

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034069	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2023
NAME OF PROVIDER OR SUPPLIER THE BRADFORD VILLAGE OF KERNERSVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 602 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 03/14/23 through 03/16/23.	D 000		
D 254	10A NCAC 13F .0801(b) Resident Assessment 10A NCAC 13F .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or substance abuse services or community resource. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 5 sampled residents (#1 and #3) had a care plan completed annually.	D 254		

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

TITLE

(X6) DATE

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D 254	Continued From page 1 The findings are: 1. Review of Resident #3's current FL2 dated 03/10/23 revealed: -Diagnoses included hypertension, anemia, overactive bladder, Parkinson's disease, hyperlipidemia, type 2 diabetes, hypothyroidism, chronic pain, and bladder muscle dysfunction. -There was no information regarding Resident #3's ambulatory status or assistance needed. Review of Resident #3's previous FL2 dated 04/29/22 revealed: -Resident #3 was semi-ambulatory and used a walker. -Resident #3 needed assistance with bathing and dressing. Review of Resident #3's care plan dated 02/11/21 revealed: -Resident #3 was ambulatory with the aide of an assistive device. -She had limited range of motion in her upper extremities. -She needed limited assistance with eating, toileting, ambulation, bathing, dressing, grooming, and transferring. Review of Resident #3's care plans revealed there were no care plans after 02/11/21 available for review. Interview with the Resident Care Coordinator (RCC) on 03/16/23 at 12:31pm revealed: -She or the Administrator were responsible for completing care plans for residents within 30 days of admission, annually, and when there was a change in a resident's condition. -She just started working at the facility in	D 254		

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D 254	Continued From page 2 December 2022 and she had not had a chance to go through the resident records to identify who needed updated annual care plans. -She did not know Resident #3 had not had a care plan completed since 2021. Interview with the Administrator on 03/16/23 at 1:51pm revealed: -She was ultimately responsible for ensuring care plans were completed for residents annually and when there was a significant change in a resident's condition. -The residents' care plans of the residents who had resided at the facility for a long time, had disappeared. -There had not been any record audits completed to determine if residents' care plans needed to be completed since she became the Administrator in November 2022 -She could not find a care plan in Resident #3's record since the care plan that was completed on 02/11/21. 2. Review of Resident #1's current FL-2 dated 08/19/22 revealed: -Diagnoses included dementia, diabetes type 2, congestive heart failure, atrial fibrillation, peripheral neuropathy and used continuous oxygen. -Resident #2 was semi-ambulatory using a wheelchair. -Resident #2 needed assistance with bathing and dressing. Review of Resident #2's Resident Register revealed an admission date of 08/05/15. Interview with Resident #1 on 03/14/23 during the initial tour at 9:35am revealed: -He used oxygen all night to sleep: he used a	D 254		

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D 254	Continued From page 3 portable oxygen concentrator. -He had diabetes and was given injections of insulin. -He saw his primary care provider (PCP) for a routine visit last Friday (03/10/23) and there were no order changes. Review of Resident #1's licensed health professional support (LHPS) review dated 01/27/23 revealed documented tasks for Resident #1 were the resident used continuous oxygen by concentrator, received medication by injection, blood pressure and weights taken daily, needed transferring supervision and finger stick blood sugars (FSBS) taken twice a day. Review of Resident #2's record revealed: -There was no assessment documentation with a care plan completed 30 days after his admission. -There was an Assisted Living Care Plan dated 02/06/19 and with the documentation that Resident #1 needed extensive assistance for bathing and limited assistance was needed for dressing, toileting, feeding and ambulation. -There were no documented annual assessments with completed care plans between 08/05/15 to 02/06/19. -There were no documented annual assessments with completed care plans since 02/06/19. Interview with the RCC on 03/15/23 at 2:45pm revealed: -She was responsible for writing the care plans for new admissions within 30 days and yearly afterwards. -The completed care plans would be kept until it was signed by the PCP and then placed into the residents' binders. -She was not aware Resident #1's care plan was missing.	D 254		

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D 254	Continued From page 4 -Resident #1's care plan should be in his record. -Some of the residents' records had been thinned to make room for other documents. Interview with the Administrator on 03/15/23 at 4:00pm revealed: -She did not know Resident #1's care plan had been missing from his record. -She went through his documents and could find any care plans except for one dated 02/06/19. -There were no care plans in the record for Resident #1 since 02/06/19. - The RCC was responsible for completing the care plans and having them signed by the PCP before placing it in the residents' records. -She was responsible for ensuring audits were done and having care plan documentation was completed and in the residents' records. -There was no documentation of a completed care plan and one was not made available for Resident #1 prior to exit on 03/16/23 except the one dated 02/06/19.	D 254		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide supervision for 1 of 5 sampled residents (#3) who had five falls in four	D 270		

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D 270	Continued From page 5 months. The findings are: Review of Resident #3's current FL2 dated 03/10/23 revealed: -Diagnoses included hypertension, anemia, overactive bladder, Parkinson's disease, hyperlipidemia, type 2 diabetes, hypothyroidism, chronic pain, and bladder muscle dysfunction. -There was no information regarding Resident #3's ambulatory status. Review of Resident #3's previous FL2 dated 04/29/22 revealed Resident #3 was semi-ambulatory with a walker. Review of Resident #3's Licensed Health Professional Support (LHPS) Review dated 01/26/23 revealed Resident #3 required assistance with ambulation and transfers. Review of Resident #3's record revealed: -There was not a current care plan. -The most recent care plan was dated 02/11/21 and documented Resident #3 needed limited assistance with ambulation and transfers, ambulated with an aide or device, and had limited range of motion of her upper extremities. Review of the facility's Accident/Falls/Emergency & Fire Safety Policy dated 10/14/14 revealed there was no information documented regarding increasing supervision of residents after a fall or implementing interventions. a. Review of Resident #3's progress notes revealed there was not a progress note dated 10/18/23.	D 270		

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D 270	Continued From page 6 Review of Resident #3's Incident Accident (I/A) Reports revealed there was no I/A report for 10/18/23. Review of Resident #3's Emergency Department (ED) After Visit Summary dated 10/18/23 revealed: -Resident #3 was seen due to multiple falls. -Diagnoses included acute midline low back pain without sciatica. Based of record reviews and interviews, there was no documentation of increased supervision or interventions implemented for Resident #3 after her fall on 10/18/22. Refer to the interview with Resident #3 on 03/16/23 at 11:20am. Refer to the interview with the Resident Care Coordinator (RCC) on 03/16/23 at 12:31pm. Refer to the interview with the Administrator on 03/16/23 at 1:51pm. Refer to the telephone interview with Resident #3's Primary Care Provider (PCP) on 03/16/23 at 3:30pm. b. Review of Resident #3's progress note dated 11/28/22 at 9:30am revealed: -Resident #3 was found on the floor. -She fell trying to get up off the bed. Review of Resident #3's Incident Accident (I/A) Reports revealed there was no I/A report for 11/28/22. Interview with the personal care aide (PCA) who documented the progress note dated 11/28/22 on	D 270		

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D 270	Continued From page 7 11/16/23 at 10:29am revealed: -She was walking down the hallway and found Resident #3 on the floor beside her bed. -She and the medication aide (MA) on duty assessed Resident #3 and she did not have any bruising, skin tears, or injuries. -She was not told to increase supervision for Resident #3, and she did not know of any interventions put in place for Resident #3 after her fall on 11/28/22. Based on record reviews and interviews, there was no documentation of increased supervision or interventions implemented for Resident #3 after her fall on 11/28/22. Refer to interview with Resident #3 on 03/16/23 at 11:20am. Refer to interview with the Resident Care Coordinator (RCC) on 03/16/23 at 12:31pm. Refer to interview with the Administrator on 03/16/23 at 1:51pm. Refer to telephone interview with Resident #3's Primary Care Provider (PCP) on 03/16/23 at 3:30pm. c. Review of Resident #3's progress note dated 12/07/22 at 1:39pm revealed: -Resident #3 fell the morning of 12/07/22 trying to get out of her wheelchair. -Resident #3 did not have any bruising or pain. Review of Resident #3's Incident Accident (I/A) Reports revealed there was no I/A report for 12/07/22. Interview with the personal care aide (PCA) who	D 270		

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D 270	Continued From page 8 documented the progress note dated 12/07/22 on 03/16/23 at 11:25am revealed: -Resident #3 was sitting in her wheelchair in the front common area when she fell. -Resident #3 did not have any injuries after her fall on 12/07/22. -She was not told to increase supervision for Resident #3, and she did not know of any interventions put in place for Resident #3 after her fall on 12/07/22. Based on record reviews and interviews, there was no documentation of increased supervision or interventions implemented for Resident #3 after her fall on 12/07/22. Refer to the interview with Resident #3 on 03/16/23 at 11:20am. Refer to the interview with the Resident Care Coordinator (RCC) on 03/16/23 at 12:31pm. Refer to the interview with the Administrator on 03/16/23 at 1:51pm. Refer to the telephone interview with Resident #3's Primary Care Provider (PCP) on 03/16/23 at 3:30pm. d. Review of Resident #3's progress note dated 01/05/23 at 5:45pm revealed: -Resident #3 was trying to get up from her wheelchair to sit on the sofa when she fell. -She did not lock her wheelchair and lost her balance. -Resident #3 was sent out to the local hospital due to hitting her head. -She was alert and oriented after her fall. Review of Resident #3's Incident Accident (I/A)	D 270		

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D 270	Continued From page 9 Report dated 01/05/23 at 5:45pm revealed: -Resident #3 had an unwitnessed fall and was observed laying on the floor on her right side in the common area. -Resident #3 had a skin tear to her right hand. -Resident #3 was transported to a local hospital emergency department (ED) for evaluation. -The severity level was a level 4 which documented the occurrence resulted in serious injury or was potentially life threatening (i.e. laceration with sutures, fracture, subdural hematoma); or treatment rendered outside the facility. Review of local hospital reports revealed there were not hospital reports available for Resident #3 for her fall on 01/05/23. Telephone interview with the medication aide (MA) who documented the progress note dated 01/05/23 on 03/16/23 at 11:29am revealed: -Resident #3 was sitting in the lobby area in her wheelchair and had tried to transfer to a sofa without locking her wheelchair. -Resident #3 stated she hit her head and was sent out to a local hospital. -Resident #3 sometimes got up from her bed or from her wheelchair without requesting assistance and pushed her wheelchair instead of sitting in it. -Staff was supposed to check on each resident every 2 hours. -Staff tried to "keep an eye on her." -She had not been told to increase supervision for Resident #3 and there were no interventions put in place for Resident #3 after her fall on 01/05/23. Based on record reviews and interviews, there was no documentation of increased supervision or interventions implemented for Resident #3	D 270		

