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FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034069	A. BUILDING: _____ B. WING _____	R 06/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey from 06/21/23 through 06/22/23.	{D 000}		
D 161	10A NCAC 13F .0504(a & b) Competency Eval & Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task. (b) The licensed health professional shall evaluate the staff person's knowledge, skills, and abilities that relate to the performance of each personal care task. The licensed health professional shall validate that the staff person has the knowledge, skills, and abilities and can demonstrate the performance of the task(s) prior to the task(s) being performed on a resident. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure a licensed health professional support (LHPS) competency validation had been completed for tasks including checking fingerstick blood sugar (FSBS) and administration of medication via injection for 1 of 3 sampled staff (Staff B).	D 161	10A NCAC 13F .0504(a & b) Competency Eval & Validation For LHPS Tasks To ensure compliance with these rule areas, The Business Office Manager will use a checklist for every new employee to ensure a licensed health professional support (LHPS) competency validation is completed for tasks including checking fingerstick blood sugar (FSBS) and administration of medication via injection. The checklist will be completed prior to allowing any staff member to work independently on tasks. The Administrator will audit the checklists and sign off on the checklist prior to the staff member working independently on tasks. Staff records will continue to be audited quarterly during QA audits.	06/30/2023

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Executive Director (X6) DATE 7/27/23

Reviewed and acknowledged 07/28/23. SG

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D 161	Continued From page 1 The findings are: Review of Staff B's medication aide (MA) personnel record revealed: -Staff B was hired on 04/13/23. -There was no documentation Staff B had completed the Licensed Health Professional Support (LHPS) competency validation checklist. Review of a resident's May 2023 electronic medication administration record (eMAR) revealed: -There was an entry to check fingerstick blood sugar (FSBS) four times daily scheduled at 7:00am, 11:30am, 4:30pm and 8:00pm. -Staff B had documented checking FSBS values 38 times from 05/01/23 through 05/31/23. -There was an entry for Novolog insulin (a rapid-acting insulin used to lower blood sugar), inject 5 units three times a day with meals, hold for FSBS less than 100 or if resident not eating, scheduled at 7:00am, 11:30am, and 4:30pm. -Staff B had documented insulin administration 36 times from 05/02/23 through 05/31/23. Review of a resident's June 2023 eMAR from 06/01/23 through 06/21/23 revealed: -There was an entry to check FSBS four times daily scheduled at 7:00am, 11:30am, 4:30pm and 8:00pm. -Staff B had documented checking FSBS values 24 times from 06/01/23 through 06/21/23. -There was an entry for Novolog insulin, inject 5 units three times a day with meals, hold for FSBS less than 100 or if resident not eating, scheduled at 7:00am, 11:30am, and 4:30pm. -Staff B had documented insulin administration 24 times from 06/01/23 through 06/21/23.	D 161		

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D 161	Continued From page 2 Interview with Staff B on 06/22/23 at 5:45pm revealed: -The Administrator re-hired her in April 2023 and she had worked for the facility previously. -She completed the LHPS competency validation checklist at the same time she completed the medication competency validation clinical skills checklist on 04/17/23. Interview with the Administrator on 06/22/23 at 5:10pm revealed: -She thought Staff B completed the LHPS competency validation checklist in April 2023 at the same time she completed the medication competency validation clinical skills checklist. -She was not aware that Staff B did not have an LHPS competency validation checklist. -The Business Office Manager (BOM) completed audits of the personnel records, and was not aware Staff B did not have the LHPS competency validation checklist because she did not know it was different from the medication competency validation clinical skills checklist. -She contacted the facility's contracted company that provided their staff training, but they were not able to find a copy of Staff B's LHPS competency validation checklist.	D 161		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure referral and follow up to meet the health care needs for 1 of 5	{D 273}	10A NCAC 13F .0902(b) Health Care To assure referral and follow-up to meet the routine and acute health care needs of residents, The RCC will ensure all outside healthcare referrals for appointments are scheduled within 48 hours of receiving the referrals from providers. The RCC will followup with the Administrator and provide a list of referrals received and appointments scheduled.	07/15//23

