The medication aide (MA) prepared 13 oral medications, and an insulin injection. -Metoprolol 25mg, one tablet (instead of one-half tablet) was included in the medications administered to Resident #3 at 8:00am. Review of Resident #3's June 2021 eMAR on 06/17/21 at 10:30am revealed: -There was an entry for metoprolol 25mg one daily scheduled for administration at 8:00am and documented as not administered at 8:00am from 06/01/21 to 06/15/21. -The reason documented for not administering metoprolol 25mg was out of facility. -There was an entry dated 06/15/21 for metoprolol 25mg take one-half tablet, equals 12.5mg, once daily. -Metoprolol 12.5mg was documented as administered at 8:00am on 06/17/21. Interview with the MA (who administered Resident #3's during the 8:00am medication pass on 06/17/21) on 06/18/21 at 9:00am revealed: -She worked as a MA and a personal care aide (PCA).	D 358		

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D 358	Continued From page 20 -She had only worked the medication cart about one week. -She recalled Resident #3 had several medications to be administered on 06/17/21. -She thought she went through the eMAR slowly and administered all the medications listed on the eMAR. -Medications were dispensed by the contracted pharmacy for a week supply in multidose plastics enclosures. -Resident #3's metoprolol 25mg one whole tablet was packaged from the contracted pharmacy along with other medications in one of the plastic enclosures dated for the day to be administered and the time of administration. -She overlooked metoprolol 25mg was changed from one tablet daily to one-half tablet daily on the eMAR. -She should have removed the metoprolol 25mg from the packet and split the tablet in half for the correct dose. Interview with Resident #3's primary care Nurse Pratitioner (NP) on 06/18/21 at 2:00pm revealed: -The NP received a phone call from Resident #3's home health agency on 06/17/21 regarding Resident #3's blood pressure being low at 90/70 with a pulse rate of 110. -Resident #3's blood pressure at today's visit (06/18/21) was 98/68 but she was not sure of the pulse rate. -She wanted to continue the medications as ordered on discharge from the hospital except metoprolol 25mg she wanted to start back to help control the heart rate. -She would write an new order for metoprolol 25mg daily on 06/18/21. Interview with the Administrator on 06/18/21 at 2:50pm revealed:	D 358		

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D 358	Continued From page 21 -The MAs were responsible to administer medications as ordered on the eMAR. -The Resident Care Coordinator (RCC) was responsible for checking the eMARs to ensure medications were administered as ordered. Interview with the RCC on 07/17/21 at 4:45pm revealed: -The MAs should administered medications according to the eMAR. -Resident #3's medications were dispensed by the contracted pharmacy. -Medications were dispensed by the contracted pharmacy for a week supply in multidose plastics enclosures dated for the day to be administered. -The medication enclosures were supposed to be compared to the physicians' orders for changes and discontinued medications. -The MA would be responsible to identify and remove any medication that was discontinued or changed from the multidose packaging (if needed to be corrected). -New medications that were ordered were sent in seperate containers until the next week's medication packets were shipped from the pharmacy, at which time the new medications should be included in the dated packets. -Orders were routinely entered by the contracted pharmacy, approved by the RCC or Administrator, and appeared for the MAs to administer. -The contracted pharmacy sent medication orders daily. d. Review of Resident #3's hospital discharge summary dated 06/15/21 revealed a physician's order to discontinue triamterene-hydrochlorthiazide 37.5-25mg (A combination diuretic used to reduce fluid retention and lower blood pressure).	D 358		

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D 358	Continued From page 22 Observation of the 8:00am medication pass on 06/17/21 at 8:07am revealed: -The medication aide (MA) prepared 13 oral medications, and an insulin injection. -Triamterene-hydrochlorthiazide 37.5-25mg one tablet was included in the medications administered to Resident #3 at 8:00am. Review of Resident #3's June 2021 eMAR on 06/17/21 at 10:30am revealed: -There was an entry for triamterene-hydrochlorthiazide 37.5-25mg one tablet daily scheduled for administration at 8:00am and documented as not administered at 8:00am from 06/01/21 to 06/15/21. -The reason documented or not administering triamterene-hydrochlorthiazide 37.5-25mg was out of facility. -There was an entry dated 06/15/21 to discontinue triamterene-hydrochlorthiazide 37.5-25mg. -The space for documenting administration of triamterene-hydrochlorthiazide 37.5-25mg was blank for administration on 06/17/21 at 8:00am even though the resident received the medication. Interview with the MA (who administered Resident #3's during the 8:00am medication pass on 06/17/21) on 06/18/21 at 9:00am revealed: -Medications were dispensed by the contracted pharmacy for a week supply in multidose plastics enclosures. -Resident #3's triamterene-hydrochlorthiazide 37.5-25mg one tablet was packaged from the contracted pharmacy along with other medications in one of the plastic enclosures dated for the day to be administered and the time of administration.	D 358		