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D 270	Continued From page 10 after her fall on 01/05/23. Refer to the interview with Resident #3 on 03/16/23 at 11:20am. Refer to the interview with the Resident Care Coordinator (RCC) on 03/16/23 at 12:31pm. Refer to the interview with the Administrator on 03/16/23 at 1:51pm. Refer to the telephone interview with Resident #3's Primary Care Provider (PCP) on 03/16/23 at 3:30pm. e. Review of Resident #3's progress note dated 01/06/23 at 4:23pm revealed: -Resident #3 was observed on the floor near her bathroom. -Resident #3 stated she was coming out of the bathroom when she slipped and fell. -Resident #3 had a large bump on her head. -Resident #3 was sent out to the hospital via emergency medical services (EMS) Review of Resident #3's Incident Accident (I/A) Report dated 01/06/23 at 4:23pm revealed: -Resident #3 fell in her room. -Staff found Resident #3 on the floor in her bedroom. -Staff asked her what happened and Resident #3 explained she was coming out of the bathroom when she slipped and fell on the floor. Review of local hospital reports revealed there were not hospital reports available for Resident #3 for her fall on 01/06/23. Attempted telephone interview with the medication aide (MA) who documented the	D 270		

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D 270	Continued From page 11 progress note dated 01/06/23 on 03/16/23 at 10:39am was unsuccessful. Based on record reviews and interviews, there was no documentation of increased supervision or interventions implemented for Resident #3 after her fall on 01/06/23. Refer to the interview with Resident #3 on 03/16/23 at 11:20am. Refer to the interview with the Resident Care Coordinator (RCC) on 03/16/23 at 12:31pm. Refer to the interview with the Administrator on 03/16/23 at 1:51pm. Refer to the telephone interview with Resident #3's Primary Care Provider (PCP) on 03/16/23 at 3:30pm. Interview with Resident #3 on 03/16/23 at 11:20am revealed: -She remembered falling in the bathroom, dining room, and in front of her bed, but she did not remember when she fell. -She went to the hospital once after a fall. -She did not remember having any skin tears or injuries after any of her falls. -Staff did not do anything differently for her after her falls. -Staff did not come by to check on her much when she was in her room. Interview with the Resident Care Coordinator (RCC) on 03/16/23 at 12:31pm revealed: -She started working at the facility on 12/12/22. -The only fall that she was aware of was when Resident #3 fell on 01/05/23. -Staff should have notified her any time a resident	D 270		

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D 270	Continued From page 12 fell. -If she was not in the facility, staff should have notified her via telephone. -Medication aides (MAs) were responsible for completing Incident/Accident (I/A) Report for all falls. -After falls, residents were monitored for bruising and complaints of pain every 2 hours. -Staff usually checked on all residents at least every 2 hours. -Sometimes staff observed Resident #3 pushing her wheelchair instead of sitting in it. -Sometimes Resident #3 tried to get up from her wheelchair or her bed and go to the bathroom by herself. -She had not instructed staff to check on Resident #3 more frequently than every 2 hours or told staff to increase supervision for Resident #3 after a fall. -She did not know if any interventions were put in place for Resident #3 after any of her falls. Interview with the Administrator on 03/16/23 at 1:51pm revealed: -If a resident had a fall, staff were to assess the resident and if the resident hit their head or was bleeding, the resident was to be sent out to the local hospital. -MAs were to complete an I/A report which was to be sent to the local department of social services if the resident was sent out to the hospital. -If a resident was not sent out to the local hospital after a fall, she expected staff to check on residents every 30 minutes for 72 hours or for at least 8 hours. -She had told staff to check on residents more often after a fall, but not specifically every 30 minutes and she had not told staff to document increased checks. -There was a shift to shift notebook in place in the	D 270		

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D 270	Continued From page 13 medication room and she expected staff to document once each shift for 72 hours regarding the resident's condition after a fall. -She went to look in the shift to shift notebook and there was no documentation of the daily shift checks for 72 hours for residents, including Resident #3, after falls. -She knew about all of Resident #3's falls except for the falls on 10/18/22 and 11/28/22. -There was no increase in supervision or interventions implemented for Resident #3 after her fall on 12/07/23. -After Resident 3's fall on 01/05/23, she checked on her every 30 minutes when Resident #3 returned from the hospital, but she did not document the increased supervision. -She told staff to "keep an eye" on Resident #3 and document her vitals every shift after her fall on 01/05/23, but there was no documentation in shift to shift notebook of vital checks after 01/05/23. -She did not realize Resident #3 was sent out to the hospital on 01/06/23 after having a fall. -There was no increase in supervision or interventions implemented for Resident #3 after her fall on 01/06/23. -She was not aware of Resident #3 having any injuries as a result of falls. -She started working as the Administrator on 11/08/22 and had a Falls Notebook, but it had not been put in place yet due to focusing on other areas, such as dietary, first. Telephone interview with Resident #3's Primary Care Provider (PCP) on 03/16/23 at 3:30pm revealed: -Resident #3 had a history of falls. -She expected staff to increase supervision for Resident #3 after a fall.	D 270			

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D 273	Continued From page 14	D 273		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the acute health care needs for 2 of 5 sampled residents (Residents #3 and #4) related to a resident who had a physician's order for a referral for an eye probe and irrigation (#3) and refusals to obtain finger stick blood sugars to administer sliding scale insulin and refusals of a lidocaine patch for pain (#4). The findings are: 1. Review of Resident #3's current FL2 dated 03/10/23 revealed diagnoses included hypertension, anemia, overactive bladder, Parkinson's disease, hyperlipidemia, type 2 diabetes, hypothyroidism, chronic pain, and bladder muscle dysfunction. Review of an encounter note from the facility's contracted ophthalmologist dated 02/28/23 revealed: -Resident #3's chief complaint was tearing in her right eye and she was concerned about visual acuity and health of her right eye. -Excessive tearing of Resident #3's right eye was observed during the examination on 02/28/23. -Resident #3 had a history of diabetes mellitus. -She had been tearing from her right eye for more than 1 month and had blurry vision. -Resident #3's visual acuity was 20/30 in her right	D 273		

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D 273	Continued From page 15 eye. -Diagnoses included a blocked tear duct. -The plan was to refer Resident #3 for an eye probe and irrigation; the findings were discussed with Resident #3 and staff. Review of Resident #3's physician's order dated 03/07/23 revealed: -There was an order to refer Resident #3 for an eye probe and irrigation due to a diagnosis of a blocked tear duct of the right eye. -There was a fax stamp on the order dated 03/07/23 from the facility's contracted ophthalmologist's office. Observation of Resident #3 on 03/14/23 at 4:43pm revealed she had a tear running from her right eye. Observation of Resident #3 on 03/15/23 at 11:29am revealed she had a tear running from her right eye. Interview with Resident #3 on 03/15/23 at 11:30am revealed: -Her right eye had been watering for about 3 months. -The facility's contracted ophthalmologist came to the facility last month and evaluated her eyes. -She had a tear duct that was closed and needed to be opened up. -She did not know if she had been scheduled to have the procedure to unclog her tear duct. -Her right eye watered all of the time, but she did not have any pain in her right eye. Interview with the Transportation and Scheduling Staff on 03/15/23 at 11:19am revealed: -The Administrator and the Resident Care Coordinator (RCC) were responsible for	D 273		

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D 273	Continued From page 16 reviewing new orders sent to the facility by contracted providers. -The process was for the RCC to provide her with the new orders for appointments and she would follow-through by making the appointments for residents. -She was not present at the facility when Resident #3 was seen by the facility's contracted ophthalmologist and she had not seen the order for Resident #3 to be referred for a probe and irrigation of her right eye. Interview with the Resident Care Coordinator (RCC) on 03/15/23 at 11:24am revealed: -She and the Administrator were responsible for reviewing new orders written by or sent to the facility by contracted providers. -She had not seen and did not know anything about the order for Resident #3 to be refer for a probe and irrigation of her right eye. -She received orders via email and fax from contracted providers and she gave the orders to the Transportation and Scheduling Staff to make an appointment for the resident. -The ophthalmologist visited the facility on 02/28/23, but she did not discuss the findings of the evaluation with her. Interview with the Administrator on 03/16/23 at 1:51pm revealed: -The RCC was responsible for speaking with outside providers after visits with residents. -New orders were placed in a file for the RCC to review, and the RCC was responsible for giving orders for referrals to the Transportation and Scheduling Staff so she could contact outside providers to make appointments. -The order for an eye probe and irrigation for Resident #3 from the contracted ophthalmologist office was faxed to the facility on 03/07/23, a	D 273		

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D 273	Continued From page 17 week after Resident #3 was seen. -She made a copy of the order for Resident #3 for a referral for a probe and irrigation and placed the original order in the file for the RCC to review. -The RCC should have passed the order for the referral to the Transportation and Scheduling Staff after reviewing. -She thought the order for Resident #3 to be referred for an eye probe and irrigation was not reviewed prior to being filed in Resident #3's record. Telephone interview with Resident #3's primary care provider (PCP) on 03/16/23 at 3:30pm revealed she expected facility staff to follow through with orders from outside providers. Attempted telephone interviews with the facility's contracted ophthalmologist on 03/15/23 at 11:13am and on 03/16/23 at 10:46am and at 1:32pm were unsuccessful. 2. Review of Resident #4's current FL2 dated 03/03/23 revealed diagnoses included type 2 diabetes, anemia and fracture of the left acetabulum. a. Review of Resident #4's physician's orders revealed: -There was an order dated 02/22/23 for Humalog (a fast-acting insulin used to lower elevated blood sugar levels) 100 unit/ml pen. Inject as per sliding scale; If FSBS (finger stick blood sugar) 180-200= 2 units, 201-250= 5 units, 152-300= 7 units, 301-350= 10 units, 351-400= 12 units subcutaneously (SQ) before meals and at bedtime. -There was an order dated 02/22/23 to discontinue Humalog and start Novolog (a rapid-acting insulin used to lower elevated blood	D 273		