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{D 273}	Continued From page 3 sampled residents (#2) who had a referral to the pain clinic ordered. The findings are: Review of Resident #2's current FL2 dated 03/17/23 revealed diagnoses included schizophrenia, type 2 diabetes, chronic obstructive pulmonary disorder, and hypertension. Review of Resident #2's physician's order dated 04/21/23 revealed an order to refer Resident #2 to the pain clinic. Review of Resident #2's record revealed there were no appointment notes from the pain clinic. Interview with Resident #2 on 06/22/23 at 10:50am revealed: -He had chronic back pain for the previous 8 years. -His narcotic pain medication had been discontinued earlier this year. -His pain level was an 8 out of 10 on the pain scale at his baseline, but was sometimes better or worse. -He never got relief from his pain regardless of which medication he tried. -He thought he remembered his primary care provider (PCP) mentioning a referral to the pain clinic, but he could not remember when the conversation took place. -He had not asked the facility staff about when his appointment at the pain clinic was scheduled for. -He would like to have an appointment at the pain clinic. Interview with a medication aide (MA) on 06/22/23 at 2:50pm revealed:	{D 273}	RCC and BOM will coordinate and update the transportation calendars located in the Business Office and the RCC office. The Executive Director will follow-up with the RCC weekly to ensure referrals are scheduled. In the absence of the RCC, the Administrator will receive and schedule all healthcare referrals within 48 hours of receiving orders to assure referral and follow-up to meet the routine and acute health care needs of residents.	07/15/2023

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{D 273}	Continued From page 4 -Either the Resident Care Coordinator (RCC) or the Administrator were responsible for processing and scheduling referral orders and appointments. -Resident #2 never complained about pain or requested an as-needed pain medication from her. -Resident #2 had never asked her about an appointment with the pain clinic. Telephone interview with Resident #2's PCP on 06/22/23 at 4:15pm revealed: -She had referred Resident #2 to the pain clinic because she was no longer prescribing him pain medication. -Resident #2 never mentioned having pain to her other than chronic back pain. -Resident #2 had no change to his activity level when he was taking pain medication versus when she discontinued it and he was not taking pain medication. -She expected the facility staff to schedule the referral orders she wrote. Interview with the RCC on 06/22/23 at 4:50pm revealed: -In April 2023 when Resident #2's referral to the pain clinic was ordered, the facility had a transportation staff person who was responsible for scheduling and transporting residents to their appointments. -The transportation staff position was currently vacant, so she and the Administrator were in the process of reviewing resident records to check for any missed appointments. -Resident #2's record had not been reviewed yet to ensure all referrals were completed. -She was aware that Resident #2's PCP had referred him to the pain clinic, because she had taken the order sheet and given it to the former transportation staff to schedule.	{D 273}		

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{D 273}	Continued From page 5 -There had not been any staff responsible for overseeing the transportation staff's work to ensure all referral orders had appointments scheduled. -Resident #2 had never complained to her about having pain or asked her about his appointment at the pain clinic so she had forgotten about his referral order. Interview with the Administrator on 06/22/23 at 5:10pm revealed: -The facility's previous transportation staff would have been responsible for ensuring Resident #2 had an appointment at the pain clinic. -The facility did not currently have a transportation staff person. -She had called both of the local pain clinics and neither one had been contacted to schedule Resident #2 an appointment in the previous few months. -Resident #2's referral to the pain clinic had been missed. -In the week that the facility had been without their transportation staff, she and the RCC had been looking through the residents' records to check for any missed appointments. -She knew about Resident #2's referral to the pain clinic, but she was not aware that he never received an appointment at the pain clinic. -Resident #2 had never asked her about an appointment at the pain clinic or mentioned having pain to her. -She had expected all referral appointments to be scheduled as ordered.	{D 273}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration	{D 358}	10A NCAC 13F .1004(a) Medication Administration	

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{D 358}	Continued From page 6 (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: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#1) related to vitamin supplements. The findings are: Review of Resident #1's current FL2 dated 03/24/23 revealed diagnoses included Type 2 Diabetes Mellitus, disorders of bone (unspecified), long term use of insulin, and abnormal weight loss. 1. Review of Resident #1's signed physician's orders date 03/24/23 revealed an order for vitamin D3 2000IU (a supplement used to treat vitamin D deficiency) one tablet daily. Review of Resident #1's primary care provider's (PCP) triage note dated 06/02/23 revealed an order to discontinue vitamin D3 2000IU. Review of Resident #1's June 2023 electronic medication administration record (eMAR) revealed: -There was an entry for vitamin D3 2000IU one tablet daily and scheduled for administration at 8:00am daily. -Vitamin D3 2000IU was documented as administered at 8:00am daily from 06/01/23 to	{D 358}	Continued From page 6 To 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, The community's RCC will receive all orders written by the residents providers. RCC will fax all orders to the pharmacy for filling and profiling of the order in the electronic MAR system. RCC will compare the instructions in the written order to the instructions profiled on the electronic MAR. If the orders match, the orders will be approved in the electronic MAR system. RCC will contact the pharmacy for discrepancies found. The RCC will verify medications, prescription and non-prescription, and treatments are received in the community within 24 hours of receiving the orders. The RCC will follow-up with the pharmacy for any orders not received, properly profiled or not discontinued. RCC will contact the prescribing provider for any issues that prevent order being received as written. RCC will sign and date orders when they are confirmed in the community and place the written orders in the box for filing in the residents chart. MAR and cart audits will be performed weekly by the RCC. Quarterly by the Administrator. In the absence of the RCC, the Administrator will perform all the tasks allocated to the RCC to assure that the preparation and administration of medications, prescription and non-prescription, and treatments are in compliance with the rule area.	07/15/23