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D 358	Continued From page 23 -She was supposed to remove any tablet discontinued from the packet while preparing the medication for administration. -She overlooked triamterene-hydrochlorthiazide 37.5-25mg was discontinued on the eMAR and should have removed triamterene-hydrochlorthiazide 37.5-25mg one tablet packaged in the medication enclosure. Interview with Resident #3's primary care Nurse Pratitioner (NP) on 06/18/21 at 2:00pm revealed: -The NP received a phone call from Resident #3's home health agency on 06/17/21 regarding Resident #3's blood pressure being low at 90/70 with a pulse rate of 110. -Resident #3's blood pressure at today's visit (06/18/21) was 98/68 but she was not sure of the pulse rate. -The facility should not give the triamterene-hydrochlorthiazide 37.5-25mg since it was discontinued on the hospital discharge. -Resident #3 was ordered a new medication for fluid on the hospital discharge and the two administered together on 06/17/21 probably caused the blood pressure to be so low. -She wanted to continue the medications as ordered on discharge from the hospital except triamterene-hydrochlorthiazide 37.5-25mg, she did not want to start back. Interview with the Administrator on 06/18/21 at 2:50pm revealed: -The MAs were responsible to administer medications as ordered on the eMAR. -The Resident Care Coordinator (RCC) was responsible for checking the eMARs to ensure medications were administered as ordered. Interview with the RCC on 07/17/21 at 4:45pm revealed:	D 358		

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D 358	Continued From page 24 -The MAs should administered medications according to the eMAR -Resident #3's medications were dispensed by the contracted pharmacy. -Medications were dispensed by the contracted pharmacy for a week supply in multidose plastics enclosures dated for the day to be administered. -The medication enclosures were supposed to be compared to the physicians' orders for changes and discontinued medications. -The MA would be responsible to identify and remove any medication that was discontinued or changed from the multidose packaging (if needed to be corrected). 2. Review of Resident #3's current hospital discharge FL2 dated 05/14/21 revealed: -Resident #3 was hospitalized from 05/14/21 through 06/15/21 for symptoms of hyperglycemia. -Resident #3's diagnoses included hyperglycemia and diabetes mellitus type 2. Review of Resident #3's physicians orders revealed: -An order dated 05/12/21 for FSBS four times daily and Novolog Flexpen (fast-acting insulin) 5 units four times daily for FSBS over 450. -An order dated 05/06/21 for FSBS four times daily and Novolog Flexpen 5 units four times daily for FSBS over 450. -A previous physician's order dated 03/18/21 for finger stick blood sugar (FSBS) four times daily and Novolog inject 5 units four times daily as needed for FSBS greater than 450. Review of Resident #3's April 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog 5 units four times daily as needed for FSBS over 450.	D 358		

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D 358	Continued From page 25 -There was an entry for FSBS four times daily scheduled at 6:30am, 11:30am, 4:30pm and 8:00pm. -There were no documentation FSBS were obtained at 8:00pm from 04/02/21 through 04/30/21. -There was no documentation Novolog 5 units was administered at 8:00pm from 04/02/21 to 04/30/21. -There was no documentation FSBS were obtained 6:30am, 11:30am and 4:30pm on 04/29/21 and 04/30/21. -There was documentation on 04/04/21 at 4:30pm that Novolog 5 units was administered for FSBS 425. No Novolog should be administered. -There was documentation FSBS was 460 on 04/22/21 at 4:30pm and no Novolog was documented as administered. Novolog 5 units should be administered. There was documentation Novolog was "withheld per MD order." -There was documentation FSBS was 493 on 04/23/21 at 4:30pm FSBS and no Novolog was documented as administered. Novolog 5 units should be administered. There was documentation Novolog was "withheld per MD order." Review of Resident #3's May 2021 eMAR revealed: -There was an entry for Novolog 5 units four times daily as needed for FSBS over 450. -There was an entry for FSBS four times daily scheduled at 6:30am, 11:30am, 4:30pm and 8:00pm. -There were no documentation FSBS were obtained at 8:00pm on 05/01/21 and from 05/03/21 through 05/07/21. -There was no documentation Novolog 5 units was administered at 8:00pm on 05/01/21 and	D 358		

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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
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from 05/03/21 to 05/07/21.
-There were documented FSBS at 8:00pm on 05/02/21 and from 05/08/21 through 05/13/21.
-There was documentation Novolog 5 units was administered on 05/06/21 at 4:30pm for FSBS 420. No Novolog should be administered.
-There was documentation on 05/10/21 at 4:30pm that Resident #3's FSBS was 529. There was no documentation Novolog was administered as ordered. There was documentation Novolog was "withheld per MD order.
-On 05/11/21 at 8:00pm, Novolog 5 units was documented as administered. There was no FSBS documented to show the FSBS was within range 450 or greater to administer Novolog.
-On 05/12/21 at 8:00pm, Novolog 5 units was documented as administered. There was no FSBS documented to show the FSBS was within range 450 or greater to administer Novolog.
-On 05/13/21 at 6:30am and 8:00pm, Novolog 5 units was documented as administered. There was no FSBS documented to show the FSBS was within range 450 or greater to administer Novolog.
-On 05/14/21 at 6:30am and 4:30pm Novolog 5 units was documented as administered. There was no FSBS documented to show the FSBS was within range 450 or greater to administer Novolog.