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D 273	Continued From page 18 sugar levels) 100units/ml flexpen "with same directions". Review of Resident #4's February 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog insulin pen. Inject as per sliding scale; If FSBS 180-200= 2 units, 201-250= 5 units, 152-300= 7 units, 301-350= 10 units, 351-400= 12 units. If below 70 or above 400 call MD. - FSBS ranged from 117 to 292 from 02/23/23-02/28/23. -There was documentation Novolog was not administered for 4 of 22 opportunities with the reason documented as held per orders. Review of Resident #4's March 2023 electronic medication administration record (eMAR) revealed: --There was an entry for Novolog insulin pen. Inject as per sliding scale; If FSBS 180-200= 2 units, 201-250= 5 units, 152-300= 7 units, 301-350= 10 units, 351-400= 12 units. If below 70 or above 400 call MD. -FSBS ranged from 114 to 283 from 03/01/23-03/15/23. -There was documentation Novolog was not administered for 22 of 57 opportunities; 9 due to resident refused, 13 held per orders. Interview with Resident #4 on 03/15/23 at 10:50am revealed: -He received insulin and FSBS 3 or 4 times a day. -He refused FSBS checks a lot because he was tired of being stuck and feels his diabetes is under control. -He had not discussed changing his FSBS times with his PCP.	D 273		

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D 273	Continued From page 19 Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/15/23 at 11:35am revealed: -Resident #4 had a physician's order for Novolog insulin pen inject per sliding scale; If FSBS 180-200= 2 units, 201-250= 5 units, 152-300= 7 units, 301-350= 10 units, 351-400= 12 units. If below 70 or above 400 call MD. -Resident #4 could experience high blood glucose levels if he did not receive his sliding scale insulin as ordered according to his FSBS. Interview with a medication aide (MA) on 03/15/23 at 3:30pm revealed: -Resident #4 would allow him to obtain his FSBS, but he refused other MAs to do the FSBS. -He did not know if any of them had informed the primary care provider (PCP), the Resident Care Coordinator (RCC) or the Administrator of his refusals. -If "R" was documented, it meant the resident refused that medication: "W" meant the PCP said not to give the medication and "PUT" meant the medication was not available to administer. Interview with the Resident Care Coordinator (RCC) on 03/16/23 at 12:30pm revealed: -Resident #4 had a FSBS and sliding scale insulin order. -She also conducted MA duties and Resident #4 had refused to allow her to obtain his FSBS so that she could administer his insulin per sliding scale as ordered. -She had notified the PCP on her weekly visits of Resident #4's refusals to allow FSBS to be obtained. -If "R" was documented, it meant the resident refused that medication: "W" meant the PCP said not to give the medication and "PUT" meant the medication was not available to administer.	D 273			

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D 273	Continued From page 20 Interview with the Administrator on 03/16/23 at 1:40pm revealed: -She had witnessed Resident #4 refuse his FSBS before herself. -She had notified the PCP in early March 2023 of his refusals, she was unsure of the date. -She now expected the MAs to document refusals and notify her or the RCC after 2 or 3 refusals so that the PCP could be informed. Telephone interview with Resident #4's PCP on 03/16/23 at 3:10pm revealed: -He had diabetes type 2 and had an order for insulin per sliding scale before meals and at bedtime. -She expected the facility staff to obtain Resident #4's FSBS so that staff could administer his insulin per the sliding scale as ordered. -If he did not receive the correct amount of units of insulin as ordered he could have high blood glucose levels. -She expected the facility staff to notify her of repeated refusal of care or medications by residents. -She would normally look at the eMAR on her visit, but she was not looking at his insulin or refusal documentation on her last visit on 03/10/23. -She was not notified of Resident #4's refusal to have his FSBS obtained. b. Review of Resident #4's physician's orders revealed an order on 03/03/23 for lidocaine pain relief 4% patch (used to treat pain), apply 1 patch to lower back daily at 8:00am. Remove for 12 hours at 8:00pm. Review of Resident #4's February 2023 electronic medication administration record (eMAR)	D 273			

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D 273	Continued From page 21 revealed: -There was an entry for lidocaine pain relief 4% patch, apply 1 patch to lower back daily at 8:00am. Remove for 12 hours at 8:00pm. -There was documentation lidocaine pain relief 4% patch was administered on 02/26/23. -There was documentation lidocaine pain relief 4% patch was refused on 02/24/23 and on 02/28/23. -There was documentation lidocaine pain relief 4% patch was withheld per doctor's order on 02/25/23 and on 02/27/23. Review of Resident #4's March 2023 electronic medication administration record (eMAR) revealed: -There was an entry for lidocaine pain relief 4% patch, apply 1 patch to lower back daily at 8:00am. Remove for 12 hours at 8:00pm. -There was documentation lidocaine pain relief 4% patch was administered 03/11/23. -There was documentation lidocaine pain relief 4% patch was refused on 03/01/23 and on 03/02/23, 03/05/23-03/10/23 and on 03/12/23-03/15/23. -There was documentation lidocaine pain relief 4% patch was withheld per doctor's order on 03/03/23 and on 03/04/23. Interview with Resident #4 on 03/15/23 at 10:50am revealed: -He had only received his pain patch one day since he was admitted 02/22/23. -He had chronic back pain and had a fall a few months ago when he broke some bones. -He never refused his pain patch because he needed it for relief of his chronic pain. Observation of medications on hand for Resident #4 on 03/15/23 at 11:15am revealed:	D 273			

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D 273	Continued From page 22 -There were 19 of 29 lidocaine pain relief 4% patches in a clear bag available to administer for Resident #4. -The instructions were to apply to lower back 1 time a day. -The bag of patches was dispensed on 02/22/23. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/15/23 at 11:35am revealed: -Resident #4 had a physician's order for lidocaine pain relief 4% patch, apply 1 time a day and remove for 12 hours. -Resident #4's lidocaine 4% patch was dispensed to the facility only one time on 02/22/23 for 30 patches. -Lidocaine 4% patch is used to treat pain and the resident could have continued pain he did not receive it as ordered. Interview with a medication aide (MA) on 03/15/23 at 3:30pm revealed: -Resident #4 had pain patches for his chronic back pain. -Resident #4 liked him and so let him put his pain patch on, but he knew he refused it from other MAs. -He also had scheduled acetaminophen to help with pain control. Interview with the Resident Care Coordinator (RCC) on 03/16/23 at 12:30pm revealed: -Resident #4 had lidocaine pain patches. -She also conducted MA duties and Resident #4 had refused his pain patch nearly every morning and then would come back when it was past due and ask for it. -She did not know how to edit the eMAR after she documented refused. -She informed Resident #4's PCP about him	D 273		

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STATE FORM

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D 296	Continued From page 24 The findings are: Review of the American Dietetic Association's (ADA) definition of a mechanical soft diet (MS) would include foods designed for people who have trouble chewing and swallowing, chopped and ground foods and foods that break apart without a knife are included. A no concentrated sweets (NCS) diet would be avoiding foods containing a lot of sugars or high calorie sweeteners. Observation of the kitchen during the initial tour on 03/14/23 at 11:45am revealed: -There was a Menu Cycle sheet with the date of 2022-2023 posted for staff reference. -There was no time period, date or signature on the document. -Above the column labeled "Friday" on the Menu Cycle sheet were the words "Regular/No Added Salt". -There were no therapeutic diets listed on the Menu Cycle sheet for staff reference. Observation of the kitchen on 03/14/23 at 12:15pm revealed: -The Dietary Manager (DM) was plating the lunch meal for the residents and placing the plates on the warming table for staff to deliver to the residents in the dining room. -There were no therapeutic diet menus to reference for the residents' lunch meal. -There were no therapeutic diet menus to reference for a NCS diet or MS diet. Observation of the lunch meal on 03/14/23 at 12:15 pm revealed: -All residents were served sliced baked ham, baked sweet potatoes, seasoned cabbage frosted cake bar, chilled water and tea.	D 296			

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D 296	Continued From page 25 -The diet selection used for the meal was Regular. -There were no MS or NCS diets offered to the residents for the lunch meal. Observation of the evening meal on 03/14/23 at 5:15pm revealed: -All residents were served vegetable beef soup, saltine crackers, marinated tomato and cucumber salad, pimento cheese sandwiches, fruited gelatin and chilled water. -The diet selection used for the meal was Regular. -There were no MS or NCS diets offered to the residents for the dinner meal 1.Review of Resident #2's current FL-2 dated 08/19/22 revealed: -Diagnoses included diabetes type II, bradycardia, hypertension recurrent UTI and transmitters amputation, -There was an order for a mechanical soft diet. Review of the facility's therapeutic diet list revealed Resident #2 was to be served an MS diet. Interview with Resident #2 ton 03/14/23 at 12:33pm revealed: -He was on a MS diet but the meat served was too tough and hard to eat. -The food was not cut up enough to eat. -Sometimes he might be given a substitute for the meats, but not always. Interview with a dietary cook on 03/14/23 at 5:05pm revealed: -She had been a cook for 2 weeks for the evening meal. -She was taught to plan resident's meals	D 296		