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{D 358}	Continued From page 7 06/21/23. -There were 19 doses documented as administered after the order to discontinue vitamin D3 2000IU on 06/02/23. Review of Resident#1's medications on hand for administration on 06/21/23 revealed: -Resident #1's medications were dispensed in multidose packages. -The medications were dispensed in 14 days supply with medications scheduled for different times of administration packaged together. -Vitamin D3 2000IU was included in each day's supply scheduled for 8:00am administration. Telephone interview with a pharmacist at the contracted pharmacy on 06/21/23 at 3:35pm revealed: -She facility was supposed to fax all physician's orders, medication orders or triage notes related to medication change to the pharmacy for entering on the residents' eMARs. -There was no documentation the pharmacy received the order to discontinue Resident #1's vitamin D3 2000IU on 06/02/23. -The pharmacy had included vitamin D3 2000IU in the medications dispensed for 06/08/23 through 06/21/23 because they did not have an order to discontinue the medication. Interview with a medication aide (MA) on 06/21/23 at 3:25pm revealed: -She did not enter medication orders into the eMAR system. -The Administrator or the Resident Care Coordinator (RCC) approved orders entered by the contracted pharmacy. -The MAs did not routinely approve orders. -The MAs faxed medication orders to the pharmacy if they were working when the orders	{D 358}	Continued From page 7	

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{D 358}	Continued From page 8 were received. -The pharmacy sent residents' medications in multidose packages. -The MAs were supposed to verify the medications listed at time of administration with the medications in the multidose package and administer the medications. -She did not know Resident #1's vitamin D3 2000IU was discontinued on 06/02/23. Interview with the RCC on 06/22/23 at 4:00pm revealed: -She or the Administrator routinely reviewed all orders and triage notes from providers including the PCP. -All triage notes or orders received from providers other than the PCP were routinely placed in the PCP's information box at the facility to be reviewed by the provider before filing in the residents' records. -The orders were filed in the residents' records after being faxed to the pharmacy provider. -She had not seen the order to discontinue Resident #1's vitamin D3 2000IU. -The RCC was supposed to conduct routine audits of resident's medication administration including comparing medication orders to the medications on the eMAR. -Due to staff shortage, the RCC had not conducted any recent record audits. Interview with the Administrator on 06/21/23 at 4:15pm revealed: -The order to discontinue Resident #1's vitamin 2000IU should have been sent to the contracted pharmacy. -The PCP liked to review all medication orders or encounter notes related to medications, not written by the PCP, prior to filing in the residents' record.	{D 358}		

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{D 358}	Continued From page 9 -There was no signature for the PCP review on the triage note. -The Administrator or the RCC routinely fax all orders and triage notes with medication orders to the pharmacy. -The Administrator had not seen the order to discontinue Resident #1's vitamin D3 2000IU. -Apparently, Resident #1's order to discontinue vitamin D3 2000IU was filed in the resident's record before being faxed to the contracted pharmacy. -The Administrator had started conducting random record audits for comparing medications orders to the resident's medications listed on the eMAR. -The Administrator had not audited Resident #1's record. Telephone interview with Resident #1's PCP on 06/22/23 at 3:00pm revealed: -She did not write the order to discontinue Resident #1's vitamin D3 2000IU. -If the order was written on a triage note, by one of the on-call staff for the PCP, the order should have been processed when received. -Resident #1 should not be receiving vitamin D3 2000IU, and it should not pose any negative health concerns to still be receiving the medication. 2. Review of Resident #1's signed physician's orders date 03/24/23 revealed an order for vitamin B12 500mcg (a supplement used to treat vitamin B deficiency) one tablet daily. Review of Resident #1's primary care provider's (PCP) triage note dated 06/02/23 revealed an order to discontinue vitamin B12. Review of Resident #1's June 2023 electronic	{D 358}		