Interview with Resident #3 on 06/18/21 at 8:12am revealed:
-She was a diabetic and was ordered insulin.
-She was administered insulin, but she did not know how much.
-She knew that she was ordered sliding scale insulin but did not know the parameters of the sliding scale.
-Staff checked her FSBS daily before each meal.
-Sometimes staff checked her FSBS in the

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evening but not every day.
-She was hospitalized from May 2021 through June 2021 for high FSBS.

Interview with the medication aide (MA) on 06/18/21 at 9:15am revealed:
-Resident #3's FSBS should be documented four times daily on the eMAR.
-If the FSBS were not documented then it was possible they were not obtained.
-Resident #3 should be administered routine insulin and sliding scale insulin based on FSBS results.
-She was unable to explain why Novolog was not documented as administered for FSBS 450 or greater.
-She was unable to explain why Novolog was documented as administered for FSBS that were less than 450.
-The Resident Care Coordinator (RCC) was responsible for checking the eMARs to ensure medications were administered as ordered.
-She did not know when or how often the RCC checked the eMARs.

Interview with a second MA on 06/18/21 at 3:50pm revealed:
-She did not know why Resident #3's FSBS were not documented at 8:00pm.
-She could not validate that she had checked Resident #3's FSBS at 8:00pm because there was no documentation on the eMAR.
-She was sure she had obtained the resident's FSBS at 8:00pm.
-She would not go a month or more without obtaining the resident's 8:00pm FSBS.
-She thought there must be problem with the eMAR system not recording the 8:00pm FSBS.
-She was unable to explain why there was documentation Novolog 5 units was administered

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at 8:00pm in May 2021, and there were no corresponding documented FSBS.
-She did not know if there was anyone responsible for checking the eMARs to ensure FSBS were obtained as ordered.

Interview with Resident #3's Primary Care Provider (PCP) on 06/18/21 at 10:56am revealed:
-Resident #3 had an order for Novolog 5 units for FSBS over 450 four times daily and FSBS four times daily.
-She expected FSBS to be obtained four times daily because the residents FSBS was sometimes high.
-Resident #3 had complications resulting from high blood sugar levels like heart disease and kidney damage.
-High blood sugar levels could cause other problems like eye and nerve damage.

Interview with the RCC on 06/18/21 at 8:15am and 1:43pm revealed:
-Resident #3's FSBS should be documented on the eMAR.
-If the FSBS were not documented on the eMAR they were not obtained.
-She was not aware Resident #3's FSBS were not obtained at 8:00pm.
-The MAs should obtain the FSBS as ordered and document the results on the eMAR.
-There were several places for the MA to document the FSBS result.
-She tried to check the eMARs every other day, but sometimes she was unable to check the eMARs.

Interview with the Administrator on 06/18/21 at 2:50pm revealed:
-FSBS should be obtained as ordered.
-She expected the MAs to record FSBS after

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D 358	Continued From page 29 obtaining the FSBS and prior to administering medications to the next resident. -If the MA obtained the FSBS and it was not showing on the eMAR the MA should inform the RCC. The RCC would contact the pharmacy to have the problem corrected. -The RCC was responsible for checking the eMARs to ensure medications were administered as ordered. The facility failed to ensure medications were administered as ordered for 1 resident observed during the medication pass, including errors with nebules for inhalation, an anxiety medication, a diuretic for fluid retention, and a medication for high blood pressure/rapid heat beat; and for 2 of 5 residents sampled (#3, and #5) for record review including not checking fingerstick blood sugar values resulting in not administering insulin for fingerstick blood sugar within specified parameters (#3) and errors with a medication for fluid retention ordered as needed (#5). Resident #3 received a diuretic used to treat high blood pressure after it was discontinued due to the resident having low blood pressure which put the resident at risk of further low blood pressures that could cause dizziness, lightheadedness, and risk for falls; The facility's failure to administer medication as ordered was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S.131D-34 on 06/18/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 6, 2021.	D 358		

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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 observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of controlled substances for 1 of 5 residents sampled (#5) who received medication for moderate pain and neuropathy. The findings are: Review of Resident #5's current FL2 dated 05/06/2021 revealed diagnoses included anasarca, arthritis, asthma, atrial fibrillation, cellulitis, chest pain, congestive heart failure, chronic atrial fibrillation, chronic obstructive pulmonary disease. 1. Review of Resident #5's physician orders dated 04/28/2021 revealed an order for Hydrocodone/Acetaminophen (APAP) (used to treat pain) 5/325mg one every six hours as needed for pain. Review of Resident #5's April 2021 electronic Medication Administration Record (eMAR) compared to the controlled substance count	D 392	See Above plan of action for POC. JMP	