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D 296	Continued From page 26 according to the regular meal plan on the Menu Cycle. -She had not seen not seen menus for NCS or MS therapeutic diets. -She was taught to go by the regular diet menu. -When making MS foods, she boiled each food until it became softened pieces. - For a NCS diet, she served a regular meal with unsweetened tea -There were no menus available for guidance MS diets or NCS diets. Interview with the Dietary Manager (DM) on 03/14/23 at 12:55pm revealed: -He did the cooking for the breakfast and lunch meals. -He posted the Menu Cycle sheet for staff to follow when preparing meals. -He had a list of the residents who had therapeutic diet orders and a binder of menus made by a licensed dietitian that were kept in the back of the kitchen in his office. -He did not keep the therapeutic menus posted for reference, only the Menu Cycle list. -If a resident was given orders for a NCS or MS diet he would tell staff to be sure foods were chopped if needed or to give a dessert of fruit and give unsweetened tea to the residents ordered to have a NCS meal. Refer to the interview with the Administrator on 03/15/23 at 9:45am. 2. Review of Resident #3's current FL-2 dated 03/10/23 revealed: -Diagnoses included gerd, anemia, vitamin D deficiency, and Parkinson's disease. -There was no diet order documented by the physician on the FL-2.	D 296		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 296	Continued From page 27 Review of Resident #3's physician's order dated 01/13/23 revealed an order for a MS diet. Review of the facility's therapeutic diet list revealed Resident #3 was to be served an MS diet. Interview with Resident #3 on 03/14/23 at 12:33pm revealed: -She had a physician's order for a MS diet. -Her lunch meal consisted of a piece of ham, cornbread, a sweet potato, cabbage and tea. -Her food was not normally cut up. -If she chews her food very slowly she can swallow. Refer to the interview with the Administrator on 03/15/23 at 9:45am. 3. Record review for Resident #6 revealed Physician's Orders dated 09/22/22 revealed: -Diagnoses included chronic kidney disease, stage 3, diabetes type II, stroke with psychosis, vascular dementia with behavioral disturbance. -There was an order for a regular, MS diet for Resident #6. Review of Resident #6's Care Plan dated 09/23/22 revealed the resident received hospice services, was totally dependent for activities of daily living (ADL). Observation of Resident #6 lying in her bed on 03/14/23 at 12:30pm revealed: -A personal care aide (PCA) was feeding the resident her noon meal.. -The PCA had to stop feeding Resident #6 to cut the ham into smaller pieces so the resident could swallow her food.	D 296		

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D 296	Continued From page 28 Interview with the PCA on 03/14/23 at 12:40pm revealed: -Resident #6 had difficulty feeding herself and needed assistance. -Resident #6 had an order for a MS meal. -Resident #6 would choke if she did not have her food softened and in small pieces. -She often needed to cut or mash the food on Resident #6's plate so the resident could eat the meal. Refer to the interview with the Administrator on 03/15/23 at 9:45am. 4. Review of Resident #7's current FL-2 dated 08/15/22 revealed: -Diagnoses included alter mental status, diabetes type II, GERD and acute kidney injury. -There was no diet order documented by the physician on the FL-2 for Resident #7. Record review for Resident #7 revealed a physician's order dated 08/19/22 for a NCS diet. Review of the facility's therapeutic diet list revealed Resident #7 was to be served a NCS diet. Attempted interview with Resident #7 on 03/15/23 at 4:10pm was unsuccessful. Attempted telephone interviews with the facility's contracted dietitian on 03/15/23 at 1:58 pm with a recall at 2:35pm was unsuccessful. Refer to the interview with the Administrator on 03/16/23 at 9:45am. Review of the contracted dietitian's menu documentation obtained by the Administrator on	D 296			

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D 296	Continued From page 29 03/15/23 at 3:15pm for cycle 2022-2023, Diet Spread Sheet revealed: -There were menus for diet categories including No Concentrated Sweets and Mechanical Soft. -There was documentation by the licensed dietitian, the cycle menu was approved as written and written on 08/12/22. Interview with the Administrator on 03/15/23 at 9:45am revealed: -The facility contracted with a dietary management company for menus for resident meals. -The company provided the dietitian to write, add to or change the menus as needed per physicians' orders. -The facility communicated electronically in obtaining the cycle menus prepared by the dietitian. -The facility had a binder in the kitchen's office containing menus, requested diet orders and dietitian information that were not posted on the wall in the kitchen by the manager. -She was not aware the residents with NCS and MS orders were not being followed due to the complete menus not being posted in the kitchen for staff reference. -The dietary manager was responsible for preparing residents' meals as per physicians' orders, and insuring dietary staff were trained correctly and had the therapeutic menus to review and served as per physician's orders. -She was responsible for being sure all residents all were receiving the correct meals.	D 296		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 358		

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D 358	Continued From page 30 (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents (#4 and #3) including an iron supplement, insulin and chronic pain medication (#4), and an estrogen steroid cream, and a pain medication (#3). The findings are: 1. Review of Resident #4's current FL2 dated 03/03/23 revealed diagnoses included type 2 diabetes, anemia and fracture of the left acetabulum. Review of Resident #4's Resident Register revealed that he was admitted 02/22/23 from another facility. Review of Resident #4's admission note by a medication aide (MA) on 02/22/23 at 2:45pm revealed: -Resident #4 was administered his nightly medications that were brought in from the previous facility. -It was not documented what medications were present on admission and who brought in the medications.	D 358			

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D 358	Continued From page 31 a. Review of Resident #4's physician's orders dated 03/03/23 revealed an order for basaglar (a long-acting insulin used to lower elevated blood sugar levels) 100 unit/ml inject 10 units subcutaneously (SQ) every morning. Review of Resident #4's February 2023 electronic medication administration record (eMAR) revealed: -There was an entry for basaglar inject 10 units SQ every morning scheduled at 8:00am. -There was documentation basaglar 10 units was administered from 02/24/23-02/28/23. -His FSBS ranged from 117 to 292 from 02/23/23-02/28/23. Review of Resident #4's March 2023 eMAR revealed: -There was an entry for basaglar inject 10 units SQ every morning scheduled at 8:00am. -There was documentation basaglar 10 units was administered from 03/01/23-03/04/23 and from 03/06/23-03/14/23. -There was documentation basaglar 10 units was refused on 03/05/23 and 03/15/23. -His FSBS ranged from 114 to 283 from 03/01/23-03/15/23. Interview with Resident #4 on 03/15/23 at 10:50am revealed: -He had not gotten all his medications since he was admitted 02/22/23. -He only got one kind of insulin injection since he was admitted, but he could not remember that name of the insulin. -He did not pay attention to the insulin or the amount he was administered. -He refused finger stick blood sugar (FSBS) checks sometimes because he was tired of being	D 358		

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D 358	Continued From page 32 stuck and felt his diabetes was under control. Observation of medications on hand for Resident #4 on 03/15/23 at 11:15am revealed: -There was no basaglar insulin on the medication cart available to administer. -When the basaglar insulin was requested, the Resident Care Coordinator (RCC) went into the medication aide's (MA) office and retrieved an unopened box of basaglar insulin. -The unopened box was labeled basaglar 100 units/ml containing 5 pens. -The label included Resident #4's name and to administer basaglar 10 units SQ every morning with a dispense date of 02/22/2023. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/15/23 at 11:35am revealed: -Resident #4 had a physician's order for basaglar 100 units/ml inject 10 units subcutaneously (SQ) every morning. -Resident #4's basaglar insulin was dispensed to the facility only one time on 02/22/23 for 5 pens, that would have been just over 100 days supply. -Basaglar insulin was used to treat diabetes and the resident could experience high blood glucose levels if he did not receive it as ordered. Interview with a MA on 03/15/23 at 3:30pm revealed: -He worked the next evening 02/23/23 after Resident #4 was admitted. -Resident #4 only had one insulin available for his sliding scale according to his FSBS that he administered on 02/23/23 at 4:30pm. -He did not work the morning shift and so he would not have had to administer Resident #4's basaglar insulin and would not have looked for the basaglar insulin pen.	D 358		

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D 358	Continued From page 33 Interview with a second MA on 03/15/23 at 3:50pm revealed: -She worked the afternoon that Resident #4 was admitted and made his admission note. -He had one dose of his nighttime medications that the previous facility sent with him. -There was only one Lispro insulin in his medications. -She remembered because it had to be changed to Novolog because the pharmacy said his insurance wouldn't pay for Lispro (a fast-acting insulin used to control blood sugar levels). -There was no other insulin pen in Resident #4's medications brought from the other facility. Interview with the RCC on 03/16/23 at 12:30pm revealed: -Resident #4 had 2 insulin pens when he was admitted. -She also conducted MA duties and Resident #4 had refused to allow her to administer his basaglar and regular insulin to him a couple of times. -She informed the PCP of his refusals during her weekly visits. -Resident #4 had a gray insulin pen that lasted until 03/15/23. -During medication cart audits she compared the medications on hand to the eMARs to make sure all medications were available. Interview with the Administrator on 03/16/23 at 1:40pm revealed: -She picked up Resident #4 from the previous facility when he was admitted. -The staff at the previous facility handed her a bag that contained his medications. -Resident #4 had 1 blue and 1 gray insulin pen when he was admitted, but she was not sure	D 358		

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D 358	Continued From page 34 what kind they were and how much was left in each. -She was responsible to conduct medication cart audits, but there was no set schedule. -During medication cart audits she compared the medications on hand to the eMARs to make sure all medications were available. -She expected the MAs to administer Resident #4's insulin as ordered. Telephone interview with Resident #4's primary care provider (PCP) on 03/16/23 at 3:10pm revealed: -She saw Resident #4 on 03/03/23 and 03/10/23 because he was a new admission to the facility. -He had diabetes type 2 and had an order for basaglar long-acting insulin inject 10 units every day to control his blood glucose. -She expected the facility staff to administer his basaglar daily as ordered. -If he did not receive his basaglar insulin every day he could have high blood glucose levels. b. Review of Resident #4's physician's orders revealed an order on 03/03/23 for ferrex 150mg capsule take 1 one a day (an iron supplement). Review of Resident #4's February 2023 electronic medication administration record (eMAR) revealed: -There was an entry for ferrex 150mg capsule take 1 once and scheduled at 8:00am. -There was documentation ferrex 150mg was administered from 02/24/23-02/28/23. Review of Resident #4's March 2023 eMAR revealed: -There was an entry for ferrex 150mg capsule take 1 once and scheduled at 8:00am. -There was documentation ferrex 150mg was	D 358			

