| 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 10/16/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE BRADFORD VILLAGE OF KERNERSVILLE - WES | 602 PINEY GROVE ROAD KERNERSVILLE, NC 27284 |

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| {D 000} | Initial Comments<br><br>The Adult Care Licensure Section conducted a follow-up survey on October 15 - 16, 2019. | {D 000} | | |
| {D 273} | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to notify the primary care provider for 1 of 5 sampled residents (#1) related to six missed doses of a medication used for gastric reflux.<br><br>The findings are:<br><br>Review of Resident #1's current FL-2 dated 08/09/19 revealed:<br>-Diagnoses included seizure disorder, borderline personality disorder, super-super obesity, and type 2 diabetes.<br>-There was an order for omeprazole 40mg daily. (Omeprazole is used to treat gastric reflux.)<br><br>Review of Resident #1's September 2019 electronic Medication Administration Record (eMAR) revealed:<br>-There was an entry for omeprazole 40mg daily. | {D 273} | | |

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|---|---|---|---|---|
| {D 273} | Continued From page 1<br>-From 09/11/19-09/16/19, there was documentation omeprazole was not administered.<br>-From 09/11/19-09/15/19, there was documentation indicating the reason for not administering omeprazole was "physically unable to take."<br>-From 09/15/19 and 09/16/19, there was documentation indicating "waiting on med."<br><br>Review of Resident #1's record revealed there was no documentation of contacting the primary care provider (PCP) regarding the missed doses of omeprazole.<br><br>Interview with Resident #1 on 10/16/19 at 12:30pm revealed:<br>-She did not receive omeprazole for several days in mid-September.<br>-She was told by the Medication Aide (MA) the medication was not in the facility.<br>-She did not experience any negative effects from not receiving the omeprazole.<br>-She did not know if staff notified her primary care provider (PCP) about not receiving omeprazole for several days.<br><br>Interview with an MA on 10/16/19 at 1:05pm revealed the PCP was to be notified when medications were not administered three times in a row.<br><br>Telephone interview with a second MA on 10/16/19 at 1:28pm revealed:<br>-The PCP was to be notified when a medication was not administered three times in a row.<br>-She usually waited for a response from the pharmacy before contacting the PCP if a medication needed to be refilled.<br>-She could not recall notifying the Resident Care Coordinator (RCC) about the missed omeprazole | {D 273} | | |

| 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 273} | Continued From page 2<br>doses.<br>-She did not notify the provider regarding Resident #1's missed omeprazole doses.<br><br>Telephone interview with the receptionist at the PCP's office on 10/17/19 at 1:41pm revealed:<br>-The PCP received several calls from the facility in late August 2019 and early September 2019 regarding "straightening out" Resident #1's medication orders.<br>-She did not know if any of the calls were specifically about omeprazole.<br><br>Interview with the RCC on 10/16/18 at 1:53pm revealed:<br>-The MAs used the physician notification form, sent by fax, to communicate with the PCP.<br>-She would make phone calls to the PCP as needed.<br>-If a medication was not administered three times in a row, the PCP was notified.<br>-She did not recall being informed about Resident #1's omeprazole not being available.<br><br>Interview with the Administrator on 10/16/19 at 2:15pm revealed:<br>-The facility faxed information to the PCP using the physician contact form.<br>-The PCP should be notified if medications were missed one time. | {D 273} | | |
| {D 358} | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(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: | {D 358} | | |

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|---|---|---|---|
| | HAL034069 | A. BUILDING: _____ B. WING _____ | R 10/16/2019 |

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|---|---|---|---|---|
| {D 358} | Continued From page 3<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>FOLLOW-UP TO TYPE B VIOLATION<br><br>Based on these findings, the previous Type B Violation was not abated.<br><br>Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered by a prescribing practitioner for 2 of 5 sampled residents (#1 and #3) including a non-steroidal anti-inflammatory medication (#3) and a medication to treat gastric reflux (#1).<br><br>The findings are:<br><br>1. Review of Resident #3's current FL-2 dated 04/28/19 revealed:<br>-Diagnoses include coronary artery disease, debility, dementia, depression, diabetes mellitus, dyslipidemia, gastro-esophageal reflux disease, hypertension, nephrolithiasis, and stroke.<br>-Ibuprofen (used to treat pain and inflammation) was documented as a prn medication but without any documentation of a dose, frequency, or route. | {D 358} | | |

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|---|---|---|---|
| | HAL034069 | A. BUILDING: _____ B. WING _____ | R 10/16/2019 |