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sheet (CSCS) for hydrocodone/APAP 5/325mg dispensed on 03/10/21 for 120 tablets revealed:
-On 04/10/21 at 8:00pm hydrocodone/APAP was documented on CSCS but not on the eMAR as administered.
-On 04/11/21 at 9:00pm hydrocodone/APAP was documented on CSCS but not on the eMAR as administered.
-On 04/14/21 at 2:45pm hydrocodone/APAP was documented on CSCS but not on the eMAR as administered.
-On 04/20/21 at 10:00pm hydrocodone/APAP was documented on CSCS but not on the eMAR as administered.
-On 04/21/21 at 1:44am hydrocodone/APAP was documented on eMAR as administered but not on CSCS.
-On 04/24/21 at 6:00am hydrocodone/APAP was documented on CSCS but not on the eMAR as administered.
-On 04/24/21 at 9:00pm hydrocodone/APAP was documented on CSCS but not on the eMAR as administered.
-On 04/26/21 at 5:40am hydrocodone/APAP was documented on CSCS but not on the eMAR as administered.
-On 04/29/21 at 4:30pm hydrocodone/APAP was documented on CSCS but not on the eMAR as administered.

Review of Resident #5's May 2021 eMAR) compared to the CSCS for hydrocodone/Acetaminophen 5/325mg dispensed on 04/28/21 for 90 tablets revealed:
-On 05/24/21 at 3:00pm hydrocodone/APAP was documented on CSCS but not on the eMAR as administered.
-On 05/28/21 at 6:00am hydrocodone/APAP was documented on CSCS but not on the eMAR as administered.

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D 392	Continued From page 32 -On 05/31/21 at 8:00pm hydrocodone/APAP was documented on CSCS but not on the eMAR as administered. Review of Resident #5's June 2021 electronic Medication Administration Record (eMAR) compared to the CSCS for hydrocodone/Acetaminophen 5/325mg dispensed on 04/28/21 for 90 tablets revealed: -On 06/02/21 at 10:00pm hydrocodone/APAP was documented on CSCS but not on the eMAR as administered. -On 06/03/21 at 9:30pm hydrocodone/APAP was documented on CSCS, but not on the eMAR as administered. -On 06/05/21 at 5:00pm hydrocodone/APAP was documented on CSCS, but not on the eMAR as administered. -On 06/08/21 at 6:00am hydrocodone/APAP was documented on CSCS but not on the eMAR as administered. Observation on 06/16/21 of Resident #5's CSCS for hydrocodone/Acetaminophen 5/325mg dispensed on 04/28/21 for 90 tablets revealed 31 tablets remained matching the quantity on hand for administration. Refer to interview with medication aide (MA) on 06/18/21 at 2:36pm. Refer to telephone interview with another MA on 06/21/21 at 11:08am. Refer to telephone interview with the Administrator on 06/21/21 at 11:00am. 2. Review of Resident #5's signed physician orders revealed an order for Pregabalin (used to treat neuropathy) 50mg one capsule three times	D 392		

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a day.

Review of Resident #5's April 2021 electronic medication administration record (eMAR) compared to control substance count sheet (CSCS) for pregabalin 50mg dispensed on 12/24/20 for 60 tablets revealed:
-On 04/16/2021 at 3:00pm pregabalin was documented as given on eMAR but was not documented on CSCS.
-On 04/19/2021 at 9:00am, 3:00pm and 9:00pm pregabalin was documented as given on eMAR but was not documented on CSCS.

Review of Resident #5's May 2021 eMAR revealed:
-There was an entry for Pregabalin 50mg to take one tablet three times a day.
-The MA documented Resident #5 was out of facility on 05/01/21 at 9:00pm, 05/02/21 through 05/06/21, 05/07/21 at 9:00am, 05/10/21 at 3:00pm and 05/30/21 at 3:00pm.

Review of Resident #5's May 2021 eMAR compared to the CSCS for pregabalin 50mg revealed:
-On 05/28/2021 at 3:00pm pregabalin was documented as given on eMAR but was not documented on CSCS.
-On 05/30/2021 at 3:00pm pregabalin was documented as given on eMAR but was not documented on CSCS.