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D 358	Continued From page 35 administered from 03/01/23-03/04/23 and from 03/06/23-03/14/23. -There was documentation ferrex 150mg was refused on 03/05/23 and 03/15/23. Interview with Resident #4 on 03/15/23 at 10:50am revealed: -He had not gotten all his medications since he was admitted 02/22/23. -He was not sure what his iron pill looked like and if it was one that the MAs had given him. -He never refused any of his medications, but had refused finger stick blood sugar (FSBS) checks sometimes. Observation of medications on hand for Resident #4 on 03/15/23 at 11:15am revealed: -There was no ferrex 150mg capsule in Resident #4's prepackaged medication dose from the contracted pharmacy. -When asked about Resident #4's ferrex, the RCC retrieved a bubble card from the bottom drawer of the medication cart. -The bubble pack was labeled with Resident #4's name and instructions of ferrex 150mg take 1 tablet daily. -The bubble pack contained 30 of 30 capsules dispensed on 02/22/23. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/15/23 at 11:35am revealed: -Resident #4 had a physician's order for ferrex 150mg take 1 a day. -Resident #4's ferrex 150mg was dispensed to the facility only one time on 02/22/23 for 30 capsules. -Ferrex was used to treat anemia and the resident could have low blood iron levels if he did not receive it as ordered.	D 358		

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D 358	Continued From page 36 Interview with a medication aide (MA) on 03/15/23 at 3:30pm revealed: -He worked the next evening 02/23/23 after Resident #4 was admitted. -Resident #4 only had some bubble cards of medications that might have contained 2-4 pills each from his previous facility. -He was not sure of every medication that came from the previous facility. -He thought the medication cards from his previous facility were disposed of when this facility's contracted pharmacy delivered Resident #4's medications. -He worked the morning of 03/11/23 and thought Resident #4's iron was in the dose pack roll from the pharmacy, but he did not remember if he saw it in the prepackaged medication dose that day. -He did not know there was a separate bubble card that contained the resident's iron. Interview with a second MA on 03/15/23 at 3:50pm revealed: -She worked the afternoon that Resident #4 was admitted and made his admission note. -He had a dose of his nighttime medications that the previous facility sent with him. -She did not remember and did not document which medications were sent with him. -She was not sure if his ferrex was received from the previous facility and how many when he was admitted. Interview with the Resident Care Coordinator (RCC) on 03/16/23 at 12:30pm revealed: -Resident #4 had ferrex in a bubble pack. -She also conducted MA duties and she had administered ferrex to him 2 times. -She and the Administrator conducted medication cart audits, but there was no set schedule.	D 358		

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D 358	Continued From page 37 -She tried to conduct medication cart audits 2 times a week while administering medications as a MA. -During medication cart audits she compared the medications on hand to the eMARs to make sure all medications are available. Interview with the Administrator on 03/16/23 at 1:40pm revealed: -She picked up Resident #4 from the previous facility when he was admitted. -The staff at the previous facility handed her a bag that contained his medications. -She was responsible to conduct medication cart audits, but there was no set schedule. -During medication cart audits she compared the medications on hand to the eMARs to make sure all medications are available. -She expected the MAs to administer Resident #4's ferrex as ordered. Telephone interview with Resident #4's primary care provider (PCP) on 03/16/23 at 3:10pm revealed: -She saw Resident #4 on 03/03/23 and 03/10/23 because he was a new admission to the facility. -He had anemia and had an order for ferrex 150mg 1 time a day. -She expected the facility staff to administer his ferrex daily as ordered. -If he did not receive his ferrex every day he could have low iron levels. c. Review of Resident #4's physician's orders revealed an order on 03/03/23 for lidocaine pain relief 4% patch (used to treat pain), apply 1 patch to lower back daily at 8:00am. Remove for 12 hours at 8:00pm. Review of Resident #4's February 2023 electronic	D 358		

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D 358	Continued From page 38 medication administration record (eMAR) revealed: -There was an entry for lidocaine pain relief 4% patch, apply 1 patch to lower back daily at 8:00am. Remove for 12 hours at 8:00pm. -There was documentation lidocaine pain relief 4% patch was applied on 02/26/23. -There was documentation lidocaine pain relief 4% patch was refused on 02/24/23 and 02/28/23. -There was documentation lidocaine pain relief 4% patch was withheld per doctor's order on 02/25/23 and 02/27/23. Review of Resident #4's March 2023 eMAR revealed: -There was an entry for lidocaine pain relief 4% patch, apply 1 patch to lower back daily at 8:00am. Remove for 12 hours at 8:00pm. -There was documentation lidocaine pain relief 4% patch was applied on 03/11/23. -There was documentation lidocaine pain relief 4% patch was refused on 03/01/23 and on 03/02/23, 03/05/23-03/10/23 and on 03/12/23-03/15/23. -There was documentation lidocaine pain relief 4% patch was withheld per doctor's order on 03/03/23 and 03/04/23. Interview with Resident #4 on 03/15/23 at 10:50am revealed: -He had not gotten his pain patch every day since he was admitted on 02/22/23. -He had chronic back pain and had a fall a few months ago when he broke some bones. -He never refused his pain patch because he needed it for relief of his chronic pain. Observation of medications on hand for Resident #4 on 03/15/23 at 11:15am revealed: -There were 19 of 29 lidocaine pain relief 4%	D 358		

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D 358	Continued From page 39 patches in a clear bag available to administer for Resident #4. -The instructions were to apply to lower back 1 time a day. -The bag of patches was dispensed on 02/22/23. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/15/23 at 11:35am revealed: -Resident #4 had a physician's order for lidocaine pain relief 4% patch, apply 1 time a day and remove for 12 hours. -Resident #4's lidocaine 4% patch was dispensed to the facility only one time on 02/22/23 for 30 patches. -Lidocaine 4% patch is used to treat pain and the resident would experience continued pain he did not receive it as ordered. Interview with a medication aide (MA) on 03/15/23 at 3:30pm revealed: -He worked the next evening 02/23/23 after Resident #4 was admitted but did not remember if he had lidocaine patches before the facility's contracted pharmacy delivered his medications. -Resident #4 had pain patches from the facility's contracted pharmacy delivered for his chronic back pain. -He had worked one day shift and Resident #4 let him apply his patch. -Resident #4 liked him and so would let him put his pain patch on, but he knew he refused it from other MAs. Interview with a second MA on 03/15/23 at 3:50pm revealed: -She worked the afternoon that Resident #4 was admitted and made his admission note. -The previous facility sent Lispro insulin and some pills to give a dose of his nighttime	D 358		

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D 358	Continued From page 40 medications until the facility's contracted pharmacy delivered his medications. -She did not remember and did not document which medications were sent with him. -Resident #4 did not have any patches in his medications from the previous facility. Interview with the Resident Care Coordinator (RCC) on 03/16/23 at 12:30pm revealed: -Resident #4 had lidocaine pain patches. -She also conducted MA duties and Resident #4 had refused his pain patch nearly every morning and then would come back when it was past due and ask for it. -She did not give it to him when he returned because she did not know how to edit the eMAR to document that it was given. Interview with the Administrator on 03/16/23 at 1:40pm revealed: -Resident #4 refused his lidocaine patch most of the time. -She had notified the PCP earlier this month (unsure of the date) of his repeated refusals. -She expected the MAs to administer Resident #4's medications as ordered. -She and the RCC were still learning ways to document in the eMAR system so that they could document and edit medication administration. Telephone interview with Resident #4's primary care provider (PCP) on 03/16/23 at 3:10pm revealed: -She saw Resident #4 on 03/03/23 and 03/10/23 because he was a new admission to the facility. -He had chronic pain and had an order for lidocaine 4/% patch for his back 1 time a day. -She expected the facility staff to apply his lidocaine patch daily as ordered. -She was not informed that he refused nearly	D 358		

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D 358	Continued From page 41 every day. -She left the lidocaine patch order because she was going to refer Resident #4 to the pain control clinic and expected him to receive it. She did not discontinue or hold the lidocaine patch. -The pain control clinic needed more progress notes regarding chronic pain and response to treatments before they would make an appointment -If he did not receive his lidocaine patch every day he could continue to have un relieved pain. 2. Review of Resident #3's current FL2 dated 03/10/23 revealed: -Diagnoses included hypertension, anemia, overactive bladder, Parkinson's disease, hyperlipidemia, type 2 diabetes, hypothyroidism, chronic pain, and bladder muscle dysfunction. -There was an order for estradiol (used to treat changes in and around the vagina such as dryness, itching, and burning) 0.01% cream, and there were no directions for use. Review of Resident #3's physician's orders dated 03/10/23 revealed an order for estradiol 0.01% cream apply a pea sized amount around the urethra 3 times a week. Review of Resident #3's previous FL2 dated 04/29/22 revealed an order for estradiol 0.01% cream apply a pea sized amount around the urethra 3 times weekly. Review of Resident #3's electronic Medication Administration Record (eMAR) for January 2023 revealed: -There was an entry for estradiol 0.01% cream apply a pea sized amount around the urethra 3 times a week. -Estradiol cream was documented as applied for	D 358		

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D 358	Continued From page 42 13 of 13 opportunities in January 2023. Review of Resident #3's eMAR for February 2023 revealed: -There was an entry for estradiol 0.01% cream apply a pea sized amount around the urethra 3 times a week. -Estradiol cream was documented as applied for 11 of 12 opportunities in February 2023. Review of Resident #3's eMAR from 03/01/23 through 03/13/23 revealed: -There was an entry for estradiol 0.01% cream apply a pea sized amount around the urethra 3 times a week. -Estradiol cream was documented as applied for 5 of 6 opportunities from 03/01/23 through 03/13/23. Observation of medications available for Resident #3 on 03/14/23 at 4:11pm revealed: -A tube of estradiol vaginal cream was available and dispensed by the pharmacy on 08/08/22. -The tube of estradiol had been opened, but it was almost full. Interview with a medication aide (MA) on 03/14/23 at 4:01pm revealed: -She usually worked on second shift, but she worked first shift occasionally. -She had not applied estradiol cream to Resident #3 and she did not know why she documented estradiol cream had been applied when it had not been applied. Interview with Resident #3 on 03/14/23 at 4:43pm revealed: -She had a history of urinary tract infections (UTI). -She had experienced itching and burning in her	D 358			