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|---|---|---|---|---|
| {D 358} | Continued From page 4<br><br>Review of Resident #3's subsequent physician orders revealed:<br>-There was a medication order dated 05/01/19 to "stop" ibuprofen.<br>-There was a medication order dated 07/26/19 Advil (ibuprofen) 200 mg one tablet three times a day.<br>-There was a medication order dated 08/30/19 to "stop" ibuprofen.<br>-There was a medication order dated 09/29/19 for ibuprofen 200 mg every 8 hours as needed for pain.<br><br>Review of Resident #3's incident reports revealed:<br>-There was an incident report dated 08/29/19 at 5:00 am that documented Resident #3 was found with blood coming from his mouth.<br>-Resident #3 was sent to the local emergency room (ER) via ambulance on 08/29/19.<br><br>Review of Resident #3's August 2019 eMAR revealed:<br>-There was an entry for ibuprofen 200 mg take one table three times a day, scheduled for 9:00 am, 1:00 pm, and 5:00 pm.<br>-There was documentation of administration from 08/01/19 to 08/31/19 at 9:00 am, 1:00 pm, and 5:00 pm.<br>-There was documentation of circled staff initials on 08/04/19 at 5:00 pm, 08/12/19 at 5:00 pm, 08/29/19, and 08/30/19 at 9:00 am, 1:00 pm, and 5:00 pm, that indicated Resident #3 was out of the facility.<br><br>Review of Resident #3's September 2019 eMAR revealed:<br>-There was an entry for ibuprofen 200 mg take one tablet three times daily, scheduled for 9:00 | {D 358} | | |

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|---|---|---|---|
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| {D 358} | Continued From page 5 | {D 358} | | |

am, 1:00 pm, and 5:00 pm.
-There was documentation of administration from 09/01/19 to 09/25/19 at 9:00 am, 1:00 pm and 5:00 pm.
-There was documentation of two dots or periods from 09/26/19 to 09/30/19 at 9:00 am, 1:00 pm, and 5:00 pm.
-There was no documentation on the eMAR for the meaning of the two dots or periods.

Review of Resident #3's October 2019 eMAR revealed:
-There was an entry for ibuprofen 200 mg take one tablet three times daily, scheduled for 9:00 am, 1:00 pm, and 5:00 pm.
-There was documentation of two dots or periods from 10/01/19 to 10/03/19 at 9:00 am, 1:00 pm, and 5:00 pm.
-There was no documentation on the eMAR for the meaning of the two dots or periods.
-There was documentation of administration from 10/04/19 to 10/14/19 at 9:00 am, 1:00 pm, and 5:00 pm and 10/15/19 at 9:00 am and 1:00 pm.
-There was documentation of circled staff initials on 10/06/19 at 5:00 pm that indicated Resident #3 was out of the facility.

Observation of Resident #3's medication on hand on 10/16/19 at 10:45 am revealed:
-There was one 100 tablets bottle of a local pharmacy brand ibuprofen 200 mg tablets.
-There was no pharmacy label on the bottle and there were approximately 50 tablets remaining in the bottle.
-Resident #3's name was handwritten on the bottle in two different areas and his initials were on the side of the bottle and the cap of the bottle.

Review of Resident #3's hospital discharge summary revealed:

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|---|---|---|---|---|
| {D 358} | Continued From page 6 | {D 358} | | |

-The resident was admitted to the hospital on 08/29/19 and had an endoscopy (a non-surgical procedure used to view a person's digestive tract) was performed.
-The resident was discharged to the facility on 08/30/19.
-There was an order to "stop" ibuprofen.
-There was documentation that Resident #3 had an endoscopy on 08/29/19 and the results of the endoscopy were that Resident #3 had severe esophagitis (inflammation that may damage the tissue of the esophagus) and irregular granular mucosa (abnormal cell tissue) in the distal esophagus.

Based on reviews of eMARs, Resident #3 received 112 doses of ibuprofen for 38 days after a hospital stay with endoscopy for esophagitis after a physician's order to stop Resident #3's ibuprofen.

Attempted telephone interview with Resident #3's family member on 10/16/19 at 12:18 pm was unsuccessful.

Telephone interview with a representative from the facility contracted pharmacy on 10/16/19 at 12:40 pm revealed:
-Medication orders were faxed to the pharmacy from the facility.
-Ibuprofen 200 mg was ordered and filled on 07/26/19 for 90 tablets a 30 day supply; it was refilled on 08/28/19 for a thirty day supply of 90 tablets.
-There were no other dispensed dates after 08/28/19 because the pharmacy received notice that Resident #3 began using another pharmacy as of 09/30/19.
-There were no discontinue orders for Resident #3's ibuprofen in the computer system.