Review of Resident #5's June 2021 eMAR compared to CSCS for pregabalin 50mg revealed:
-On 06/09/2021 at 3:00pm pregabalin was documented as given on eMAR but was not documented on CSCS.
-On 06/11/2021 at 9:00am pregabalin was

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D 392	Continued From page 34 documented as given on eMAR but was not documented on CSCS. Observation on 06/17/21 of Resident #5's CSCS for pregabalin 50mg dispensed for 90 capsules on 03/17/21 revealed 52 capsules remained matching the quantity on hand for administration. Refer to interview with medication aide (MA) on 06/18/21 at 2:36pm. Refer to telephone interview with another MA on 06/21/21 at 11:08am. Refer to telephone interview with the Administrator on 06/21/21 at 11:00am _____ Interview with a MA on 06/18/21 at 2:36pm revealed she documented on the CSCS as soon as she removed medication from blister pack. Telephone interview with another MA on 06/21/21 at 11:08am revealed: -She signed the narcotics out on the CSCS at the end of her medication pass. -She verified the time the narcotic was given on the eMAR and documented the time on CSCS. Telephone interview with the Administrator on 06/21/21 at 11:00am revealed: -The Resident Care Coordinator (RCC) was to audit narcotic sheets weekly. -Controlled medications should be signed out on the CSCS immediately when they were administered.	D 392		
D912	G.S. 131D-21(2) Declaration of Residents' Rights	D912		

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D912	Continued From page 35 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, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to residents' rights, medication administration, and Adult Care Home infection prevention requirements. The findings are: 1. Based on observation, record review and interviews, the facility failed to ensure residents were treated with respect, consideration, and dignity as related to vaccinated residents being required to wear face masks when not in their room and not being allowed to leave the facility. [Refer to Tag 0338, 10A NCAC 13F .0909 Residents' Rights (Type B Violation).]. 2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 1 of 2 residents (#3) observed during the medication passes including errors with nebules for inhalation, an anxiety medication, a diuretic for fluid retention, and a medication for high blood pressure/rapid heat beat; and for 1 of 5 residents (#3) sampled for record review including errors in administration of insulin for fingerstick blood sugar within specified parameters. [Refer to Tag D0358, 10A NCAC	D912		

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D912	Continued From page 36 13F .1004(a) Medication Administration (Type B Violation).] 3. Based on observations, interviews and record reviews, the facility failed to implement a written infection control policy consistent with the Federal Centers for Disease Control and Prevention (CDC) guidelines to ensure proper infection control procedures for the use of glucometers for 3 of 3 sampled diabetic residents (#3, #5, and #6) with orders for fingerstick blood sugar (FSBS) monitoring resulting in the sharing of glucometers between residents. [Refer to Tag 932, G.S.131D-4.4A(b) Adult Care Home Infection Prevention Requirements (Type B Violation).].	D912		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies.	D932	See attached [illegible] for POC [illegible]	

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D932	Continued From page 37 d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C and other bloodborne pathogens. This Rule is not met as evidenced by:	D932		

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D932	Continued From page 38 TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to implement a written infection control policy consistent with the Federal Centers for Disease Control and Prevention (CDC) guidelines to ensure proper infection control procedures for the use of glucometers for 3 of 3 sampled diabetic residents (#3, #5, and #6) with orders for fingerstick blood sugar (FSBS) monitoring resulting in the sharing of glucometers between residents. The findings are: Review of the CDC guidelines for infection control revealed the CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residents. If the glucometer is to be used for more than one resident, it should be cleaned and disinfected per the manufacturer's instructions. If the manufacturer does not list disinfection information, the glucometer should not be shared between residents. Telephone interview with a representative for the manufacturer of the Brand A glucometer on 06/18/21 at 1:34pm revealed the Brand A glucometer should be used by a single person and should not be shared. Review of the manufacturer's instruction manual for Brand A glucometer revealed the Brand A glucometer was intended for single use only and should not be shared. 1. Review of Resident #5's current FL2 date 05/07/21 revealed diagnoses of anasarca, arthritis, asthma, atrial fibrillation, cellulitis, chest pain, congestive heart failure and chronic atrial	D932		

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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
D932	Continued From page 39 fibrillation. Review of Resident #5's Physician orders dated 03/16/21 revealed: -Diagnoses included Type II diabetes mellitus. -There was an order for fingerstick blood sugar (FSBS) three times a day before meals. Observation of the back hall medication cart on 06/18/21 revealed: -There were six black, zippered pouches with glucometers, each labeled with a resident's name. -Resident #5 had a zippered pouch with a glucometer, labeled with his name. -Resident #5 had a Brand A, single use only glucometer. Review of Resident #5's FSBS values recorded in the memory of Resident #5's glucometer revealed FSBS values recorded in the memory of the glucometer were not consistent with FSBS values documented on the resident's May 2021 eMARs. Review of Resident #5's May 2021 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS checks three times a day before meals scheduled at 6:30am, 11:30am, and 4:30pm. -There was documentation Resident #5 was in the hospital from 05/02/21 to 05/07/21. Review of the memory of Resident #5's glucometer on 06/17/21 for the month of May 2021 compared to the resident's May 2021 eMAR revealed on 05/06/21 there was a FSBS reading at 5:33am of 288 recorded in the glucometer's memory when Resident #5 was in the hospital.	D932		

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	HAL034069	A. BUILDING: _____ B. WING _____	R-C 06/21/2021