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D 358	Continued From page 43 vaginal area after she urinated for about 2 months. -Staff had never applied a cream to her vaginal area. -She had not told staff about burning in her vaginal area because she was embarrassed. Interview with a pharmacist from the facility's contracted pharmacy on 03/15/23 at 8:55am revealed: -Resident #3 had an order for estradiol 0.01% cream apply a pea sized amount around the urethra 3 times a week. -Estradiol cream was dispensed to the facility on 08/08/22 and 03/14/23. -The facility had not requested to reorder estradiol cream for Resident #3 between 08/08/22 and 03/14/23. Interview with a nurse from Resident #3's hospice provider's office on 03/15/23 at 2:43pm revealed: -A hospice nurse visited Resident #3 once a week. -Resident #3 had an order for estradiol for burning and dryness in the vaginal area due to changes in hormones. -On 03/01/23, she visited Resident #3 and she complained about burning after urination. -She reviewed Resident #3's medication orders and saw Resident #4 had an active order for estradiol cream. -Resident #3 told her the MAs had not been applying the cream. -She talked to the MA who was on duty on 03/01/23 about the cream and the MA told her Resident #3 had not been getting the estradiol cream according to the date on the medication box and the amount remaining in the estradiol tube. -She requested a new physician's order for	D 358		

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D 358	Continued From page 44 estradiol cream from Resident #3's hospice provider on 03/01/23. -She visited with Resident #3 on 03/15/23 and one of her biggest complaints was burning after urination. Telephone interview with a nurse from Resident #3's urologist's office on 03/16/23 at 1:32pm revealed: -Resident #3 had an order for estradiol 0.01% cream apply a pea sized amount around the urethra 3 times a week. -Estradiol was originally prescribed for Resident #4 in 03/30/22 to help reduce the risks of recurrent UTI's. -The urologist expected for estradiol to be applied to Resident #3 vaginal area as ordered 3 times weekly. -Resident #3 had positive urine cultures on 07/14/22, 10/05/22, and 12/15/22. -Ongoing use of estradiol cream could have potentially decreased the likelihood of positive urine cultures. Interview with the Resident Care Coordinator (RCC) on 03/16/23 at 12:31pm revealed: -She worked as the RCC and as a MA. -As a MA, she had not applied estradiol cream to Resident #3. -She once gave the cream to a personal care aide (PCA) to apply. -She did not know until 03/14/23 that the estradiol cream available for Resident #3 had been dispensed by the pharmacy on 08/08/22 and there was almost a full tube remaining. -MAs should not have documented estradiol cream was applied if it had not been applied. -She did not know why she or the other MAs documented the cream was applied when it was not.	D 358		

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D 358	Continued From page 45 -She conducted medication cart audits twice with the last audit being in January 2023. -She did not notice estradiol had not been used as ordered during her last cart audit. Interview with the Administrator on 03/16/23 at 1:51pm revealed: -She worked as a MA in as well as the Administrator. -She had not applied estradiol cream to Resident #3 during her medication administration because she did not know she had a vaginal cream. -She did not know MAs had not applied estradiol cream to Resident #3. -She expected MAs to apply estradiol cream to Resident #3 3 times a week as ordered. -She conducted a cart audit when she worked as a MA a few weeks ago. -She did not notice estradiol cream was dispensed to the facility on 08/08/23 and that there was almost a full tube remaining. 3. Review of Resident #3's current FL2 dated 03/10/23 revealed diagnoses included chronic pain. Review of Resident #3's physician's orders dated 03/10/23 revealed no orders for Ultracet (used to treat pain) 37.5mg-325mg as needed. Review of Resident #3's primary care provider's (PCP) progress note dated 04/15/22 revealed an order for Ultracet 37.5mg-325mg 1 tablet twice a day. Review of Resident #3's PCP's progress note dated 01/06/23 revealed: -Resident #3 had a diagnosis of chronic pain syndrome and was seen on 01/06/23 for follow-up on pain management.	D 358		

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D 358	Continued From page 46 -Resident #3 was on Ultracet 37.5-325mg 1 tablet twice daily as needed for pain. -Resident #3 reported on 01/06/23 that she was "doing good and her pain was okay." -There was a prescription written for Ultracet 37.5-325mg 1 tablet twice daily as needed on 01/06/23, but staff reported Resident #3 had many Ultracet tablets remaining and there was no need for a new prescription to be sent to the pharmacy. Interview with a pharmacist from the facility's contracted pharmacy on 03/14/23 at 3:23pm revealed: -Resident #3 had an order dated 09/01/22 for Ultracet 37.5-325mg 1 tablet twice daily as needed for pain. -Ultracet was last dispensed to the facility on 09/07/22 with a 30 day supply. -The facility would have needed to reorder and provide a new prescription for Ultracet. -There had not been any other requests for refills or new prescriptions for Ultracet. Observation of the medication available for Resident #3 on 03/14/23 at 3:54pm revealed Ultracet was not available on the medication cart. Interview with a medication aide (MA) on 03/14/23 at 4:01pm revealed: -There was no Ultracet available for Resident #3. -Resident #3 had not asked her for any as needed pain medication. -She had not administered Ultracet to Resident #3. -MAs were responsible for reordering medications and for sending a message to the PCP to obtain new orders for medications. Interview with Resident #3 on 03/15/23 at	D 358		

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D 358	Continued From page 47 11:30am revealed: -She did not currently have any pain in her body, but she was having a migraine headache. -She did not remember if she was administered Ultracet or what medications she currently received. -She requested to let a MA know she was having a migraine headache and needed medication. Interview with the Resident Care Coordinator (RCC) on 03/16/23 at 12:31pm revealed: -She did not know there was no Ultracet available in the facility for Resident #3. -She did not know Ultracet was not on the eMAR. -She expected staff to reorder Ultracet, if it ran out. -The MAs, the RCC, or the Administrator could have sent a message to Resident #3's PCP requesting a new prescription for Ultracet. -The MA on duty when the PCP visited the facility could have requested a new prescription at the time of her visit. -She did not know why a new prescription for Ultracet had not been requested from the PCP. -She had not completed an eMAR audit nor a record audit; she had completed a medication cart audit twice with the last medication cart audit being in January 2023. Interview with the Administrator on 03/16/23 at 1:51pm revealed: -The eMARs were printed for the PCP to review when she came to the facilities on Fridays to ensure medication orders were correct. -She did not know Ultracet was not available in the facility for Resident #3. -The RCC was responsible for reviewing the PCP's progress notes, but she assisted if the RCC was administering medication. -When she reviewed the PCP's progress notes,	D 358		

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D 358	Continued From page 48 she looked for new orders and referrals; she did not review other documented details of the visit. -She would have expected the RCC to follow up with the PCP regarding her documentation of Ultracet if Ultracet was not available in the facility and was not on the eMAR. Telephone interview with Resident #3's PCP on 03/16/23 at 3:30pm revealed: -Resident #3 had a diagnosis of chronic pain and had a current order for Ultracet as needed. -She expected the facility to have Ultracet available for Resident #3 if she needed it. -Facility staff should have contacted her for a new order for Ultracet to ensure it was available for Resident #3. The facility failed to ensure medications were administered as order for 2 of 5 sampled residents including a resident who required long-acting insulin placing the resident at risk for high blood glucose levels, a topical patch for chronic pain relief causing the resident to have unrelieved chronic pain and an iron supplement placing the resident at risk for low blood iron levels (#4); and a resident who had physician's orders for an estrogen steroid cream and the cream had not been applied which resulted in the resident continuing to experience burning in her vaginal area, and the resident had a diagnosis of chronic pain with orders for pain medication as needed and the medication was not available placing the resident at risk for increased pain (#3). This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/15/23 for this violation.	D 358		

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D 358	Continued From page 49 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, April 30, 2023.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on interviews, observations and record reviews, the facility failed to ensure electronic medication administration records (eMAR) were accurate for 3 of 5 residents (Resident #3, #4, and #5) related to documenting an eyedrop that had been discontinued and no documentation of	D 367		

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D 367	Continued From page 50 a hypothyroid medication (#3) and not documenting the amount of insulin administered to residents (#4 and #5). The findings are: 1. Review of Resident #3's current FL2 dated 03/10/23 revealed: -Diagnoses included hypertension, anemia, overactive bladder, Parkinson's disease, hyperlipidemia, type 2 diabetes, hypothyroidism, chronic pain, and bladder muscle dysfunction. -There was an order for olopatadine HCL 0.1% eyedrops (used to treat itchy eyes), but there were no directions for use. -There was an order for olopatadine HCL 0.2% eye drops, but there were no directions for use. a. Review of Resident #3's physician's orders dated 03/10/23 revealed: -There was an order for olopatadine HCL 0.1% eye drops, instill 1 drop into both eyes twice daily. -There was an order for olopatadine HCL 0.2% eye drops, instill 1 drop into each eye once daily. Review of Resident #3's pharmacy review dated 12/01/22 revealed: -There was a comment to Resident #3's primary care provider (PCP) documenting Resident #3 appeared to have started a new dose of olopatadine 0.2%, 1 drop in both eyes daily on 11/22/22. -The review documented the electronic medication administration record (eMAR) showed the previous dose of olopatadine 0.1%, 1 drop in both eyes twice daily still being administered as well; please clarify. -The PCP's response was to continue olopatadine 0.2% and discontinue 0.1% (not covered).	D 367		