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{D 358}	Continued From page 10 medication administration record (eMAR) revealed: There was an entry for vitamin B12 500mcg one tablet daily and scheduled for administration at 8:00am daily. -Vitamin B12 500mcg was documented as administered at 8:00am daily from 06/01/23 to 06/21/23. -There were 19 doses documented as administered after the order dated 06/02/32 to discontinue vitamin B12 500mcg. Review of Resident#1's medications on hand for administration on 06/21/23 revealed: -Resident #1's medications were dispensed in multidose packages. -The medications were dispensed in 14 days supply with medications scheduled for different times of administration packaged together. - Vitamin B12 500mcg was included in each day's supply scheduled for 8:00am administration. Telephone interview with a pharmacist at the contracted pharmacy on 06/21/23 at 3:35pm revealed: -She facility was supposed to fax all physician's orders, medication orders or triage notes related to medication change to the pharmacy for entering on the residents' eMARs. -There was no documentation the pharmacy received the order to discontinue Resident #1's vitamin B12 500mcg on 06/02/23. -The pharmacy had included vitamin B12 500mcg in the medications dispensed for because they did not have an order to discontinue the medication. Interview with a medication aide (MA) on 06/21/23 at 3:25pm revealed: -She did not enter medication orders into the	{D 358}		

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{D 358}	Continued From page 11 eMAR system. -The Administrator or the Resident Care Coordinator (RCC) approved orders entered by the contracted pharmacy. -The MAs did not routinely approve orders. -The MAs faxed medication orders to the pharmacy if they were working when the orders were received. -The pharmacy sent residents' medications in multidose packages. -The MAs were supposed to verify the medications listed at time of administration with the medications in the multidose package and administer the medications. -She did not know Resident #1's vitamin B12 500mcg was discontinued on 06/02/23. Interview with the RCC on 06/22/23 at 4:00pm revealed: -She or the Administrator routinely reviewed all orders and triage notes from providers including the PCP. -All triage notes or orders received from providers other than the PCP were routinely placed in the PCP's information box at the facility to be reviewed by the provider before filing in the residents' records. -The orders were filed in the residents' records after being faxed to the pharmacy provider. -She had not seen the order to discontinue Resident #1's vitamin B12 500mcg. -The RCC was supposed to conduct routine audits of resident's medication administration including comparing medication orders to the medications on the eMAR. -Due to staff shortage, the RCC had not conducted any recent record audits. Interview with the Administrator on 06/21/23 at 4:15pm revealed:	{D 358}		

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{D 358}	Continued From page 12 -The order to discontinue Resident #1's vitamin B12 500mcg should have been sent to the contracted pharmacy. -The PCP liked to review all medication orders or encounter notes related to medications, not written by the PCP, prior to filing in the residents' record. -There was no signature for PCP review on the triage note. -The Administrator or the RCC routinely fax all orders and triage notes with medication orders to the pharmacy. -The Administrator had not seen the order to discontinue Resident #1's vitamin B12 500mcg. -Apparently, Resident #1's order to discontinue w vitamin B12 500mcg as filed in the resident's record before being faxed to the contracted pharmacy. -The Administrator had started conducting random record audits for comparing medications orders to the resident's medications listed on the eMAR. -The Administrator had not audited Resident #1's record. Telephone interview with Resident #1's PCP on 06/22/23 at 3:00pm revealed: -She did not write the order to discontinue Resident #1's vitamin B12 500mcg. -If the order was written on a triage note, by one of the on-call staff for the PCP, the order should have been processed when received. -Resident #1 should not be receiving vitamin B12 500mcg,and it should not pose any negative health concerns to still be receiving the medication.	{D 358}		
{D 367}	10A NCAC 13F .1004(j) Medication Administration	{D 367}	10A NCAC 13F .1004(j) Medication Administration	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034069	A. BUILDING: _____ B. WING _____	R 06/22/2023

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{D 367}	Continued From page 13 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 2 of 5 residents (Resident #1 and #2) related to documenting the amount of insulin administered to residents. The findings are: 1. Review of Resident #1's current FL2 dated 03/24/23 revealed diagnoses included Type 2 Diabetes Mellitus, disorders of bone (unspecified), long term use of insulin, and abnormal weight loss.	{D 367}	Continued From page 13 The facility RCC and Administrator will conduct a full audit of all residents electronic MAR (eMar) to ensure they are accurate and include (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). On going, the RCC will conduct weekly eMAR audits to identify any issues, clarify with providers and pharmacy to correct any issues or discrepancies that are discovered during the audits. Medication Administration training is scheduled with an RN for all medication aides of the community on August 22 and 23. The Administrator will audit a sampling of resident eMars monthly to help ensure continued compliance.	06/30/23 06/30/23 08/23/23