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D932	Continued From page 40 Review of Resident #5's eMAR for June 2021 revealed: -There was an entry for FSBS checks three times a day before meals scheduled at 6:30am, 11:30am, and 4:30pm. -FSBS values were documented 3 times a day from 06/01/21 to 06/17/21. Review of Resident #5's FSBS values recorded in the memory of Resident #5's glucometer revealed: -FSBS values recorded in the memory of the glucometer were not consistent with FSBS values documented on the resident's June 2021 eMARs. -There were multiple FSBS values recorded within a short period of time on some days. Review of FSBS values recorded in the memory of Resident #5's glucometer compared to the FSBS values documented on the June 2021 eMAR revealed: -There were sixty-one FSBS values that were documented in the memory of Resident #5's glucometer (should have been 51 FSBS values for three times a day for 17 days). -There were twenty-two FSBS values recorded in the memory of the glucometer that did not match FSBS values documented on the June 2021 eMAR. -Examples of additional values recorded in the memory of Resident #5's glucometer in a short period of time but not documented on Resident #5's June 2021 eMAR were as follows: -On 06/01/21 at 5:33am., FSBS=316, at 5:44am-FSBS=266; FSBS of 266 was documented on Resident #5's eMAR on 06/01/21 at 6:30am. -On 06/01/21 at 12:07pm, FSBS=288 and at 12:27pm FSBS=118; neither value was documented on Resident #5's eMAR at 11:30am. -On 06/01/21 at 4:36pm, FSBS=129, and at	D932		

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D932	Continued From page 41 4:45pm and FSBS=242; neither value was documented on Resident #5's eMAR at 4:30pm. -On 06/01/21 at 7:51pm, FSBS=120; FSBS value 120 was not documented on Resident #5's eMAR. -On 06/10/21, at 5:49am, FSBS=377 and at 5:52am FSBS=407; FSBS=337 was documented on Resident #5's eMAR at 6:30am. -On 06/10/21 at 9:21pm, FSBS=361; FSBS=361 was not documented on Resident #5's eMAR. -On 06/12/21 at 3:41pm, FSBS=213; FSBS=213 was not documented on Resident #5's eMAR at 4:30pm but was consistent with FSBS value recorded in the memory of another resident's glucometer and documented on the other resident's eMAR on 06/12/21 at 4:30pm. -On 06/14/21 at 6:06am, FSBS=316; FSBS=316 was not documented on Resident #5's eMAR. -On 06/14/21 at 4:27pm, FSBS=286 and at 4:31pm FSBS=131; FSBS=286 was documented on Resident #5's eMAR at 4:30pm. Refer to the interview with a Medication Aide (MA) on 06/18/2021 at 2:36pm. Refer to the interview with the Resident Care Coordinator (RCC) on June 06/17/2021 at 5:05pm Refer to the interview with the Administrator on 06/18/21 at 2:58pm. 2. Review of Resident #3's current hospital discharge FL2 dated 05/14/21 revealed: -Diagnoses included diabetes mellitus type. -Resident #3 was hospitalized from 05/14/21 through 06/15/21 with hyperglycemia and diabetes mellitus type 2. Review of Resident #3's physicians orders	D932		

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D932	Continued From page 42 revealed: -There was an order dated 05/12/21 for FSBS four times daily and Novolog Flexpen 5 units four times daily for FSBS over 450. -There was an order dated 05/06/21 that included medication and treatment orders for FSBS four times daily and Novolog Flexpen 5 units four times daily for FSBS over 450. -There was an order dated 03/18/21 for finger stick blood sugars (FSBS) four times daily and Novolog inject 5 units four times daily as needed for FSBS greater than 450. Review of Resident #3's electronic medication administration record (eMAR) for 05/15/21 - 06/15/21 revealed: -There was an entry to check and record FSBS four times daily scheduled at 6:30am, 11:30am, 4:30pm and 8:00pm. -There was documentation Resident #3 was out of the facility from 05/14/21 through 06/15/21. Observation of the facility's medication cart for the front hallway on 06/18/21 at 9:10am revealed: -There were 10 or more pouches with residents' names hand written on each pouch. -Inside each pouch was a black Brand A glucometer. -Residents' names were typed on a piece of clear tape that was stuck to the side of the glucometer. Review of the memory of Resident #3's Brand A glucometer from 05/15/21 through 06/15/21 on 06/18/21 at 9:21am revealed: -A date of 06/17/21 with a time of 6:10pm was on the glucometer when turned on. -There were FSBS readings on dates when the resident not in the facility as follows: -On 05/25/21 at 7:16am, there was a FSBS of 253.	D932		