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D 367	Continued From page 51 Review of Resident #3's eMAR for January 2023 revealed: -There was an entry olopatadine HCL 0.1% eye drops instill 1 drop into both eyes twice daily at 8:00am and 4:00pm. -There was documentation olopatadine was administered for 62 of 62 opportunities from 01/01/23 to 01/31/23. Review of Resident #3's eMAR for February 2023 revealed: -There was an entry for olopatadine HCL 0.1% eye drops instill 1 drop into both eyes twice daily at 8:00am and 4:00pm. -There was documentation olopatadine was administered for 54 of 56 opportunities from 02/01/23 to 02/28/23. Review of Resident #3's eMAR from 03/01/23 through 03/14/23 revealed: -There was an entry for olopatadine HCL 0.1% eye drops instill 1 drop into both eyes twice daily at 8:00am and 4:00pm. -There was documentation olopatadine was administered for 27 of 27 opportunities form 03/01/23 to 03/14/23. Observation of medications available for administration for Resident #3 on 03/14/23 at 3:54pm revealed: -Olopatadine HCL 0.1% was not available for administration. -Olopatadine HCL 0.2% was available and was dispensed to the facility on 02/21/23. Interview with a pharmacist at the facility's contracted pharmacy on 03/14/23 at 3:23pm revealed: -There was a clarification order dated 11/21/22	D 367		

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D 367	Continued From page 52 that confirmed Resident #3 was to continue olopatadine 0.2% and discontinue olopatadine 0.1%. -The pharmacy entered a stop date for the olopatadine 0.1% on 11/21/22. -Olopatadine 0.1% should not be on the eMAR and should have been discontinued as ordered on 11/21/22. -When the pharmacy entered a stop date for a medication, someone from the facility had to approve or reject the order; there was no information in the pharmacy's system as to whether the stop date for olopatadine 0.1% was approved or rejected by the facility. Interview with a medication aide (MA) on 03/14/23 at 4:01pm revealed: -Olopatadine HCL 0.1% was not available on the medication cart. -Resident #3 had 2 eye drops on the medication cart which did not include olopatadine HCL 0.1% -There was only 1 eye drop with the name olopatadine and that was the olopatadine HCL 0.2%. -She did not notice olopatadine 0.1% was on the eMAR. -She compared the eMAR to most medications before administering them to residents, but there were some medications that she did not compare to the eMAR. -She administered medications that were available in the medication cart to residents and then came back and documented the medications on the eMAR as administered. -She assumed what was on the eMAR matched what was on the medication cart. Interview with a second MA on 03/15/23 at 4:25pm revealed: -When she administered medication, she looked	D 367			

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NAME OF PROVIDER OR SUPPLIER THE BRADFORD VILLAGE OF KERNERSVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 602 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 53 at the computer to see the medication, pulled the medication from the medication cart, administered the medication, then went back to the eMAR to document the medications that were administered. -She did not notice olopatadine HCL 0.1% was not on the medication cart and had not been dispensed by the pharmacy since 2022. She documented administration of olopatadine HCL 0.2%, but she did not realize she documented she administered olopatadine HCL 0.1% when it was not available on the medication cart. -If she had noticed olopatadine HCL 0.1% was not on the medication cart, she would have contacted the pharmacy to see what was going on. Interview with the RCC on 03/16/23 at 12:31pm revealed: -She contacted the pharmacy in 2022 regarding olopatadine for Resident #3 because there were 2 orders for olopatadine with different strengths. -The pharmacy told her they would discontinue olopatadine HCL 0.1%. -She had not reviewed the eMARs to ensure olopatadine HCL 0.1% had been discontinued. -When she administered medication, it looked like a duplicate order for olopatadine rather than 2 separate orders with different strengths and different directions. -She just documented both entries for olopatadine HCL 0.1% and olopatadine HCL 0.2%. -She administered medications on the medication cart to residents, and went back to the eMAR to check the medications off as administered. -She, the Administrator or any MA could have contacted the pharmacy regarding olopatadine.	D 367		

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D 367	Continued From page 54 Interview with the Administrator on 03/16/23 at 1:40pm revealed: -The RCC was responsible for conducting eMARs audits, but she helped when there were a lot of new orders. -There was not a set schedule to review eMARs. -The pharmacy entered new orders on the eMAR, but the orders would not show up on the eMAR until she, the RCC or a second shift MA approved or denied the order on the eMAR. -She looked for flags on the eMAR daily that indicated there was an order that needed to be approved or denied. -She thought MAs were not paying attention to what they were documenting as administered on the eMAR. -She expected MAs to pull the resident's medications from the medication cart, identify the medications on the eMAR and check off the medications that were pulled. -If the resident refused the medication or the medication was not administered for some reason, the MA should return to the eMAR to uncheck the medication prior to saving as administered. -She reached out to Resident #3's PCP regarding olopatadine, but she did not contact the pharmacy. -She expected MAs to reach out to the pharmacy regarding medication questions and if the MAs were too busy, they should have let her know so that she could contact the pharmacy. Telephone interview with Resident #5's primary care provider (PCP) on 03/16/23 at 3:30pm revealed: -Resident #3 only had a current order for olopatadine 2% eye drops. -Resident #3 did not have a current order for olopatadine 1% eyedrops.	D 367			

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D 367	Continued From page 55 b. Review of Resident #3's current FL2 dated 03/10/23 revealed diagnoses included hypertension, anemia, overactive bladder, Parkinson's disease, hyperlipidemia, type 2 diabetes, hypothyroidism, chronic pain, and bladder muscle dysfunction. Review of Resident #3's physician's orders dated 03/10/23 revealed there was an order for levothyroxine (used to treat hypothyroidism) 200mcg, 1 tablet every day. Review of Resident #3's physician's orders dated 02/04/22 revealed there was an order for levothyroxine 25mcg 1 tablet every morning, take together with 200mcg to equal 225mcg daily. Review of Resident #3's electronic Medication Administration Record (eMAR) for January 2023 revealed: -There was an entry for levothyroxine 200mcg 1 tablet daily scheduled for administration at 7:00am. -Levothyroxine 200mcg was documented as administered for 31 of 31 opportunities from 01/01/23 to 01/31/23. -There was an entry for levothyroxine 25mcg, 1 tablet daily each morning (Take in addition to current dose to equal 225mcg total.). -Levothyroxine 25mcg was documented as administered for 30 of 30 opportunities from 01/01/23 to 01/30/23. -There was documentation levothyroxine was discontinued from the eMAR on 01/30/23. Review of Resident #3's eMAR for February 2023 revealed: -There was an entry for levothyroxine 200mcg 1 tablet daily scheduled for administration at	D 367		

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D 367	Continued From page 56 7:00am. -Levothyroxine 200mcg was documented as administered for 28 of 28 opportunities from 02/01/23 to 02/28/23. -There was not an entry for levothyroxine 25mcg, 1 tablet daily each morning (Take in addition to current dose to equal 225mcg total.). Review of Resident #3's eMAR for 03/01/23 through 03/14/23 revealed: -There was an entry for levothyroxine 200mcg 1 tablet daily scheduled for administration at 7:00am. -Levothyroxine 200mcg was documented as administered for 14 of 14 opportunities from 03/01/23 to 03/14/23. -There was not an entry for levothyroxine 25mcg, 1 tablet daily each morning (Take in addition to current dose to equal 225mcg total.). Observation of medications available for administration for Resident #3 on 03/14/23 at 3:54pm revealed levothyroxine 25mcg and levothyroxine 200mcg were available for administration. Interview with a pharmacist at the facility's contracted pharmacy on 03/14/23 at 3:23pm revealed: -Resident #3 had a current order for levothyroxine 25mcg. -The order for levothyroxine was deleted from the eMAR in January 2023, but the pharmacy had not received an order to discontinue levothyroxine 25mcg. -Levothyroxine 25mcg should be taken in addition to levothyroxine 200mcg to equal 225mcg daily. Interview with a medication aide (MA) on 03/14/23 at 4:01pm revealed:	D 367		

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D 367	Continued From page 57 -She administered levothyroxine 200mcg in addition to levothyroxine 25mcg to Resident #3. -She documented she gave levothyroxine 200mcg, but she had not noticed levothyroxine 25mcg was not on the eMAR to document administration. -She compared the eMAR to most medications before administering them to residents, but there were some medications that she did not compare to the eMAR. -She administered medications that were available in the medication cart to residents and then came back and documented the medications on the eMAR as administered. -She assumed what was on the eMAR matched what was on the medication cart. Interview with the RCC on 03/16/23 at 12:31pm revealed: -She knew Resident #3 had an order for levothyroxine 200mcg and for levothyroxine 25mcg to be taken together. -The eMAR only had an entry for levothyroxine 200mcg and she had never seen an entry for levothyroxine 25mcg. -She did not know she needed to document levothyroxine 25mcg were administered. Interview with the Administrator on 03/16/23 at 1:40pm revealed: -She administered medications to residents including Resident #4. -She knew Resident had orders for levothyroxine 200mcg and levothyroxine 25mcg. -She asked Resident #4's primary care provider (PCP) about levothyroxine and confirmed Resident #4 should have received 200mcg and 25mcg of levothyroxine to total 225mcg. -She had not reached out to the pharmacy about adding an entry on the eMAR for levothyroxine	D 367		

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D 367	Continued From page 58 25mcg. -She thought that documenting on the entry for levothyroxine 200mcg covered the administration for levothyroxine 25mcg. -The RCC was responsible for conducting eMARs audits, and she helped when there were a lot of new orders. -There was not a set schedule to review eMARs. Telephone interview with Resident #5's PCP on 03/16/23 at 3:30pm revealed Resident #5 should have been administered levothyroxine 25mcg in addition to levothyroxine 200mcg. 2. Review of Resident #5's current FL2 dated 03/04/23 revealed: -Diagnoses included type 2 diabetes mellitus with diabetic polyneuropathy. -There was an order for Humalog (brand name for Novolog) kwik pen (a fast-acting insulin used to treat high blood sugar levels) 100 unit/ml inject per the sliding scale before meals. Review of Resident #5's physician's orders dated 03/07/23 revealed an order for Humalog kwik pen 100unit/ml inject before meals per sliding scale: 201-250=4u, 301-350=8u, 351-400=10u, 401 and greater give 12 units, recheck in 1 hour and call PCP. Review of Resident #5's electronic medication administration record (eMAR) for 03/07/23 through 03/15/23 revealed: -There was an entry for Novolog 100units/ml flex pen inject before meals per sliding scale: 201-250=4u, 301-350=8u, 351-400=10u, 401 and greater give 12 units, recheck in 1 hour and call PCP scheduled for administration at 8:00am, 12:00pm, and 5:00pm. -FSBSs ranged from 178 to 420.	D 367		