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{D 367}	Continued From page 14 Review of Resident #1's physician's order dated 05/03/23 revealed: -There was an order to check fingerstick blood sugar (FSBS) 3 times a day, before meals. -There was an order for Novolog (a rapid acting insulin used to treat elevated blood sugar) inject subcutaneously 3 times a day, before meals per sliding scale for blood sugar (BS) less than 150= 0 units, 150-200= 5 units; 201-250= 6 units; 251-300= 7 units; 301-350= 8 units; 351-400= 9 units, and greater than 400= 10units. Review of Resident #1's May 2023 electronic medication administration record (eMAR) from 05/04/23 to 05/31/23 revealed: -There was an entry for FSBS checks 3 times a day scheduled at 6:30am, 11:30am, and 4:30pm. -There was an entry for Novolog 100 units/ml insulin inject per sliding scale three times daily before meals, per sliding scale insulin (SSI) blood sugar (BS) less than 150= 0 units, 150-200= 5 units; 201-250= 6 units; 251-300= 7 units; 301-350= 8 units; 351-400= 9 units, and greater than 400= 10 units scheduled at 6:30am, 11:30am, and 4:30pm. -Novolog insulin was scheduled for administration at 6:30am, 11:30am, and 4:30pm daily. -There were 27 of 81 opportunities for administration of Novolog insulin per SSI when the amount of Novolog insulin administered was not documented. -On 05/24/23 at 6:30am, FSBS was 315, Resident #1 should have received 8 units and Novolog was documented as not administered due to withheld per doctor's orders. -On 05/31/23 at 6:30am, FSBS was 355, Resident #1 should have received 9 units and Novolog was documented as not administered due to withheld per doctor's orders.	{D 367}		

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{D 367}	Continued From page 15 -On 05/24/23 at 11:30am, FSBS was 498, Resident #1 should have received 10 units and Novolog was documented as not administered due to withheld per doctor's orders. -On 05/31/23 at 11:30am, FSBS was 340, Resident #1 should have received 8 units and Novolog was documented as not administered due to withheld per doctor's orders. -On 05/09/23 at 4:30pm, FSBS was 334, Resident #1 should have received 8 units and Novolog was documented as not administered due to withheld per doctor's orders. -On 05/20/23 at 4:30pm, FSBS was 288, Resident #1 should have received 7 units and Novolog was documented as not administered due to withheld per doctor's orders. -Resident #1's documented FSBS range for May 2023 was 105-597. Review of Resident #1's June 2023 eMAR from 06/01/23 to 06/22/23 revealed: -There was an entry for FSBS checks 3 times a day scheduled at 6:30am, 11:30am, and 4:30pm. -There was an entry for Novolog 100 units/ml insulin inject per sliding scale three times daily before meals, per sliding scale insulin (SSI) blood sugar (BS) less than 150= 0 units, 150-200= 5 units; 201-250= 6 units; 251-300= 7 units; 301-350= 8units; 351-400= 9 units, and greater than 400= 10units scheduled at 6:30am, 11:30am, and 4:30pm. -Novolog insulin was scheduled for administration at 6:30am, 11:30am, and 4:30pm daily. -There were 38 of 50 opportunities for administration of Novolog insulin per SSI when the amount of Novolog insulin administered was not documented. -On 06/05/23 at 6:30am, FSBS was 223, Resident #1 should have received 6 units and Novolog was documented as not administered	{D 367}		

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{D 367}	Continued From page 16 due to withheld per doctor's orders. -On 06/12/23 at 6:30am, FSBS was 194, Resident #1 should have received 5 units and Novolog was documented as not administered due to withheld per doctor's orders. -On 06/08/23/23 at 11:30am, FSBS was 232, Resident #1 should have received 6 units and Novolog was documented as not administered due to withheld per doctor's orders. -On 06/15/23 at 11:30am, FSBS was 271, Resident #1 should have received 6 units and Novolog was documented as not administered due to withheld per doctor's orders. -On 06/09/23 at 4:30pm, FSBS was 311, Resident #1 should have received 8 units and Novolog was documented as not administered due to withheld per doctor's orders. -On 06/20/23 at 4:30pm, FSBS was 225, Resident #1 should have received 6 units and Novolog was documented as not administered due to withheld per doctor's orders. -Resident #1's documented FSBS range for June 2023 was 63-421. Telephone interview with a pharmacist at the contracted pharmacy on 06/21/23 at 3:40pm revealed: -She had worked with the facility a few months ago to ensure the eMAR was documenting the time of administration, amount or insulin administered, and the site of injection. -She did not know why Resident #1's amount of Novolog SSI administered was blank on the eMAR. -There was no documentation the facility had contacted the pharmacy regarding Resident #1's eMAR not properly documenting the administration of Novolog SSI. -She would have worked with the facility to correct the problem.	{D 367}		