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D932	Continued From page 43 -On 05/25/21 at 7:20am, there was a FSBS of 148. -On 05/25/21 at 7:24am, there was a FSBS of 278. -On 06/09/21 at 5:00pm, there was a FSBS of 102. -On 06/12/21 at 5:07pm, there was a FSBS of 324. -On 06/12/21 at 6:04pm, there was a FSBS of 275. -On 06/12/21 at 7:10pm, there was a FSBS of 264. -On 06/13/21 at 5:35pm, there was a FSBS of 231. Interview with Resident #3 on 06/18/21 at 8:10am revealed: -She had been out of the facility in the hospital for a month. -She was hospitalized from mid-May 2021 and returned to the facility three days ago. -When the medication aide (MA) checked her FSBS she did not know whose glucometer the MA used. Interview with a MA on 06/18/21 at 2:27pm revealed: -Resident #3's glucometer was kept on the medication cart. -Resident #3 had been in the hospital for one month and returned to the facility on 06/15/21. -There should be no FSBS readings in Resident #3's glucometer on the dates the resident was in the hospital. -Resident #3's glucometer should not have been used when the resident was in the hospital. -She did not know any MAs that were sharing glucometers. -If a glucometer did no. work she checked the batteries, and if that did not work she waited for	D932		

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D932	Continued From page 44	D932		

the Resident Care Coordinator (RCC) to arrive and informed her the glucometer did not work.
-The RCC had extra glucometers.
-The RCC was supposed to audit glucometers with the eMARs to ensure there was no sharing of glucometers.
-She sanitized with germicidal wipes all the glucometers on her medication cart at the end of her shift each day.

Interview with the RCC on 06/18/21 at 1:43pm revealed:
-If Resident #3 was not in the facility there should be no FSBS readings in the resident's glucometer on the dates the resident was out of the facility.
-She was responsible for auditing glucometers and comparing them with the eMARs.
-She had not done an audit for at least one week.
-Resident #3 was out of the facility so she would not have audited Resident #3's glucometer.

Refer to the interview with a Medication Aide (MA) on 06/18/2021 at 2:36pm.

Refer to the interview with the Resident Care Coordinator (RCC) on June 06/17/2021 at 5:05pm.

Refer to the interview with the Administrator on 06/18/21 at 2:58pm.

3. Review of Resident #6's current FL2 date 02/12/21 revealed diagnoses of diabetes mellitus type 2 and atrial fibrillation.

Review of Resident #6's Physician orders signed 02/17/21 revealed an order for fingerstick blood sugar (FSBS) three times a day before meals.

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D932	Continued From page 45 Observation of the back hall medication cart on 06/18/21 revealed: -There were six black, zippered pouches with glucometers, each labeled with a resident's name. -Resident #6 had a zippered pouch with a glucometer labeled with his name. -Resident #6 had a Brand A, single use only glucometer. Review of Resident #6's June 2021 electronic medication administration record (eMAR) for 06/01/21-06/18/21 revealed: -There was an entry to check and record FSBS three times daily scheduled at 6:30am, 11:30am, and 4:30pm. -FSBS values documented on the eMAR were inconsistent with FSBS values recorded in the memory of the Brand A glucometer labeled with Resident #6's name. Examples of FSBS values documented on Resident #6's June 2021 eMAR inconsistent with FSBS values recorded in the memory of the glucometer labeled for Resident #6 were as follows: -On 06/10/21 at 6:00am, there was a FSBS value of 213 documented on the eMAR but not recorded in the memory of his glucometer. -On 06/10/21 at 3:39pm., there was a FSBS value of 265 documented on the eMAR but not recorded in the memory of his glucometer. -On 06/12/21 at 12:11pm, there was a FSBS value of 187 documented on the eMAR but not recorded in the memory of his glucometer. Review of FSBS values recorded in the memory of Resident #6's glucometer compared to the June 2021 eMAR revealed: -There were twenty-seven FSBS values from	D932		

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D932	Continued From page 46 06/01/21-06/18/2021 documented on the June 2021 eMAR from 06/01/21 to 06/18/21 that were not recorded in his glucometer. -On 06/01/2021 at 5:44am, there was a FSBS value of 154 recorded in the memory of the glucometer, but not documented on the eMAR. -On 06/01/2021 at 12:10pm, there was a FSBS value of 169 recorded in the memory of the glucometer, but not documented on the eMAR. -There were no FSBS values recorded in the memory of the glucometer after 06/01/2021 at 12:10pm. Refer to the interview with a Medication Aide (MA) on 06/18/2021 at 2:36pm. Refer to the interview with the Resident Care Coordinator (RCC) on June 06/17/2021 at 5:05pm Refer to the interview with the Administrator on 06/18/21 at 2:58pm. Interview with a Medication Aide (MA) on 06/18/2021 at 2:36pm revealed: -The glucometers were wiped down with micro wipes after each use. -Each resident used a single use lancet. -Each diabetic resident had their own glucometer. -If a glucometer was not working, she would change the batteries and if it still was not working she would notify the Resident Care Coordinator (RCC). -She did not share glucometers. -The RCC was responsible for glucometer audits. -She had not seen the RCC do an audit. -She documented FSBS in the eMAR. Interview with the Resident Care Coordinator (RCC) on June 06/17/2021 at 5:05pm revealed:	D932		