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D 367	Continued From page 59 -There was a space to document the site where insulin was administered and the fingerstick blood sugars (FSBS), but there was no space to document the amount of units administered. -There was no documentation of the amount of units administered for 15 of 24 opportunities 03/07/23 to 03/15/23. Observation of medications available for administration for Resident #5 on 03/14/23 at 3:54pm revealed Novolog insulin was available for administration. Interview with a medication aide (MA) on 03/15/23 at 3:49pm revealed: -Resident #5 did not have a space on his eMAR to document the amount of units administered per the insulin sliding scale. -Other residents had a space to document the amount of units administered. -She documented the amount of units administered for Resident #5's novolog in the exception notes section of the eMAR, but other MAs did not. -She had not talked to the Resident Care Coordinator (RCC) or the Administrator about there not being a space on the eMAR to document the amount of units given of Resident #5's Novolog. -She had not told the RCC or the Administrator because "They should know because they administer medications and insulin to Resident #5 too." -The Administrator was responsible for contacting the pharmacy regarding adding an entry to the eMAR. -The Administrator contacted the pharmacy regarding there not being a space on the eMAR for units of insulin administered for other residents, and the pharmacy made a space on	D 367		

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D 367	Continued From page 60 the eMAR for those residents. Interview with a second MA on 03/15/23 at 4:25pm revealed: -She did not notice there was not a space to document the amount of units of Novolog administered to Resident #5. -She normally just administered how many units she was supposed to according to the sliding scale without documenting it anywhere on the eMAR. Interview with the RCC on 03/16/23 at 12:31pm revealed: -She sometimes administered insulin to Resident #5 when she worked on the floor as a MA. -This was her first time working with a resident who had sliding scale insulin and she did not know units of insulin administered should have been documented on the eMAR. -She just found out on 03/15/23, from a MA that there was a space in the notes section of the eMAR where she could document units of Novolog that were administered. -She did not review eMARs and she had not been told she needed to review eMARs. Interview with the Administrator on 03/16/23 at 1:40pm revealed: -The RCC was responsible for conducting eMARs audits, and she helped when there were a lot of new orders. -There was not a set schedule to review eMARs. -When eMARs were reviewed, she or the RCC would only look for exceptions and refusals and would not pay attention to whether the amount of units of insulin administered were documented. -She only found out 03/15/23 that MAs could enter notes to document how many units of insulin were administered per sliding scale on the eMAR.	D 367		

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D 367	Continued From page 61 -She did not know the pharmacy could enter a space to document how many units of insulin were administered on the eMAR. -She had spoken to staff at the pharmacy before and was told they could not enter a space for the units of insulin administered. -She now expected the MAs to document the amount of units of insulin administered per sliding scale in the eMAR exceptions notes. Telephone interview with Resident #5's primary care provider (PCP) on 03/16/23 at 3:30pm revealed: -She expected the facility staff to administer Resident #5's Novolog per the sliding scale and document how many units of insulin were administered. -She would not be able to tell if Resident #5 received the correct amount of insulin if it was not documented. 3. Review of Resident #4's current FL2 dated 03/03/23 revealed diagnoses included type 2 diabetes, anemia and fracture of the left acetabulum. Review of Resident #4's physician's orders revealed: -There was an order dated 02/22/23 for Humalog (a fast-acting insulin used to lower elevated blood sugar levels) 100 unit/ml pen. Inject as per sliding scale; If FSBS (finger stick blood sugar) 180-200= 2 units, 201-250= 5 units, 152-300= 7 units, 301-350= 10 units, 351-400= 12 units subcutaneously (SQ) before meals and at bedtime. -There was an order dated 02/22/23 to discontinue Humalog and start Novolog (a rapid-acting insulin used to lower elevated blood sugar levels) 100units/ml flexpen "with same	D 367		

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D 367	Continued From page 62 directions". Review of Resident #4's February 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog insulin pen inject as per sliding scale; If FSBS (finger stick blood sugar) 180-200= 2 units, 201-250= 5 units, 152-300= 7 units, 301-350= 10 units, 351-400= 12 units. If below 70 or above 400 call MD. -Resident #4's FSBS ranged from 117 to 292 for 02/23/23 to 02/28/23. -There were spaces to document staff initials and FSBS at 6:30am, 11:30am, 4:30pm and 8:00pm each day. -There were no spaces to document the amount of units of insulin administered. -There was documentation Novolog was not administered for 4 of 22 opportunities due to held per orders from 02/22/23 to 02/28/23. -There was documentation Novolog was administered for 18 of 22 opportunities with no documentation for the amount of units administered from 02/22/23 to 02/28/23. -There were no exceptions notes entered for the amount of units administered per sliding scale from 02/22/23 to 02/28/23. Review of Resident #4's March 2023 eMAR from 03/01/23 to 03/15/23 revealed: --There was an entry for Novolog insulin pen inject as per sliding scale; If FSBS 180-200= 2 units, 201-250= 5 units, 152-300= 7 units, 301-350= 10 units, 351-400= 12 units. If below 70 or above 400 call MD. -Resident #4's FSBS ranged from 114 to 375 for 03/01/23 to 03/15/23. -There were spaces to document staff initials and FSBS at 6:30am, 11:30am, 4:30pm and 8:00pm. -There were no spaces to document the amount	D 367			

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D 367	Continued From page 63 of units of insulin administered. -There was documentation Novolog was not administered for 22 of 57 opportunities; with 9 opportunities due to resident refused, 13 opportunities due to held per orders from 03/01/23 to 03/15/23. -There was documentation Novolog was administered for 35 of 57 opportunities from 03/01/23 to 03/15/23. -There was documentation in the eMAR exceptions notes that 5 units of Novolog was administered on 03/14/23 at 8:43pm. Review of Resident #4's record revealed there was no other documentation for the amount of units of insulin the staff administered per sliding scale from 02/22/23 to 03/15/23. Interview with Resident #4 on 03/15/23 at 10:50am revealed: -He had not gotten all his medications since he was admitted 02/22/23. -He only received one kind of insulin injection since he was admitted, but he could not remember that name of the insulin. -He did not pay attention to the insulin or the amount he was administered. -He refused FSBS checks sometimes because he was tired of being stuck and felt his diabetes was under control. Observation of medications on hand for Resident #4 on 03/15/23 at 11:15am revealed there was a Novolog insulin pen available for administration and dispensed on 02/22/23. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/15/23 at 11:35am revealed: -Resident #4 had a physician's order for Novolog	D 367		

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D 367	Continued From page 64 insulin pen inject per sliding scale; If FSBS 180-200= 2 units, 201-250= 5 units, 152-300= 7 units, 301-350= 10 units, 351-400= 12 units. If below 70 or above 400 call MD. -Resident #4's Novolog insulin was dispensed to the facility on 02/22/23. -Pharmacy staff entered orders into the facility's eMAR system. -If the amount of units of insulin button was not activated when the order was entered; the entry would not include a space to enter the amount of units administered. -Novolog insulin was used to treat diabetes and the resident could experience high blood glucose levels if he did not receive his sliding scale insulin as ordered. Interview with a medication aide (MA) on 03/15/23 at 11:20am revealed: -She worked evenings and did not usually give Resident #4's insulin. -She administered his insulin 1 time and documented the amount of units she administered in the eMARs exceptions notes. -There was no other place in the eMAR or on paper that the MAs could document the amount of units administered. -She had not told anyone that there was no space to document amounts of insulin given. Interview with a second MA on 03/15/23 at 3:30pm revealed: -He worked evening shift and had obtained Resident #4's FSBS and administered his sliding scale insulin. -He did not enter the amount of units administered in the eMAR or anywhere else. -He was never told or shown how to enter the amount of units he administered in the eMAR exceptions notes.	D 367			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034069	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/16/2023
NAME OF PROVIDER OR SUPPLIER THE BRADFORD VILLAGE OF KERNERSVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 602 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 65 -He obtained Resident #4's FSBS and administered his Novolog according to the FSBS result and amount of insulin according to the sliding scale. -He did not know to tell someone that there was no space to document amounts of insulin given. Interview with the Resident Care Coordinator (RCC) on 03/16/23 at 12:30pm revealed: -Resident #4 had a sliding scale Novolog insulin order. -She also conducted MA duties and Resident #4 had refused to allow her to obtain his FSBS so she could administer his Novolog insulin to him as ordered. -She did not know until 03/16/23 that MAs were able to enter notes in the eMAR to document the amount of units of insulin administered or the pharmacy could enter a space to record the amount of units administered. -She had not contacted the pharmacy to inquire if they could enter a space to document the amount of units of Resident #4's Novolog sliding scale insulin. Interview with the Administrator on 03/16/23 at 1:40pm revealed: -The RCC was responsible to audit resident's eMARs, but she helped when there were a lot of new orders. -There was not set schedule to review eMARs and they would only look for exceptions and refusals and so would not pay attention if the amount of units of insulin was documented or not. -She only found out 03/15/23 that MAs could enter the amount of units administered per sliding scale in the eMAR system in the exceptions notes. -She did not know the pharmacy could enter a space to document the amount of units	D 367		

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER THE BRADFORD VILLAGE OF KERNERSVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 602 PINEY GROVE ROAD KERNERSVILLE, NC 27284		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 66 administered on the eMAR. -She had spoken to staff at the pharmacy before and was told they could not enter a space for the amount of units of insulin administered. -She now expected the MAs to document the amount of units of insulin administered per sliding scale in the eMAR exceptions notes. Telephone interview with Resident #4's primary care provider (PCP) on 03/16/23 at 3:10pm revealed: -He had diabetes type 2 and had an order for Novolog insulin per sliding scale before meals and at bedtime. -She expected the facility staff to administer Resident #4's Novolog per the sliding scale as ordered and document the amount of units given. -If he did not receive the correct amount of units of Novolog insulin as ordered he could have high blood glucose levels. -She would not be able to tell if he received the correct amount of units of insulin if it was not documented somewhere. -She would normally look at the eMAR on her visit, but she was not looking at his insulin on her last visit on 03/10/23.	D 367		