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{D 367}	Continued From page 17 Interview with Resident #1 on 06/22/23 at 10:00am revealed: -She received FSBS check 3 to 4 times a day. -The staff administered insulin every time her FSBS was above 150. -She documented FSBS checks most of the time in a notebook beside her chair. -She did not document how much insulin was administered. Interview with a medication aide (MA) on 06/22/23 at 2:55pm revealed: -She did not know if the residents' eMAR were audited by anybody at the facility. -She had been working a the facility since 04/13/23. -Resident #1 was the only resident currently receiving SSI. -The eMAR system was not working correctly for documenting Resident #1's SSI because the system asked for the amount of SSI administered first but would not allow a value to be entered. -She and other staff had to "enter not administered, withheld per doctor's orders" as an exception code to allow the screen to move to the next page; she documented the FSBS value, the computer displayed the corresponding amount of insulin to administer (which she entered),then the site of administration. She exited the administration at that point. -She assumed the amount of Novolog SSI was recording on the eMAR. -She did not know sometimes the eMAR documented the amount of Novolog SSI and other times it did not. Interview with the Administrator on 06/22/23 at 5:07pm revealed: -The facility had experienced a problem with the	{D 367}		

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{D 367}	Continued From page 18 eMAR system documenting insulin administration on diabetic resident in March 2023. -She had worked with a pharmacist at the contracted pharmacy at that time to correct the documentation for diabetic residents. -The eMAR was recording correctly for a while, but apparently it changed back to previous settings and was not documenting correctly at present. -Resident #1 was currently the only resident receiving SSI. -The amount of Novolog SSI administered was documented on some of the opportunities. -She had requested the MAs document the amount of Novolog SSI administered in the resident's medication note field of the eMAR but there were only 3 or 4 entries available for review. -She and the Resident Care Coordinator (RCC) were responsible for auditing residents's eMARs for accuracy. -Due to staffing shortages, the RCC had not had an opportunity recently to audit residents' eMARs. -She had not done a record audit for Resident #1 and did not know the eMAR was not accurate to show the amount of Novolog SSI administered. 2. Review of Resident #2's current FL2 dated 03/17/23 revealed: -Diagnoses included type 2 diabetes, chronic obstructive pulmonary disease, and hypertension. -There was an order for Novolog insulin (a rapid-acting insulin used to treat blood sugar spikes associated with meal consumption) inject 5 units three times daily with meals, hold for fingerstick blood sugar (FSBS) less than 100 or if resident not eating. Review of Resident #2's signed physician orders	{D 367}		

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{D 367}	Continued From page 19 dated 03/17/23 revealed an order for Novolog insulin inject 5 units four times daily as needed for FSBS greater than 450, recheck FSBS in one hour and notify primary care provider (PCP) if not lower. Review of Resident #2's May 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog insulin inject 5 units three times daily with meals, hold for FSBS less than 100 or if resident not eating, scheduled at 7:00am, 11:30am, and 4:30pm. -On 05/02/23 at 7:00am, FSBS was 229 and Novolog was documented as not administered due to withheld per doctor's orders. -On 05/04/23 at 7:00am, FSBS was 303 and Novolog was documented as not administered due to withheld per doctor's orders. -On 05/20/23 at 11:30am, FSBS was 285 and Novolog was documented as not administered due to withheld per doctor's orders. -On 05/30/23 at 11:30am, FSBS was 198 and Novolog was documented as not administered due to withheld per doctor's orders. -There was an entry for Novolog insulin inject 5 units four times daily as needed for FSBS greater than 450, recheck FSBS in one hour and notify PCP if not lower. -On 05/02/23 at 8:00pm, FSBS was 296 and Novolog 5 units was documented as administered. -On 05/11/23 at 7:00am, FSBS was 310 and Novolog 5 units was documented as administered. -On 05/30/23 at 11:30am, FSBS was 198 and Novolog 5 units was documented as administered. Review of Resident #2's June 2023 eMAR	{D 367}		