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D932	Continued From page 47 -Each resident should have their own glucometer and the glucometer should be labeled. -The MA's should not be sharing glucometers because of the risk of infection. -The glucometers were cleaned after each use. Interview with the Administrator on 06/18/21 at 2:58pm revealed: -The MAs should not be sharing glucometers. -The facility's policy was that each resident had their own glucometer. -There was not need to use another resident's glucometer. -The RCC was supposed to audit the glucometers with the eMARs at least weekly. The facility failed to implement infection control procedures consistent with the federal Center for Disease Control (CDC) guidelines for finger stick blood sugar checks. The facility's failure placed the residents at risk to possible exposure and transmission of blood borne pathogens by sharing of glucometers for Residents (#3, #5, and #6,). This failure was detrimental to the health, safety and welfare of the residents receiving FSBS checks and insulin injections and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S.131D-34 on 06/18/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 6, 2021.	D932		

The following is a summary of the Plan of Correction for Bradford Village West. This Plan of Correction is in regards to the Corrective Action Report dated July 12th, 2021. This plan of Correction is not to be constructed as an admission of or agreement with the findings and conclusions in the State of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation, nor have we identified mitigating factors.

10A NCAC 13F .0902(c)(3-4) Health Care (Corrected 8/1/2021 – D276)

- Orders Will be reviewed by Resident Care Coordinator or Designee within 72 hours to ensure compliance with documentation and follow up on MAR documentation
- Vitals will be reviewed by the Resident Care Coordinator or Designee weekly to ensure that documentation reflects entry on the MAR

10A NCAC 13F .0904 (e)(4) Nutrition and Food Service (Corrected 7/1/21 – D310)

- Education Provided for therapeutic diets to dietary aides.
- Department Heads will monitor dining routinely unannounced to ensure compliance with therapeutic diets.

10 NCAC 13F .0909 Resident Rights (Corrected 7/1/21 – D 338)

- Appropriate team members will review resident rights.
- Resident Council Meeting Held to Review Visitation Policy, Smoking Policy, and COVid Infection Control Policy with Residents while State Present.
- Resident Rights Training and Infection Control Training will be Ongoing

10A NCAC 13F .1004 (a) Medication Administration (Corrected 8/1/21 – D 358)

- Resident Care Coordinator or Designee will conduct periodic medication pass observations on various medication aides to ensure compliance with medication administration adherence.
- Med Pass Exception report will be audited weekly by Resident Care Coordinator or Designee to ensure Medication Aide compliance to medication availability, administration, and refusal or medication.
- Medication Aides Current and those training will attend ongoing training to ensure understanding or medication administration, storage, availability and documentation.
- New Medication Aides will be shadowed by the Resident Care Coordinator or Designee to ensure they are comfortable with the medication pass and techniques needed to ensure 100% medication pass compliance.

10A NCAC 13F .1008 (a) Controlled Substances (Corrected 8/6/21 – D 392)

- Medication Aides will be educated to review narcotic counts to ensure accuracy in administration as part of the routine narcotic count prior to shift or key exchange.

- Resident Care Coordinator or Designee will review weekly at minimum to ensure medication is complaint with administration. This will include looking at narcotic count and verifying that the count reflects the correct dosing measures.
- Resident Care Coordinator or Designee will compare a sample of narcotic administrations (MAR to NARC Sheet) to ensure compliance.
- Controlled Substance Sheets will be reviewed again by Resident Care Coordinator at the end of the prescription card/count to again verify that all narcotics were given as noted by the MD in a timely manner.

G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (Corrected 7/2/21 – D 932)

- Glucometers were immediately replaced with new glucometers
- Medication Aides and Personal Care Aides were asked to attend an additional infection control training offered 7/1/2021 to ensure understanding and compliance in regards to medication administration.
- Glucometers will be checked at random weekly to ensure compliance – right resident – right glucometer. Resident Care Coordinator or Designee will ensure compliance checked routinely.

G.S. 131D-21 (4) Declaration of Resident Rights (Corrected 7/1/21 – D 912)

- Appropriate team members will review resident rights.
- Resident Council Meeting Held to Review Visitation Policy, Smoking Policy, and COVid Infection Control Policy with Residents while State Present.
- Resident Rights Training and Infection Control Training will be Ongoing

Peedin, Ray

From: laura@bradfordvillage.org
Sent: Thursday, July 29, 2021 7:32 PM
To: Peedin, Ray; Greg McManus
Subject: [External] Bradford Village West Response
Attachments: 4728_001.pdf

Importance: High

-----Original Message-----
From: noreply@bradfordvillage.org
Sent: Thursday, July 29, 2021 4:58pm
To: "Laura Rumley" <laura@bradfordvillage.org>
Subject: Attached Image