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| {D 358} | Continued From page 7<br><br>Telephone interview with Resident #3's physician on 10/16/19 at 9:40 am revealed:<br>-Resident #3's last office visit was 07/10/19 and the visit was for Resident #3's annual wellness check.<br>-Since the 07/10/19 visit, the facility had contacted the office to obtain orders for the ibuprofen and Tylenol to treat Resident #3's shoulder pain.<br>-He wrote the ibuprofen order for Resident #3 dated 07/26/19.<br>-He ordered ibuprofen to treat Resident #3's right shoulder pain, which Resident #3 was supposed to have surgery to repair.<br>-He did not write the order to stop the ibuprofen on 08/30/19 but he agreed with the discontinue order because of the results of Resident #3's endoscopy report.<br>-He had a letter from the gastroenterologist that reported the results of Resident #3's endoscopy as severe esophagitis and Barrett's mucosa (normal cells lining the esophagus replaced by abnormal cells).<br>-If Resident #3 continued to receive ibuprofen after it was discontinued, Resident #3 was at risk to have a gastric intestinal bleed.<br>-"The ibuprofen for Resident #3 should have been stopped" on 08/30/19 because it placed Resident #3 at greater risk for gastrointestinal bleeding.<br><br>Interview with the former Resident Care Coordinator (RCC) on 10/16/19 at 9:09 am revealed:<br>-Resident #3 had a medication order for ibuprofen dated 07/26/19 and then a discontinue order dated 08/30/19.<br>-There were no other orders for ibuprofen for Resident #3 . | {D 358} | | |

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|---|---|---|---|
| | HAL034069 | A. BUILDING: _____ B. WING _____ | R 10/16/2019 |

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|---|---|---|---|---|
| {D 358} | Continued From page 8<br><br>Interview with a first shift Medication Aide (MA) on 10/16/19 at 8:10 am, 11:15 am and 1:06 pm revealed:<br>-The MAs and the RCC faxed new medication orders to the pharmacy.<br>-The MAs did not have any other responsibilities with new medication orders other than faxing it to pharmacy.<br>-All new orders were checked in the eMAR system by the RCC after the pharmacy entered them into the eMAR system.<br>-New orders appeared in the eMAR system as highlighted and the word "new" was indicated with the medication on the screen.<br><br>Interview with the RCC on 10/16/19 at 11:40 am revealed:<br>-She received medication orders for residents or the physician's office emailed orders to her and she printed them off.<br>-She faxed all new or changed medication orders to the pharmacy and pharmacy entered the orders into the eMAR system.<br>-She reviewed the new or changed medication orders in the eMAR system before the MAs could administer the medication.<br>-When she reviewed new or changed medication orders, she looked at the directions for administering the medication, and the dose.<br>-If the order was not correct, she contacted the pharmacy.<br>-Resident #3 went to see the physician on 09/24/19 and received pre-operative orders to stop non-steroidal anti-inflammatory drugs (NSAIDS) one week before surgery.<br>-She entered instructions into the eMAR system to hold Resident #3's ibuprofen from 09/26/19 to 10/03/19 because he was scheduled for right shoulder surgery on 10/04/19. | {D 358} | | |

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|---|---|---|---|
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|---|---|---|---|---|
| {D 358} | Continued From page 9<br><br>-She was not able to change the hold instructions for the ibuprofen in the eMAR system after she put the instructions into the computer.<br>-She did not know Resident #3 had an order to stop the ibuprofen on 08/30/19.<br>-She thought Resident #3 was supposed to receive ibuprofen and that was the reason he continued to receive it after 08/30/19 and after the hold order stopped on 10/04/19.<br>-She did not know Resident #3 had an endoscopy or the results of the endoscopy.<br>-She overlooked Resident #3's order to discontinue ibuprofen dated 08/30/19 on his paperwork.<br>-She was responsible for ensuring medication administration was accurate for the residents.<br><br>Interview with the Administrator on 10/16/19 at 12:35 pm revealed:<br>-He expected the Supervisor/MAs and the RCC to ensure medication orders were processed for residents.<br>-He expected the orders to be double checked by the RCC for accuracy so that errors were prevented.<br>-He expected the staff on duty (MAs) to check the hospital paperwork and the RCC to review it to ensure all orders were followed.<br>-If staff had any questions or difficulty with the medication orders or the hospital paperwork, he and the former RCC were always on call and only a phone call away.<br>-The RCC was responsible for all resident clinical matters.<br><br>2. Review of Resident #1's current FL-2 dated 08/09/19 revealed:<br>-Diagnoses included seizure disorder, borderline personality disorder, super-super obesity, and type 2 diabetes. | {D 358} | | |