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{D 367}	Continued From page 20 revealed: -There was an entry for Novolog insulin inject 5 units three times daily with meals, hold for FSBS less than 100 or if resident not eating, scheduled at 7:00am, 11:30am, and 4:30pm. -On 06/09/23 at 11:30am, FSBS was 201 and Novolog was documented as not administered due to withheld per doctor's orders. -There was an entry for Novolog insulin inject 5 units four times daily as needed for FSBS greater than 450, recheck FSBS in one hour and notify PCP if not lower. -On 06/09/23 at 11:30am, FSBS was 201 and Novolog 5 units was documented as administered. Interview with Resident #2 on 06/22/23 at 10:50am revealed: -The medication aides (MAs) always checked his FSBS before each meal and at bedtime. -He received insulin before every meal; the only time he did not receive an insulin injection was if he was skipping the meal. -He would know if he did not receive his insulin before a meal and would ask for it, but he never had to ask. -He never received more than 5 units of insulin at a time. -He never needed his as-needed insulin for FSBS greater than 450. Interview with a MA on 06/22/23 at 2:50pm revealed: -The only time Resident #2 would not have received insulin before a meal was if he was not eating that meal and the insulin was held per his order. -She did not always document an additional note explaining why a medication was not administered, such as Resident #2 was skipping	{D 367}		

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{D 367}	Continued From page 21 a meal so his insulin was held, because Resident #2 rarely skipped meals. -There were no staff responsible for completing audits of the eMARs that she was aware of because nobody had ever asked her why she documented Resident #2's scheduled insulin as not administered. Interview with the Resident Care Coordinator (RCC) on 06/22/23 at 4:50pm revealed: -On 06/09/23 she thought she had documented erroneously and documented Resident #2's as-needed insulin as administered instead of his scheduled insulin. -Both of Resident #2's Novolog insulin orders, the scheduled and the as-needed, popped up on the eMAR screen right next to each other and looked the same until you clicked on one to read the full order. -On 05/11/23 she had documented both the as-needed and the scheduled insulin as administered to Resident #2, but had made a documentation error because she had never administered 10 units of insulin to Resident #2. -The Administrator audited the eMARs, but she did not know what she looked for during the audit or how often she completed the audits. Interview with the Administrator on 06/22/23 at 5:10pm revealed: -She was not aware of any documentation errors for Resident #2's insulin administration. -She audited insulin administration once per week but had not noticed erroneous documentation for Resident #2. -She expected the MAs to read the full entry on the eMAR prior to documenting insulin administration to ensure accuracy.	{D 367}		

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D 382	Continued From page 22	D 382		
D 382	10A NCAC 13F .1006 (f) Medication Storage 10A NCAC 13F .1006 Medication Storage (f) Medications requiring refrigeration shall be stored at 36 degrees F to 46 degrees F (2 degrees C to 8 degrees C). This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure medications requiring refrigeration were stored at temperatures between 36 degrees F to 46 degrees F. The findings are: Observation of the facility's medication refrigerator on 06/22/23 at 9:28am revealed: -There was an under the counter sized medication refrigerator located at the nurse's station/medication aide room. -On the outside of the refrigerator door, there was a handwritten sign that read "Do Not Turn Temperature Up!!". -The refrigerator had a compartment for freezing items located in the upper right corner of the refrigerator. -There was heavy build-up (2 to 3 inches thick) of frosted ice on the entire freezer section. -There was a facility refrigerator thermometer placed on the bottom shelf of the refrigerator. -The facility's medication refrigerator thermometer registered a temperature of 28 degrees F. (Temperatures below 32 degrees F can result in freezing of medications.) -There was no temperature log attached or located close to the refrigerator.	D 382	10A NCAC 13F .1006 (f) Medication Storage The facility will ensure Medications requiring refrigeration shall be stored at 36 degrees F to 46 degrees F (2 degrees C to 8 degrees C) at all times by keeping a temperature log daily to assure the temperature of the refrigerator is compliant to this rule area and the instructions of the medications. Daily temperatures will be recorded on the log by the medication aide on the "front hall" cart. any issues noted will be documented to the log and reported to the RCC immediately. The RCC will review the log twice a week on Monday and Thursday to ensure continued compliance. Completed logs will be stored monthly. In the absence of the RCC, the Administrator will complete the tasks assigned to the RCC.	06/23/23