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|---|---|---|---|---|
| {D 358} | Continued From page 10<br>-There was an order for omeprazole 40mg daily. (Omeprazole is used to treat gastric reflux.)<br><br>Review of Resident #1's September 2019 electronic medication administration record (eMAR) revealed:<br>-There was an entry for omeprazole 40mg daily.<br>-From 09/11/19-09/16/19, there was documentation omeprazole was not administered.<br>-From 09/11/19-09/15/19, there was documentation indicating the reason for not administering omeprazole was "physically unable to take."<br>-From 09/15/19 and 09/16/19, there was documentation indicating "waiting on med."<br><br>Interview with Resident #1 on 10/16/19 at 12:30pm revealed:<br>-She did not receive omeprazole for several days in mid-September.<br>-She was told by the Medication Aide (MA) that the medication was not in the facility.<br>-She did not experience any negative effects from not receiving the omeprazole.<br>-She did not know if staff notified her primary care provider (PCP) about the unavailability of the omeprazole.<br><br>Telephone interview with the pharmacist on 12:50pm on 10/16/19 revealed:<br>-The pharmacy dispensed 30 capsules on 08/26/19.<br>-The facility staff faxed requests for refills of omeprazole on 09/11/19 and 09/14/19.<br>-Both requests were rejected by Resident #1's insurance company because it was too early to refill the prescription.<br>-She did not know why the facility would have run out of Resident #1's omeprazole.<br>-On 09/16/19, the pharmacy dispensed eight | {D 358} | | |

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|---|---|---|---|---|
| {D 358} | Continued From page 11<br>capsules that were paid for by the facility.<br><br>Interview with an MA on 10/16/19 at 1:05pm revealed:<br>-Medication cart audits were done by first or third shift staff.<br>-Cart audits included making sure the medication on the eMAR was available in the carts.<br>-The medication may have been put in the wrong place on the cart.<br><br>Telephone interview with a second MA on 10/16/19 at 1:28pm revealed:<br>-She audited the medication cart twice a week.<br>-The audit consisted of verifying the medication ordered on the eMAR was available on the cart.<br>-She could not recall notifying the Resident Care Coordinator (RCC) about the missed omeprazole not being available for administration.<br><br>Interview with the RCC on 10/16/18 at 1:53pm revealed:<br>-She audited the medication carts every two weeks or when orders changed.<br>-The audit consisted of verifying the medication ordered on the eMAR was available on the cart.<br>-It was possible for medication to be misplaced on the cart.<br>-She did not recall being informed about Resident #1's omeprazole not being available.<br>-She did not recall contacting the pharmacy regarding Resident #1's omeprazole.<br>-The MAs communicated with the pharmacy on their own.<br><br>Telephone interview with a third MA on 10/16/19 at 2:08pm revealed:<br>-She audited the medication cart every other night.<br>-The audit included matching the available | {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 10/16/2019 |

| 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 12<br>medication to the order on the eMAR.<br>-She remembered notifying the pharmacy the second time the omeprazole was not available.<br>-She ordered the omeprazole again on 09/14/19 and told the supervisor on first shift that it had been ordered.<br><br>Interview with the Administrator on 10/16/19 at 2:15pm revealed:<br>-The supervisor audited the carts to make sure the medications on the eMAR were stocked in the cart.<br>-The pharmacy was notified when medication was not available.<br><br>The facility failed to administer medications as ordered by a licensed practitioner to Resident #3 who continued to received ibuprofen after it was discontinued for 38 days because he was diagnosed with severe esophagitis and Barrett's mucosa. This failure increased the residents risk for gastrointestinal bleeding, which. was detrimental to the health, safety and welfare of the residents and constitutes a Unabated Type B Violation.<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/16/19 for this violation. | {D 358} | | |
| {D912} | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. | {D912} | | |

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|---|---|---|---|---|
| {D912} | Continued From page 13<br><br>This Rule is not met as evidenced by:<br>Based on observation, interviews and record reviews, the facility failed to assure each resident received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations as related to medication administration.<br><br>The findings are:<br><br>Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered by a prescribing practitioner for 2 of 5 sampled residents (#1 and #3) including a non-steroidal anti-inflammatory medication (#3) and a medication to treat gastric reflux (#1). [10A NCAC 13F .1004 (a) Medication Administration (Unabated B Violation)] | {D912} | | |