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D 382	Continued From page 23 Observation of the medication refrigerator on 06/22/23 at 9:30am revealed: -There was a medication bottle containing 2 vials of injectable haloperidol decanoate in the door of the refrigerator close to the freezer compartment (Injectable haloperidol decanoate is used to treat psychosis.) -The contents of the vials was frozen as witnessed by turning the vials upside down and the liquid contents not moving. -After 3 minutes outside of the refrigerator, the contents of the vials moved around when inverted. Observation of the facility's medication refrigerator thermometer on 06/22/23 between 9:42am to 1:58pm revealed: -At 9:42am, the medication refrigerator's thermometer registered a temperature of 29 degrees F. -At 11:51am, the medication refrigerator's thermometer registered a temperature of 28 degrees F. -At 1:58pm, the medication refrigerator's thermometer registered a temperature of 20 degrees F. Further observation of the facility's medication refrigerator on 06/22/23 at 1:51pm revealed: -There were medications labeled for more than 12 residents stored in the refrigerator. -Medications stored in the refrigerator with full or partial cartons labeled with residents' names included: Levemir Flexpen prefilled syringes, Novolog Flexpen prefilled syringes, Tresiba FlexTouch prefilled syringes, insulin glargine prefilled syringes, (Levemir, Novolog, Tresiba and glargine insulins are injectable medications used to decrease blood glucose levels).	D 382		

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

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D 382	Continued From page 24 -Review of the manufacturers' storage recommendations of insulin products revealed the storage of all insulins instructed to avoid freezing and do not use if the product had been frozen. (Freezing insulin may alter the protein structure decreasing the potency. The American Diabetes Association recommends not using insulin that may have been frozen.) Observation on 06/22/23 at 1:53pm revealed the contents of a partial box of 5 Novolog Flexpen prefilled syringes dispensed on 04/17/23 for a resident had a distinct aroma and the aluminum seal on the rubber stopper of the syringe had separated indicating the insulin had expanded (as would be expected from freezing) and pushed the stopper out instead of the glass syringe bursting. Interview with the Administrator on 06/22/23 at 2:00pm revealed: -She knew medications should be stored above freezing, but did not know the exact temperature range for storing medications in the refrigerator. -She did not know the medication refrigerator was below 32 degrees F. -She checked the refrigerator occasionally for residents' insulin supply and expiration dates. -Once insulin was opened, it was routinely stored on the medication cart until used or the specified number of days had passed (routinely 28 days after opening for most prefilled syringes). -She checked the refrigerator last Saturday on 06/24/23, but was not sure if she observed the refrigerator's temperature on the thermometer. -She did not notice any frozen medications in the refrigerator, but she did not specifically check either. -The facility did not have a temperature log for documenting the refrigerator temperature. -She added the medication refrigerator	D 382		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034069	A. BUILDING: _____ B. WING _____	R 06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 382	Continued From page 25 thermometer a few months ago, but had not started a temperature log for routinely monitoring the medication refrigerator's temperature. -She knew the freezer section of the refrigerator needed defrosting and she had not assigned staff to defrost the refrigerator. -She had not taken the time to defrost the refrigerator's freezer due to staff shortage and having to work providing patient care and medication administration. -She acknowledged that an odor from the insulin syringe and/or the seal on the rubber stopper at the end of the syringe most likely indicated the insulin was or had been frozen. -She would call the contracted pharmacy's staff for guidance related to administering insulin that had frozen or potentially had been frozen. -There was no way to know if the refrigerator had gotten too cold today only or previous days. Interview with the Resident Care Coordinator (RCC) on 06/22/23 at 2:15pm revealed: -She did not check the medication refrigerator's temperature. -She was not able to identify the temperature range for medication storage when refrigeration was required. -She had never seen a refrigerator temperature log used at the facility. -She had not instructed medication aides (MA) to check and log the medication refrigerator's temperature for monitoring. Interview with a MA on 06/22/23 at 2:22pm revealed: -She had seen a thermometer on the bottom shelf of the medication refrigerator. -She had never been instructed to check the medication refrigerator temperature. -She had not checked the temperature in the	D 382		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 382	Continued From page 26 medication refrigerator. -There was no log for recording the medication refrigerator's temperature. -She was not able to identify the temperature range for medication storage when refrigeration was required. Telephone with a pharmacist at the contracted pharmacy on 06/22/23 at 2:35pm revealed: -Insulin that had been frozen should not be administered according to the manufacturers' storage requirements. -If there was no temperature log, all insulin stored in a refrigerator with a temperature below 32 degrees F would be treated as having been frozen. -Haloperidol decanoate was not supposed to be stored below 59 degrees F according to the manufacturer's storage requirements and once frozen it was no longer usable. -The facility would need to replace insulin and other medications with manufacturers' warning to do not use if frozen that were subjected to below freezing temperatures stored in the medication refrigerator.	D 382		